RESPONDING TO DRUNKENNESS IN SCOTTISH SOCIETY:

A SOCIO-HISTORICAL STUDY OF RESPONSES TO ALCOHOL PROBLEMS

Thesis
1389

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CONTENTS

Acknowledgements i

List of Tables iv

List of Figures v

1. Problem Drinking & the Sociology of Social Problems 1

The Sociology of Social Problems 2
Symbolic action, moral enterprise and bureaucratic imperatives 7
Alcohol problems and social control 11
The structure of the thesis 15

Notes 18

Part One - The Historical Landscape

2. Drunkenness in History & the Discovery of Alcohol Problems 19

Drinking and drunkenness in pre-industrial Scotland 20
The emergence of Temperance 23
Tee-totalism and legislative control 25
The era of legislative control 30
A natural history of Temperance? 35
Symbolic and instrumental aspects of Temperance 37
Temperance & the disease concept of alcoholism 49
Conclusion 54

Notes 55

3. Asylums for Drunkards: Ideology & Practice
Issues in the Treatment of Inebriates 60

Sober houses, reformatories, and retreats 62
The institutional structure 66
The operation of the Inebriates Act 71
Reformatory life and regimes of reform 75
The inmates' tale 85
Disinterest and decline 90
Conclusions 93

Notes 96

Part Two - The Contemporary Scene

4.	Researching the Contemporary Scene	101
	Aims of the study	102
	Working methods	103
	Designing the study	105
	The interview schedule	108
	The sample	113
	Fieldwork and representativeness of the sample	118
	Analysis and presentation of findings	120
	Reports, official statistics, and other documents	121
	Defining the limits	124
	Notes	125
5.	Thinking About Drunkenness: Problems of Professional Belief	127
	Professional beliefs	127
	The medical model	131
	Legislative control of drinking and drunkenness	140
	Social welfare	150
	Conclusions	153
	Notes	154
6.	The Nature and Extent of Alcohol Problems	157
	After Clayson: licensing reform ten years on	158
	Perceptions of alcohol problems	167
	Conclusions	171
7.	The Limitations of Medical Response and Responsibility	172
	The decline in medical interest 1918-1945	173
	Specialist treatment and general neglect: the medical response to alcohol problems 1948-1981	175
	Medical views of problem drinkers	179
	Conclusions: Wee DRAMS for G.P.s	186
	Notes	188

8. The Social Welfare Response to Alcohol Problems 190

Issues in social work policy & practice 191
Alcohol problems in social work caseloads 195
Perceptions of alcohol problems 197
Social workers attitudes to drinking and drunkenness 201
Managing the problem drinker 206
Conclusions: A new direction for social work? 209

Notes 213

9. Society's Dustmen: the police and public drunkenness 215
The drunken offender 216
Criminal justice attitudes to drinking and drunkenness 225
To arrest or not to arrest 232
Social police or society's dustmen? 236
Conclusions 241

Notes 242

10. Prosecuting Drunkenness 245

The drunk in court 245
Prison for the overdue 251
What should be done? 255
Keeping drunkenness offenders out of court 259
The limits of diversion 265
Coercive therapy versus constructive confrontation 268

Notes 272

11. The Future is a Serious Matter 275

Training and knowledge of alcohol related services 278
Conclusions: Back into the community 286

Notes 290

Appendix I: Summary of Scottish Office Notes of Guidance Relating to the Provision of Designated Places 291

Appendix II: The Interview Schedule 294

References 314

List of Tables

1.1	Dilemmas of social policy and professional response with problem drinkers	13
2.1	Tax revenue raised from alcohol, 1819-1985	27
2.2	The effects of war-time licensing restrictions on indicators of alcohol related harm	34
2.3	Spirits dealers in the West of Scotland, 1834	41
3.1	Dunlop's survey of crime and offences relevant to the Inebriates Act, 1898	72
3.2	Characteristics of Reformatory inmates by age, sex, marital status, and religion	80
4.1	Regional patterns of alcohol related harm	107
4.2	Distribution of research interviews	118
4.3	Comparison of achieved sample with police and social work populations, Scotland 1983	121
5.1	Professional ideologies & approaches to alcohol problems	130
6.1	Regular extensions of permitted hours granted, by period of extension, 1980	160
6.2	Perceptions of the seriousness of alcohol problems	167
7.1	Residential services and facilities for problem drinkers in Strathclyde Region, 1984	180
7.2	Non-residential services for problem drinkers in Strathclyde Region, 1984	180
8.1	Perceptions of problem drinking	199
8.2	Social work responses to positive and negative statements about drinking and drunkenness	200
8.3	Distribution of social workers in four ideological categories, by their response to moralistic and therapeutic items	204
8.4	Preferred referral agencies for social work clients with alcohol problems	208
9.1	Analysis of Central Scotland Police reports on drunkenness related offenders, 1981	218

9.2 Source of complaints in police encounters with public drunkenness 219

9.3 Age of drink related offenders 219

9.4 Sex of drink related offenders 221

9.5 Police responses to positive and negative statements about drinking and drunkenness 228

9.6 Distribution of police officers in four ideological categories, by their response to moralistic and therapeutic items 231

9.7 Perceived degree of intoxication of subject 234

9.8 Police perceptions of the demeanour of offenders 235

10.1 Suggested strategies for dealing with alcohol problems 256

11.1 Experience of alcohol education 279

11.2 Recommendations appropriate to those seeking help with an alcohol problem 282

List of figures

2.1 Drink in Scotland 1840-1914 30

2.2 Drunkenness arrests in Glasgow, 1862-1894 30

2.3 A ballad on the introduction of Sunday closing of public houses 31

2.4 Drink in Scotland, 1795-1840 39

3.1 Frontpiece of the first edition of the Proceedings 64

3.2 Timetable for Girgenti Inebriate Reformatory 81

4.1 Map showing research sites 117

5.1 Number and types of licences granted in Scotland, 1973 and 1983 148

6.1 Alcohol related mortality, 1970-1983 165

6.2 Hospital admissions for alcoholism and alcohol dependency, 1970-1982 165

6.3 Drunkenness in Scotland and England & Wales, 1970-1983 166

6.4 Drunk driving convictions in Scotland and England & Wales, 1970-1983 166

6.5 Social workers' estimates of the incidence of alcohol problems as a percentage of their total caseload 170

6.6 Drunkenness in Scotland, 1970-1983 170

9.1 Cartoon from the cover of *Police Review*, February 1984 227

10.1 The structure of the criminal courts in Scotland 247

10.2 Flowchart of the prosecution and diversion process in Scotland 250

1 Problem Drinking and the Sociology of Social Problems

This thesis explores the nature of responses to problems associated with drinking and drunkenness. The aim is to consider how perceptions and responses to the issue have changed over time, and, crucially, to analyze the implications of the resulting evidence for policy and practice. There are two interdependent issues which the thesis seeks to expose and debate. First there is the process of emergence, the historical development of alcohol abuse as a social problem. It is possible to see in the historical record the continuities and (just as importantly) the discontinuities of responses to drinking behaviour from the Industrial Revolution to the present day. It is important to realise that some important aspects of contemporary explanations of problem drinking are in fact 'hangovers' from an earlier tradition and, in particular, from the Temperance response to alcohol problems. Ultimately, however, this is a thesis about the practice of managing contemporary alcohol related problems. It is about how the modern institutional network of criminal justice, medical, and social welfare agencies perceive and respond to problem drinking in Scotland. How do police officers, procurators fiscal, magistrates, doctors, and social workers view problem drinking? How do they respond to the problem drinker? The thesis then is about attempts to control, treat, and/or rehabilitate deviant drinkers, but it is also about the attitudes, perceptions, and experiences of the individuals whose job it is to realise policy as practice.

In as much as it is based on the belief that in order to understand the modern system of management of the problem, it is necessary to understand how 'alcoholism' came to be defined as a social problem in the first place, the analysis is informed by perspectives and concepts that have been developed in the sociology of social problems. Chapter 1 considers the main features of this analytical framework and outlines the structure of the thesis.

The Sociology of Social Problems

The study of social problems, and of deviance in general, is an area of sociological inquiry that has developed rapidly since the 1960's. This development, accompanied as it was by a good deal of theoretical argument and earnest debate, contributed much to the intellectual vigour and excitement of the discipline.[1] As part of what Cohen (1976) described as "the sceptical revolution in criminology and the Sociology of Deviance" of the 1960's and 1970's, this whole area of sociological enquiry was subjected to a radical re-orientation. The old order, operating with what were seen as authoritative, standard, given, and incontrovertible concepts, was displaced by a new sceptical tradition. Concepts and terms such as 'deviant' that would once have been taken for granted were now being challenged. The sceptical tradition asked 'deviant to whom?' or 'deviant from what?'. When told that something was a social problem, it asked 'problematic to whom'? When certain conditions or behaviours are described as dysfunctional, embarrassing, threatening or dangerous, it asked 'says who'? and 'why?' (Cohen, 1973).

By challenging the naive scientism and ethnocentricity of the reigning theoretical orthodoxy, this new orientation provided a useful conduit for the introduction of fresh ideas into the study of social problems. The range of sociological inquiry expanded to include discourses which would have previously been regarded as the province of 'experts' and beyond the concerns of sociological researchers.[2]

There is no denying that the more traditional images and explanations have come increasingly under attack over the last two decades as a variety of social problems have been exposed to critical analysis. To understand the distinctive nature of the alternative analysis, this new orientation, and how it relates to the issue of alcohol problems, it is useful to know something of the critique of the social problems orthodoxy. The debate focused on four major themes.

First, there was a concern that the study of social problems had become isolated from the operation of the social control processes. Research and theories, it was argued, should do more than merely chart the characteristics and causes of deviant behaviour. What was required was an overall analyze of the nature of the social control processes. No understanding of deviant behaviour was possible without consideration of the interdependence between the control processes (responses), the deviant behaviour (actions) and the nature of laws, rules and norms. Increasingly it was argued that the nature and general shape of deviance could not be understood by studying deviants and their behaviour in isolation from the processes of defining and responding to the issues.

Secondly, there was a perceived need to challenge the assumption that the extant approach to the study of social problems was 'value free'. Even the most cursory review of the literature revealed a wide range of value positions masquerading as objectivity. The use of highly evaluative terms such as 'inadequate', 'disordered', 'disorganised', 'dysfunctional', 'undersocialised', were common. Therefore, it was seen to be important that such value judgements were explicitly made and openly discussed.

This general critique of value free sociology was coupled with a rejection of the 'scientism' which sought to identify the methodology of social research with a natural science, specifically positivist, approach to social phenomena. Typically, the concerns of positivists are characterised in terms of a preoccupation with issues such as operational definitions, objectivity, replicability, and causality (Giddens, 1974; Bryman, 1984). Only by applying the scientific standards of natural science, they argued, can scientific laws be discovered which might explain, and point the way to the amelioration of deviant behaviours. What positivism was seen to lack was any sense of history or process or any understanding of the meaning of the behaviour from the point of view of the actors (deviants) themselves.

Finally, the study of social problems had tended to emphasise the importance of explaining the aetiology of deviant behaviour as a means of predicting and/or preventing future occurrences. These explanations tended to be deterministic in nature and again failed to take account of the meaning of the behaviour from the point of view of the deviant or of the significance of social and institutional processes. The development of new, critical theories of deviance and social problems was predicated upon the acceptance of a more relative and context specific orientation and the rejection of the traditional absolutist position.

From the outset, this re-orientation was associated with the concept of labelling. Labelling theorists argued that the social processes by which deviance is defined and responded to are themselves subject to negotiation and, therefore, cannot be treated as unproblematic. In Becker's oft quoted phrase:

> Social groups create deviance by making rules whose infraction constitutes deviance and by applying those rules to particular people and labelling them as outsiders. From this point of view deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions of an 'offender' The deviant is one to who that label has successfully been applied: deviant behaviour is behaviour that people so label.
>
> (Becker, 1963:8)

The rules (laws) whose infraction form the basis of response activities thus become part of the research exercise, part of the explanation, rather than simply a means of defining the boundaries of investigation. Labelling stressed the need to examine the political nature of deviance and its control and the relationship between theory and ideology. But as Pearson (1975) has pointed out, labelling is a remarkable ambiguous perspective. In reality it is not a theory nor is it a proposition (Plummer, 1979). What it is, is a perspective which asks a series of questions about the 'nature', 'emergence', 'application' and 'consequences' of deviancy labels.

One of the main aims of the thesis, particularly in Part One, is to consider just these sorts of issue. What are the characteristics, the variations and forms of problem drinking

labels? What are the sources of the labels, historically, and societally? Above all, I am interested in understanding why 'the drink question' emerged as a social problem in Scotland when it did and in the form in which it did.

In order to understand alcohol problems it is necessary to analyze the nature of the phenomenom and how it was constructed and legitimated as a social problem demanding of some kind of official response. Fuller and Myers (1941) provides a useful starting point with their definition of a social problem as:

> . . . a condition which is defined by a considerable number of persons as a deviation from some social norm which they cherish. Every social problem thus consists of an objective condition and a subjective definition. The objective condition is a verifiable situation which can be checked as to existence and magnitude (proportions) by impartial and trained observers. The subjective definition is the awareness of certain individuals that the condition is a threat to certain cherished values.
>
> (Fuller and Myers, 1941:320)

Thus, Fuller and Myers argue that it is important to distinguish objective conditions from the definition of these conditions as social problems. In making this distinction, however, they do not deny the importance of objective conditions and, in fact, they qualified their definition by stating that, "the objective condition is necessary, but not in itself sufficient to constitute a social problem."

It was left to the next generation of social problems theorists - the social constructivists - to argue that the proper goal of the sociology of social problems was to account for the emergence, maintenance, history and conceptualisation of what is defined as a social problem and what should be done about it (Blumer, 1971; Rubington and Weinberg, 1971; Spector and Kitsuse, 1973). Viewed from this perspective, the debate about what constitute objective conditions deflects attention from what should be the central focus of analysis. For many constructivists it is the assertion that a problem exists, the claim-making activity *alone* that is crucial.

On this point, however, I must dissent. Constructivist sociology has many attractions. It offers a space for meaningful engagement between and across discipline's and traditions, something that the "creative falsehood" - the disease model of alcoholism - has conspicuously failed to achieve. Within this space the parameters of which are defined in terms of the history of conceptualisations and their relationship to social conditions and practices we can detect not only the sociological antecedents of perspectives such as Durkheim's and Weber's, but also influences and interests derived from Marxist-influenced critical theory, from the work of Foucault, and from the Khunian tradition.[3]

To accept Kitsuse and Spector's definition of the sociological of social problems as being concerned exclusively with the claim-making process would, I think, place serious limits on the sorts of intellectual and ideological interaction that have been so much a part of the developing interest in social constructionism. Certainly it is important that we understand the processes of construction and definition by which "individuals and groups become engaged in collective activities" that direct towards "putative conditions as problems" (Kitsuse and Spector, 1975:593). The development of 'the drink question' will be viewed from a natural history perspective. By this means one can investigate the processes of development; the 'emergence' of the issue with the anti-spirits movement of the 1830's; 'legitimation' (recognition and response) in the latter half of the nineteenth century; and the 're-emergence' of claim-making activities at various points throughout the twentieth century. But such an approach would be incomplete were we to ignore the interplay between ideas and their translation into action.

My concerns, therefore, are threefold; to outline the process of construction, to consider how the way the problem was defined influenced the formation of policy, *and* to examine the routine implementation of these polices as practice. A more complete account of the management of alcohol problems requires an approach that is sensitive to the historical and the contemporary context. The policing of public drunkenness, for example,

cannot be explained simply in terms of the historical legacy of Temperance legislation, but must take account of the way the policies (force orders) are mediated by interpretation on the street. I am also interested in the interaction between these processes and objective conditions.

At its best, when directing attention to the dialectic between social definitions and material circumstances, 'constructivist' accounts of the emergence and development of alcohol problems (re)introduce a specifically historical dimension to the study of social problems that the more mechanical 'natural histories' have a tendency to underplay.[4] Certainly, from my point of view, this is very much a part of the appeal of constructivism. At this level, the constructivist approach can be seen as part of an attempt by sociology to regain what one must call, for lack of a more precise term, its 'historicism'.

Symbolic action, moral enterprise and bureaucratic imperatives

These reservations notwithstanding, it is true that the constructivist approach places the issue of values and possible value conflicts at the centre of the analysis. Values are important not only for whether and how a situation is defined as a problem but also in how, or indeed if, the problem is responded to. Thus the emergence of 'the drink question' depended on the collective activities that were organised around the assertion that some putative condition(s) was a problem which ought to be eliminated, or ameliorated or, at the very least, controlled in some way.

This approach has been widely used in an attempt to explain the emergence of specific social problems and, through such case studies, as a means of developing different explanatory concepts. Perhaps the classic example is the debate that has surrounded attempts to explain creation of social control policies by the U.S. drug enforcement agencies. Two main questions were addressed: (i) why did these agencies seek to control, and ultimately to proscribe, the supply of narcotic substances to addicts, and (ii) what motivated them to

promote the introduction of additional laws against the consumption of other 'dangerous drugs' such as marijuana.

One side of the debate hinges on the importance of 'moral enterprise' and the 'moral entrepreneur' as explanatory concepts. According to Becker:

> Wherever rules are created and applied we should be alive to the possible presence of an enterprising individual or group. Their activities can properly be called "moral enterprise" for what they are enterprising about is the creation of a new fragment of the moral constitution of society, its code of right and wrong.
>
> (Becker, 1963:145)

The 'moral entrepreneur' is the archetypal rule creator. He is profoundly disturbed by some evil which he feels the the existing rules is unable to remedy. This is the 'crusading reformer'. According to Becker:

> He feels that nothing can be right in the world until rules are made to correct it. He operates with an absolute ethic; what he sees is truly and totally evil with no qualification. Any means is justified to do away with it. The crusader is fervent and righteous, often self-righteous.
>
> (Becker, 1963:147-48)

Therefore, following Becker, an adequate explanation is provided once the activities of a 'moral entrepreneur' have been identified and analyzed.

Dickson (1968) has argued, against Becker, that the narcotics enforcement agencies had a natural tendency to extend their power. Moral enterprise, therefore, is derived not from 'humanitarian' concerns, but from 'bureaucratic imperatives' - the need for bureaucratic institutions to perpetuate themselves. Rather than the moral entrepreneur mobilising the agency, according to Dickson the agency mobilises the individual or group.

Gusfield's analysis of the 'status politics' of the American temperance movement offers yet another theoretical perspective (Gusfield 1963). Gusfield draws a distinction between instrumental and symbolic action. The laws that were introduced and the other responses to alcohol abuse that were promoted by the temperance reformers were, he argues, primarily symbolic actions. Gusfield defines symbolic action as action in which "the object

referred to has a range of meaning beyond itself" (Gusfield, 1963:167). Thus temperance as 'disinterested reform' developed around moral, non-economic issues. The temperance reformers are seen to be involved in 'acting out' a drama which symbolically enhances the prestige and self-esteem of their status group and degrades the culture, values and life-style of the opposition.

This notion of symbolic action has been taken up by other social problems theorists. Platt (1969), for example, draws on similar themes to support his analysis of the role of the nineteenth century 'child saving movement' in 'inventing' (constructing) delinquency and introducing a system of juvenile justice in the U.S. He argues that the activities of the movement were related to 'a nostalgic allusion to the stability and intimacy of a pre-industrial way of life' (Platt, 1969:61) and to the changing role of middle-class women, in particular, who attempted to re-build the moral fabric of the society in line with this illusion. The changes were of both instrumental and symbolic significance. Instrumental in as much as they legitimated new career openings for such women. Symbolic because they also served to preserve their prestige in a rapidly changing society and institutionalised certain values and ways of life for women, children and the family. Platt see the 'child savers' as essentially disinterested reformers because they saw themselves engaged in a 'moral crusade, a matter of conscience and morality, and not one which sought to improve their economic or class interests.

These studies suggest some important questions and explanatory concepts that might be relevant to the analysis of alcohol problems. It might be useful to consider how far the concepts of moral enterprise, bureaucratic imperatives and symbolic action help to explain why the issue was recognised as a problem when it was.

Gusfield (1982) and Weiner (1981), both looking at aspects of the politics of alcohol abuse, have suggested that the way in which the problem is defined and conceptualised has

had a direct bearing on response strategies. Two concepts, 'ownership' and 'responsibility', are identified as being important for this process of conceptualisation.

Gusfield points to two usages of the term 'responsibility' - 'cognitive responsibility' which explains why a problem occurs, and 'political responsibility' which establishes responsibility for solving the problem.

Cognitive responsibility focuses attention on the factors or events which gave rise to the problem. So, for example, it might be argued that a major factor causing alcohol problems is to be found in the family background of the deviant drinker - the sons of alcoholic fathers are predisposed to become alcoholics themselves!

Political responsibility on the other hand focuses attention on policies. It attempts to answer two questions - what is to be done, and who ought to be responsible for doing it? Political responsibility is the assertion that some person or agency is responsible for preventing, ameliorating, or eradicating the problem. The problem drinker, for example, has often been seen as primarily the responsibility of the police and the criminal justice system. They are charged with doing something about the more public manifestations of alcohol problems, so that when things go wrong they are held to blame. As Gusfield points out, the concept of 'ownership of public problems' has:

> .... much in common with Howard S. Becker's concept of "moral entrepreneurs" but emphasizes two aspects of the process by which issues emerge in the public arena: (1) The diversity of "interests" and groups - including political officials concerned with power and economic groups with "pure" material concerns as well as "moral" reformists; (2) The specific impact of achieving, failing to achieve or preventing legitimate responsibility for leadership in solving public problems.
>
> (Gusfield, 1975:301)

Ownership refers to a group's ability to create and influence the public definition of a problem. The owners of the problem are seen to have credibility and public trust. They claim factual authority and moral leadership. The owners of the problem are crucial for establishing the 'facts' of the problem and for the capacity to fix political responsibility.

Establishing ownership of the problem, however, does not determine the content of these facts and the solutions implied or recommended. As Gusfield points out, quite often ownership and political responsibility may not vested in the same people or agency. It is not unusual to find that the 'owners' of a problem are concerned to ensure that others, not themselves, take responsibility for the issue.

The way(s) in which a problem is defined, then, has important implications for what (if anything) is done about it. The 'facts' of social problems are socially constructed:

> At every stage in this process human choices of selection and interpretation operate. Events are given meaning, and assumptions and values guide the selection. Public 'facts' are not like pebbles on the beach, lying in the sun and waiting to be seen. They must be picked, polished, shaped and packaged. Finally ready for display, they bear the marks of their shapers.
>
> (Gusfield, 1975:291)

It is not enough to be concerned with the processes by which alcohol abuse was recognised as a social problem, we must also recognise the importance of how the facts regarding the problem have been 'shaped' (Gusfield, 1975). The concepts of ownership, causal responsibility and political responsibility are useful in that they help elucidate the the process of construction. In understanding how alcohol problems have been defined and redefined, we should recognise the importance of the interplay between causal responsibility and political responsibility. The key to the policies and practices of responding to alcohol problems is in understanding the perceptions of the actors involved, and in particular their professional ideologies:

> We need to turn our attention to how certain issues. . . can come to take on an apolitical and technical appearance and can come to be the 'property' of socially-defined 'experts'. . . as intersubjective constructs.
>
> (Haines, 1979:123)

Alcohol problems and social control

The concepts of symbolic action, moral enterprise and bureaucratic imperatives may prove helpful in this analysis of alcohol problems. However, there are difficulties in the way these

concepts have been used and it is doubtful whether moral enterprise and bureaucratic interests can ever be sufficient explanatory variables. It cannot be assumed, for example, that all organisations will be willing or be able to act in a way that is consistent with the notion of bureaucratic interests. Not all agencies want to expand their sphere of influence and/or responsibility. Certainly, very few of the agencies that participated in this study viewed the possibility of expanding their involvement with alcohol-related problems with enthusiasm. Bureaucratic expansion, it seems, depends on a variety of factors both internal and external to the agency (Stein, 1980).

From this point of view an understanding of 'how the problem arose' and 'how it is responded to' requires that we take account of the involvement of the State in alcohol problems. As Single *et al* argue, the problems of alcoholism are no longer deemed to be 'private troubles' which must be dealt with alone, but are increasingly identified as the responsibility of the State. The increased involvement of the State with alcohol problems is associated with two other common trends: the rise of the welfare state and the medicalization of alcohol problems. As Single has pointed out, the development of welfare ideology has meant that the State has had to assume much of the responsibility for dealing with social problems:

> With the rise of the welfare state the state has become gradually more involved not only in regulating the economy, but also in assuming responsibility for the management of all kinds of social problems, including those deemed to be alcohol-related. . . . Further, increasing welfare state bureaucracies and professionalised alcohol treatment systems have developed as alternative means of social control. Increased state responsibility over the management of alcohol-related problems has, in this framework, allowed the state to broaden the definition of, and the intervention into, "alcohol-related" social problems.
>
> (Single, *et al*, 1981:5)

The changing role of the State or, more directly, the involvement of State sponsored agencies of social control is a crucial factor in understanding why and how certain forms of drinking behaviour are responded to as deviant. The way alcohol problems are defined and

policies developed is a product not only of the demands made by moral entrepreneurs who promote the issue, but also the response of different formal agencies of social control.

It is now generally recognised that such agencies have an important part to play in responding to alcohol problems (Advisory Council on Alcoholism, 1978). However, in acknowledging that fact it is also important that we critically analyze the different forms that intervention can take.

The central issues in developing policies and practices to deal with alcohol problems can be represented as two dichotomies - individual autonomy versus coercive intervention; and treatment versus control. Table 1.1 illustrates the range of options in terms of institutional responses to alcohol problems.

Table 1.1 Dilemmas of social policy and professional response with problem drinkers

Response	Individual Autonomy		versus	Coercive Intervention	
Therapeutic: medical/social welfare	**I**	1. Self-referral to treatment or counselling services		**II**	1. Case reporting of family crisis and mandated family intervention
		2. Guaranteed basic supports (e.g. income, housing, and health services)			2. Court-ordered delivery of services
			versus		
Legalistic: Police, courts, prison programmes	**III**	1. Formal Diversion: Detox & access to services and support if wanted		**IV**	1. Formal Diversion: Court ordered participation in alcohol treatment/education
		2. Discretion: Inconsistent or no access to services			2. Criminal prosecution

In some respects of course the options are not mutually exclusive and might more usefully be understood as points on a continuum. At one end of the continuum the response can be characterised in terms of empathy. Intervention is designed to be supportive, providing counselling and treatment services. Although most agencies put great stress on the voluntary nature of this sort of intervention, there has been a steady growth in the more coercive forms of intervention such as court-ordered diversion programmes.

At the other extreme responses tend towards more overt social control. Ideas of individual responsibility, 'blaming the victim' and the criminal prosecution of offenders are the norm.

Problems of professional ideology

Schema such as the one outlined above are a useful way of trying to specify the range of policy options that are currently available. And, of course, it is important to understand the ways in which the facts and the assumptions about alcohol problems impinge upon policies and practices. These issues will be discussed, particularly in Part Two of the thesis. However, in exploring the particular ways in which alcohol problems have been responded to, it is also important to recognise the influence which competing professional ideologies (operational philosophies) can have on the processes of definition and response.

Ideology here refers to the general beliefs held about human behaviour, its causes and how to change it. It is being used to characterize a shared or collective set of ideas that are an important influence on the work of groups such as social workers, police officers and health care professionals. In discussing the alternative accounts of alcohol problems that were provided by these different groups it seems at times that what we are seeing are very different ways of looking at reality. While the concept is here an ideal type referring to relatively abstract ideas and attitudes it is nevertheless clear that certain beliefs have been crucial in policy and practice. Chapter 5 will consider the main institutional approaches to

alcohol problems in more detail. In concluding this chapter, I will outline the overall structure of the thesis.

The Structure of the Thesis

The thesis falls into two parts. My main concern in Part One is with the historical processes by which deviant drinking came to be defined as a social problem. In order to understand the modern system of responding to alcohol problems it is necessary to have some understanding of how the issue developed over time. It is necessary to demonstrate and explain the emergence, the impact, and the implications of alcohol-related problems. In this respect the response activities of social control agencies - the criminal justice system, health care professionals, and (increasingly) social work practitioners - are central to the development of our knowledge of the issues.

Chapter 2 is devoted to an historical account of the developing concern about alcohol-related problems. Here I am primarily concerned with shifting definitions of appropriate drinking behaviour, and the changing patterns of social response. The issue has several facets. There is the matter of the 'claim-making' activities of the temperance movement and their influence on public policy both locally and nationally. For the most part, whether the discussion is of the temperance campaigns of the mid-nineteenth century or the Clayson reforms of the 1970's, the nature of this response was restrictive and legalistic. Policy options, however, were also shaped by other considerations and, in particular, by the emergence during the nineteenth century of new institutional forms of control. Part One finishes, in Chapter 3, by looking at an example the therapeutic and the legalistic nexus in practice. The Inebriate Reformatories (c1901-1921), not only serve to illustrate the growing importance of medical imagery (ideology), but also to argue that in practice there was a good deal of convergence between the medical model and the needs of the criminal justice system. Additionally, the experience of the inebriate institutions raises issues about coercive

treatment and so on that may have some relevance for the contemporary management of public drunkenness.

Having devoted the first part of the thesis to locating the issue of alcohol misuse in its historical and social context, Part Two carries the analysis forward in time, to the present day, and 'down', to consider how alcohol problems are responded to in practical terms by the rank-and-file of the various 'front line' agencies. The main emphasis is on the attitudes, perceptions, and experiences of those involved in responding to alcohol problems. These are: social workers and alcohol counsellors; police, procurators fiscal, sheriffs and lay magistrates; psychiatrists and general practitioners. Understanding the way in which the various agencies respond to alcohol-related problems depends upon an understanding not only of the nature of the problem, but also, albeit in very general terms, of the perceived role of a given agency. We need to have some understanding of the possible responses. And that is where Chapter 5 slots in. Chapter 6 assesses the nature and extent of alcohol problems and, in doing so, considers the effectiveness of some of the more recent alcohol control polices. Taken together, Chapters 5 and 6 set the scene for a study of the contemporary management of alcohol problems.

Chapter 4 provides a detailed methodology of the research project. In the course of this study, I interviewed over 300 people representing a range of criminal justice and social welfare agencies throughout Scotland. The background and design of the study is detailed and the basic concepts used in analyzing the data are explained. Chapters 7 to 10 present the findings of the study of present day responses and explore the various issues relating to institutional responses to alcohol problems.

Chapter 7 focuses on the continuing influence of the medical perspective. The concern is both with describing the background to the burgeoning of interest in alcohol problems in the last two or three decades and also with the role played by the medical profession (as distinct from medical ideology) in responding to the problem.

Chapter 8 considers the role of local authority and non-statutory social work provision. After discussing social workers' knowledge of and attitudes to alcohol problems, various conclusions are drawn. From the outset, it was clear that alcohol was a significant factor in many of the problems dealt with by social workers. Although increasingly aware of the situation, social work practitioners were not confident of the appropriateness, or the desirability, of social work intervention.

Chapters 9 and 10 concentrate on the criminal justice response to the problem. As *the* front-line managers of alcohol problems the attitudes and responses of the police are particularly important. The structural demands and organisational restraints, the continual negotiation of the policy and practices of police work, and the degree of discretion afforded individual officers, are all important factors in the police response to alcohol-related incidents. Chapter 9, therefore, concentrates on the theme of policing drunkenness.

Chapter 10 looks at the other half of the criminal justice equation the prosecution of drunken offenders. The processing of offenders through the criminal justice system is described. The chapter also deals with the reciprocal theme of alternatives to prosecution and outlines some of the possibilities.

In presenting this thesis, my intention was to go beyond the immediate demands of explanation or the discussion of theoretical perspectives and to make some contribution to the practical task of responding to alcohol problems. In this, as with so many other social problems, however, it has to be recognised that the relationship of theory to practice is a difficult one. It is impossible to talk with those people whose work demands that they deal with the consequences of alcohol abuse on a routine basis without being struck by the gap that exists between many of the grand theories and the realities of everyday practice. Cohen (1975) makes the point with reference to social work that the most familiar response to sociological wisdom can be summed up in the phrase, 'Its alright for you to talk'. I have

heard similar remarks (sometimes couched in more forthright language) from all of the agencies involved in this study:

> The implication is that, however interesting, amusing, correct and even morally uplifting our message might be, it is ultimately a self indulgent intellectual exercise, a luxury which cannot be afforded by anyone tied down by the day-to-day demands of a social work job.
>
> (Cohen, 1975:76)

The final chapter is in a sense a recognition that such criticism is not entirely without foundation. It attempts to draw the various strands of the research together to focus on the implications of the research findings for policy and practice in responding to alcohol problems.

Notes

1. See Taylor, I., P. Walton and J. Young, The New Criminology: For a Social Theory of Deviance (Routledge & Kegan Paul, 1973); Taylor, I., P. Walton and J. Young (eds), Critical Criminology (Routledge & Kegan Paul, 1975); Wiles, P. (ed) The Sociology of Crime and Deviance in Britain: Volume Two: The New Criminologies (Robertson, 1976); Downes, D. and P. Rock (eds), Deviant Interpretations; Problems in Criminological Theory (Robertson, 1979); Downes, D. and P. Rock, Understanding Deviance: A Guide to the Sociology and Rule-Breaking (Oxford University Press, 1982); Fine, B., R. Kinsey, J. Lea, S. Picciotto and J. Young, Capitalism and the Rule of Law: From Deviance Theory to Marxism (Hutchinson, 1979); Inciardi, J.A. (ed) Radical Criminology (Sage,1980).

2. Denise Herd's paper on the development of cirrhosis of the liver as a medical category (Herd, 1984), provides a rare example of the 'constructionist' approach being applied into an area of accepted medical expertise.

3. It would be less than honest of me not to mention that my membership of the International Group for Comparative Alcohol Studies (IGCAS) provided opportunities to observe this inter-disciplinary convergence at first hand. From my point of view, however, one event exemplified the possibilities of an historically informed 'constructivist sociology'. Some time after I had begun my research, I was fortunate enough to be asked to present a paper at a conference on *The Social History of Alcohol* that was being organised by the Alcohol Research Group in Berkeley, California. Apart from giving me an opportunity to meet and discuss with people whose work I had hitherto only read, this conference provided a very clear indication of the sort of convergence that is possible between disciplines as apparently diverse as social history, social anthropology, and sociology.

4. See Levine's account of 'the discovery of addiction' for an interesting example of this use of historical material (Levine, 1978).

Part One

The Historical Landscape

> Who shall be the rectors of our daily rioting? And what shall be done to inhibit the multitudes that frequent those houses where drunkenness is sold and harboured.
>
> (Milton, *Areopagitica*)

2 Drunkenness in History & the Discovery of Alcohol Problems

The opening chapter stressed the importance of studying the socio-historical development of social problems. In recognising that social problems are socially defined, it must be clear that no explanation that is confined to the motivation and behaviour of the individual can ever be considered complete. The sociology of social problems has to be concerned with the historical and comparative context of 'public issues' as social phenomena. Seen from this perspective, a major emphasis must be put on understanding how the definition of a problem has been "socially processed":

> Rather than investigating how institutional arrangements produce social conditions, we examine how individuals and groups become engaged in collective activities organised and directed towards establishing institutional arrangements, recognizing putative conditions as problems, and attempting to relieve, ameliorate, and eliminate them.
> (Kitsuse and Spector, 1975:593)

The importance of the context to any system of response is almost self-evident. It is clear for example that the drinking habits of modern industrial societies and the definition of deviant drinking behaviour are in important respects very different from those which obtained in earlier periods (Edwards, 1973; Heath, 1975). The point is not simply of academic concern, because much of the claim-making that has taken place around the issue rests on 'knowledge' that was socially produced and has significantly effected the way in which societies respond to alcohol problems. To understand the nature of contemporary responses to alcohol problems, it is, therefore, necessary that we consider the historical development of the issue.

In this chapter I will trace the "career" of alcohol abuse from its emergence, through the claim-making activities of Temperance alliances, to its legitimation and recognition as a social problem in the response activities of government and quasi-official institutions. Such

an approach will also reveal how the development of new institutional arrangements, particularly in the areas of medical science and criminal justice, influenced this "career".

Drinking and drunkenness in pre-industrial Scotland

Drunkenness has been a part of the Scottish web of experience for centuries. In Scotland, as in most cultures, habitual drunkenness has been subject to systems of constraint (Austin and Prendergast, 1983). It is only comparatively recently, however, in the last two hundred years or so, that drinking has come to be discussed in terms of the normal and the deviant and, more recently still, in terms of sickness and health. Until the late eighteenth century, the most striking historical characteristic of drunkenness in Scottish society was the intermittent nature of the public concern it provoked. Drunkenness did not noticeably exercise the authorities, church or State, nor did it have the taint of social disapprobation that it was to acquire in later years. Once we go back beyond that moment, and certainly as we go back into the seventeenth century, people no longer seem to be talking about the same thing when they talk about drinking and drunkenness.

At the outset of the industrial revolution alcohol was seen as part of the normal diet. It was valued as much for its supposed health giving, curative, and life-sustaining qualities, as for its intoxicating properties (Wilson, 1973; Spring and Buss, 1977). Drink was freely available and drinking was very much a part of everyday life. Home brewed ale was often used as a substitute for water not without good reason since drinking water was often polluted. Whisky, on the other hand, was the drink of hospitality which lent conviviality to many formal and informal social gatherings.[1] Smollett's *Henry Clinker* for example provides an interesting commentary on the drinking habits of the Scots. Describing the drunkenness that often attended weddings and funerals, he relates how Highlanders in particular made it a habit to "regale themselves with whisky; a malt spirit as strong as geneva." So habituated

to whisky were they that they drank it "in great quantities, without any sign of inebriation" (Smollett, 1929:288).

The perceived relevance of alcohol to all social occasions was so strong that, according to one writer, an inn close-by the Kirk was considered essential that the faithful might have access to food and drink between services (Mechie, 1960:81). Not even the ministers of the Kirk, though many acknowledged the widespread use of alcohol, could be said to be seriously concerned about habitual drunkenness. The Statistical Account of Scotland (OSA) which was published in the 1790's, affords us an interesting record of the parish ministers' views on a variety of issues relating to the social life of late eighteenth century Scotland. Many of the published accounts make no mention of drink at all.[2] Of those that do mention the subject, a fair number are not so much anti-drink, or even anti-drunkenness *per se*, as expressions of concern about the economic necessity of alcohol production. The minister of Urray, near Dingwall had 'no doubt' that the proliferation of whisky stills in the parish 'has a tendency to corrupt morals.' Nevertheless he was of the opinion that:

> ... the bad effects of this trade are less discernible than might be feared. Were the effects worse than they are, there is a fatal necessity of continuing the distillery, until some other manufacture be established in its stead, whereby the people will be enabled to find money to pay their rents.
>
> (OSA, VII, 1793:258)

There were of course those who habitually drank to excess, but the assumption seems to have been that such people could be dealt with by the normal processes of social control.

A number of writers have suggested that in the American colonies drinking was limited and managed within a network of community control. Drunkenness occurred and was punished, but it was seldom frequent or widespread (Gusfield, 1962; Parades, 1976; Lender, 1978). The same may be said of Scotland. Certainly, there were statutory controls on drinking and drunkenness. The earliest of these statutes dates from 1436 and provided

for the imprisonment not only of violators, but also of any "Aldermen and Bailies" who failed to carry out its provisions.[3] Habitual drunkenness was also punished. Church courts and later Justice of the Peace courts had powers to impose fines[4] or public rebukes on habitual drunkards. More serious sanctions such as the 'warding' (imprisonment) of drunkards, or the use of the 'jougs'[5], were also available but there is little historical evidence to suggest that such punishment was ever anything but rare (Cameron, 1983; Davies, 1980; Robertson, 1878).

The way in which the social control of drunkenness operated does not suggest that it was seen as a major social problem. We should, however, be wary of using the experiences, perceptions, or normative standards of today when attempting to analyze those other periods in history. Social concerns and norms change with time and so too does the interpretation that is placed on a particular behaviour such as alcohol abuse. In contemporary society we are accustomed to seeing the problem in terms of addiction, dependency, and/or illness. Alcohol is the problem. The pre-industrial view of addiction was radically different. Addiction at that time, in as much as the term had any meaning at all, referred to an habituation to drunkenness, not to liquor (Levine, 1978). The drinker not the drink was to blame. Those who were habituated to drink, abused alcohol because it was a self-indulgent pleasant experience.

By the end of the eighteenth century, the traditional network of social control by church and community had fallen into disuse. Admittedly, many of the problems which this system had addressed continued to elicit a response from the civil authorities. Justices of the Peace were as concerned as the Kirk with the need to regulate moral standards, "relaiting especially to the punishing of uncleane persons, drunkards, cursers and breakers of the sabbath" (Smith, 1980). Nevertheless, that the nature of that response was changing, moving slowly but perceptively towards regulation by an abstract system of justice by parliament, the police, the courts, and the prisons. Where drunkenness was concerned, this transition

was greatly aided by the emergence of the Temperance Movement and its campaign to promote alcohol abuse as a major social problem.

The emergence of Temperance

By the turn of the eighteenth century a new concern about the role of drinking and drunkenness in Scottish society began to be expressed in a variety of ways. Academics and churchmen began to speak out against the increasing use of 'ardent spirits'. In 1804, for example, Thomas Trotter published the first British contribution to the literature on alcoholism as a disease (Trotter, 1804). One or two attempts were even made around this time to introduce Temperance societies into Scotland (Hamilton, 1929:8-19).

These pioneering efforts met with little conspicuous success. The importance of Trotter's thesis was not immediately recognised, though it did stimulate some medical interest in the area. The nascent Temperance societies were stillborn. And as for the ministers, they were as likely to rage against the 'vice of tea drinking' as against drink.[6] Even so, there are indications that, among the rising middle class at least, traditional attitudes about drink and drunkenness were beginning to change and harden. Bourgeois society began to rethink its attitude towards 'license' of every sort and towards alcoholic license in particular. Middle class drinking was increasingly characterised by discretion, restraint, and by a general distaste for intoxication as a betrayer of dignity and respectability. Middle class drinking became less visible, an activity carried out by consenting adults in private. The intemperance of the urban working class became, by contrast, more visible. The banishment of drunkenness from polite society was in a sense a necessary condition for the rise of Temperance. Only as bourgeois drunkenness quit the public stage and drunkenness was redefined as a vice of the poor, only then could it be successfully promoted as a problem for respectable society. Out of this transformation of

beliefs and values there emerged one of the most influential mass reform movements of the nineteenth century - the Temperance Movement.

The first significant year in the history of British temperance is 1829. In October of that year John Dunlop, a Greenock businessman and magistrate, launched the Glasgow and West of Scotland Temperance Society (later restyled the Scottish Temperance Society). Dunlop was joined in the venture by William Collins, of the well-known Glasgow firm of booksellers and publishers, and together they toured both Scotland and England, giving lectures and distributing propaganda. By the summer of 1830, the movement claimed a membership of over 3000 and had launched the first Temperance periodical, the Temperance Society Record. Thereafter, the cause gathered momentum as men like Joseph Livesey responded to the call and devoted their not inconsiderable talents and organising energies to the crusade.

In this early phase the Temperance Movement was clearly able to promote drunkenness as a major social problem and at the same time establish its 'ownership' of the problem. It could also claim some official recognition, some legitimation of its claim, in the establishment in 1834 of a Select Committee to enquire into "the prevailing vice of Intoxication among the Labouring Classes of the United Kingdom." [7] Nothing came of the deliberations of the Select Committee and, in truth, little enough was expected of them (Harrison, 1968).

It is worth pointing out that the character of the temperance campaign in this early period was very different from that of the tee-total, prohibitionist image that comes down to us from the mid to late nineteenth century. Initially at least, Temperance was anti-spirits, not anti-drink, and as such did not oppose "the moderate us of ale, porter, or wine." There is no doubt that this anti-spirits movement saw itself as a paternalistic campaign dedicated to the moral reformation of the urban working class. It was, however, neither prohibitionist nor overtly political.

The paternalistic, non-prohibitionist ambitions of the anti-spirits crusade may have contributed to its initial success. These same factors, however, might also account for the movement's failure to thrive. At the end of the day, it seems, the anti-spirits message could command no mass audience. Whatever the reason, by 1836 the Scottish Temperance Society the organisational core of the anti-spirits movement had all but ceased to exist.

Tee-totalism and legislative control

The failure of the anti-spirits movement was followed by almost two decades of retrenchment and it is not until after 1850 that the drink question re-emerged as an issue in the mainstream of public and political debate. Now, however, it quickly became *the* issue for Victorian society, the common denominator that linked so many of the social problems that blighted the landscape of their brave new industrial world. The focus was still upon the reformation of the urban working class, indeed the fundamentally anti-working class ideology of evangelical Scottish presbyterianism would not allow it to be otherwise (Wood, 1972). The re-born Temperance Movement, however, was soon split by disputes over the aims and tactics to be pursued.

There were two major points of contention. First there was the struggle between those who favoured temperance, defined as moderation and the avoidance of 'ardent spirits', and the more militant advocates of total abstinence from all forms of alcohol. The total abstinence faction was ultimately triumphant and, thereafter, the Temperance Movement was identified with tee-totalism.[8] The second and in many respects the more important division concerned the means by which this tee-total goal was to be achieved. The debate finds its clearest expression in the struggle between the Scottish Temperance League (STL) and the United Kingdom Alliance for the Suppression of the Traffic in All Intoxicating Liquors (UKA)[9] over the question of 'moral suasion'. Put simply, the STL believed that the necessary moral reformation could be achieved through voluntary temperance. The UKA

took a very different line, arguing that, people's characters and morals being essentially flawed, it was necessary to impose legal controls on drink and drinking. Whereas the STL sought 'assimilative reform' (to use Gusfield's terms), the UKA, as its full title clearly indicated, pursued a more radical course, seeking the legal prohibition of the liquor industry through 'coercive reform' (Gusfield, 1963; Paton, 1977).

The debate was long and acrimonious, but the emphasis turned more and more towards the radical policies of tee-totalism and legislative control and, indeed, the whole tenor of the debate became increasingly coercive and prohibitionist. Tee-totalism and legislative coercion were seen as the key to re-establishing drunkenness as a social problem and prodding governments into some kind of response. The quickening tempo was marked by the enactment of the so-called Forbes-Mackenzie Act in 1853.

Opposition to legislative control

The reformers did not have it all their own way. Their ambitions in attempting to promote legislation to control the drink traffic brought them into contact with formidable vested interests, both inside and outside Parliament. The State itself had a substantial financial interest to protect. Government throughout the nineteenth century raised 30 - 40 per cent of its revenue from taxes on alcoholic drink (Table 2.1). At the height of this tax bonanza the Chancellor of the Exchequer, Robert Lowe, described the habitual drunkard as "the sheet anchor of the British Constitution" (Harrison, 1971:347). This from a Liberal, a member of the political party most closely identified with Temperance!

Table 2.1 Tax revenue raised from alcohol, 1819-1985

£1,000's

	Alcohol Revenue (A)	All Revenue (B)	% Alcohol Revenue (A/B)
1819	17,014	54,460	31.2
1829	16,932	52,523	32.2
1839	16,208	49,033	33.0
1849	16,356	54,325	30.1
1859-60	21,750	65,327	33.3
1869-70	24,899	66,727	37.3
1879-80	28,980	66,682	43.4
1889-90	31,162	78,678	39.6
1899-1900	41,686	108,496	38.4
1909-10	38,834	140,679	27.6
1919-20	133,873	998,960	13.4
1929-30	129,634	676,576	19.1
1939-40	130,806	1,049,189	12.5
1949-50	400,761	3,924,031	10.2
1959-60	390,72	85,630,529	6.9
1966-67	688,700	10,278,900	6.7
1976-77	2,364,000	35,283,582	6.7
1985	4,147,000	90,707,000	4.6

Sources:Wilson (1940); Harrison (1971); Annual Abstract of Statistics.

Bearing in mind Government's reliance on revenue from duty on alcohol and the influence of the drink lobby in Parliament,[10] it would be naive not to recognize the limitations of official responses to the promotional activities of the tee-totalers. Given the nature and extent of the vested interests ranged against tee-totalism, we must be more circumspect about the effectiveness of legislative coercion.

Perhaps we have got hold of the wrong end of the stick altogether when inferring that there was widespread support for legislation to control drunkenness. Was society in general really convinced of the need to respond to drunkenness by either punitive or therapeutic means? The more charismatic reformers such as Father Matthew might attract a

crowd of 50,000 to Glasgow Green (Handley, 1943:247), but did Temperance ever have more than a minority appeal? The rate of convictions for drunkenness offences and the consumption figures for the period, would suggest that there was a substantial body of people who were unlikely to embrace the temperance cause with any relish. Of course, no one canvassed the views of the working class community. There are no opinion polls to guide us and, since a large proportion of the population were politically disenfranchised throughout this period, most could not even express themselves via the ballot box. The rioting crowds who demonstrated against the restrictions imposed by the 1872 Licensing Act were no doubt making a point. Riots, however, offer a very imprecise mode for the articulation of grievances. It is not clear if the opposition was against the Act *per se*, or against the class bias inherent in its implementation.9

Resistance to the increasingly restrictive licensing system of the late nineteenth century, however, was not confined to the working class. Legislative initiatives continued to attract opposition from some sections of the middle class and even from the aristocracy. On the one hand, there were those who felt that capitalist society had more to fear from working men who think, than from those who drink (Public Houses Act Conference, 1857).[11] For others, the motivation was the preservation of individual freedom in the face of what was perceived to be increasing government interference. Lord Salisbury, in this respect, made something of a career of attacking social welfare measures which 'threatened' personal liberties.[12] The Times also reflected the strength of this wariness of State intervention when, as in 1878, it posed an age old question for the reformers, "Am I my brother's keeper?". The answer for The Times, as for a large section of the society, was a resounding no!

Reality, in the closing years of the nineteenth century, however, was moving (albeit slowly) in the opposite direction. State intervention on a wide range of issues was an increasingly obvious fact of life. Such intervention was not always successful. A fact well illustrated by the history of alcohol control policies. Whatever else they may have achieved,

the alcohol control policies of the late nineteenth century did not curb the drunken excesses of the Victorian working class. Figure 2.1 shows that consumption continued at very high levels even after the Temperance Movement had established itself as an influential political pressure group. This high level of consumption, together with equally high rates of convictions for drunkenness - a trend exemplified by the experience of Glasgow, 'the second city of the Empire' (Figure 2.2)[13] - continued throughout the remainder of the nineteenth century.

Accommodation to State intervention

The success of tee-totalism, if we call it that, was to involve the State in 'responsibility' for, if not 'ownership,' of the drink problem. By the close of the nineteenth century, drunkenness had been put firmly on the political agenda. In time, of course, the situation changed and the initiative moved away from the Temperance Movement, but in a very real sense tee-totalism had already defined the repertoire of possible responses. Tee-totalism, by its forceful propaganda and bureaucratic apparatus, helped redefine the social problems arena in such a way as to make possible the legislative control not only of working class drinking habits, but also of the social, cultural, and moral aspects of working class life. State intervention came to be accepted because it was the public interest that was now shown to be at risk and not merely the individual drunkard.

Habitual drunkenness was portrayed as a threat to economic advancement. The activities of the eugenics movement identified the drunkard with more general concerns such as national efficiency and the welfare of future generations. In this context, the family became the primary locus of intervention. One of the most common themes of temperance tracts was the threat which the drunkard represented to the family by his/her conduct. The contrast between the squalid home of the drunkard and the genteel home of the sober man was an enduring theme of temperance literature.

Figure 2.1 Drink in Scotland, 1840-1914

(proof gallons per caput)

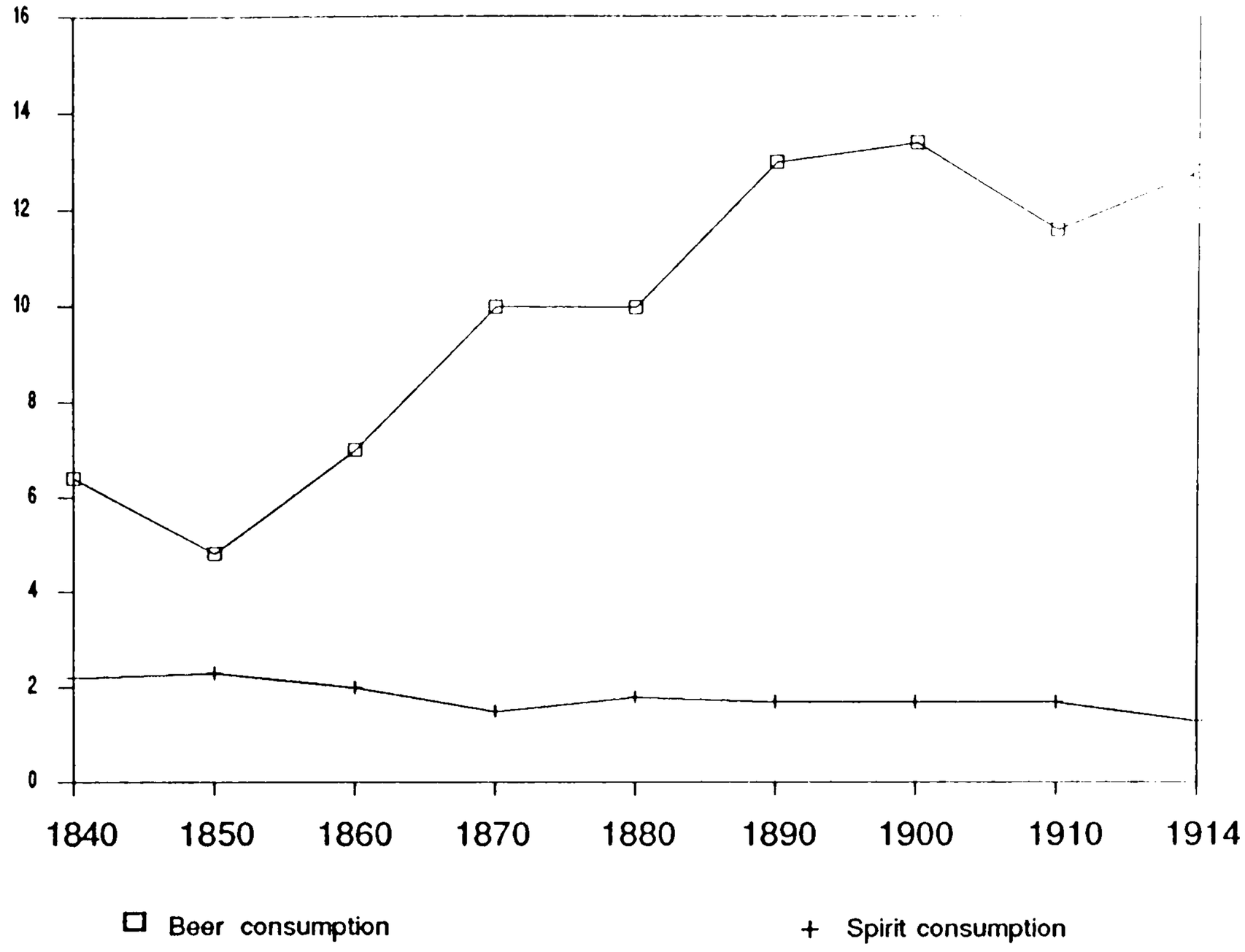
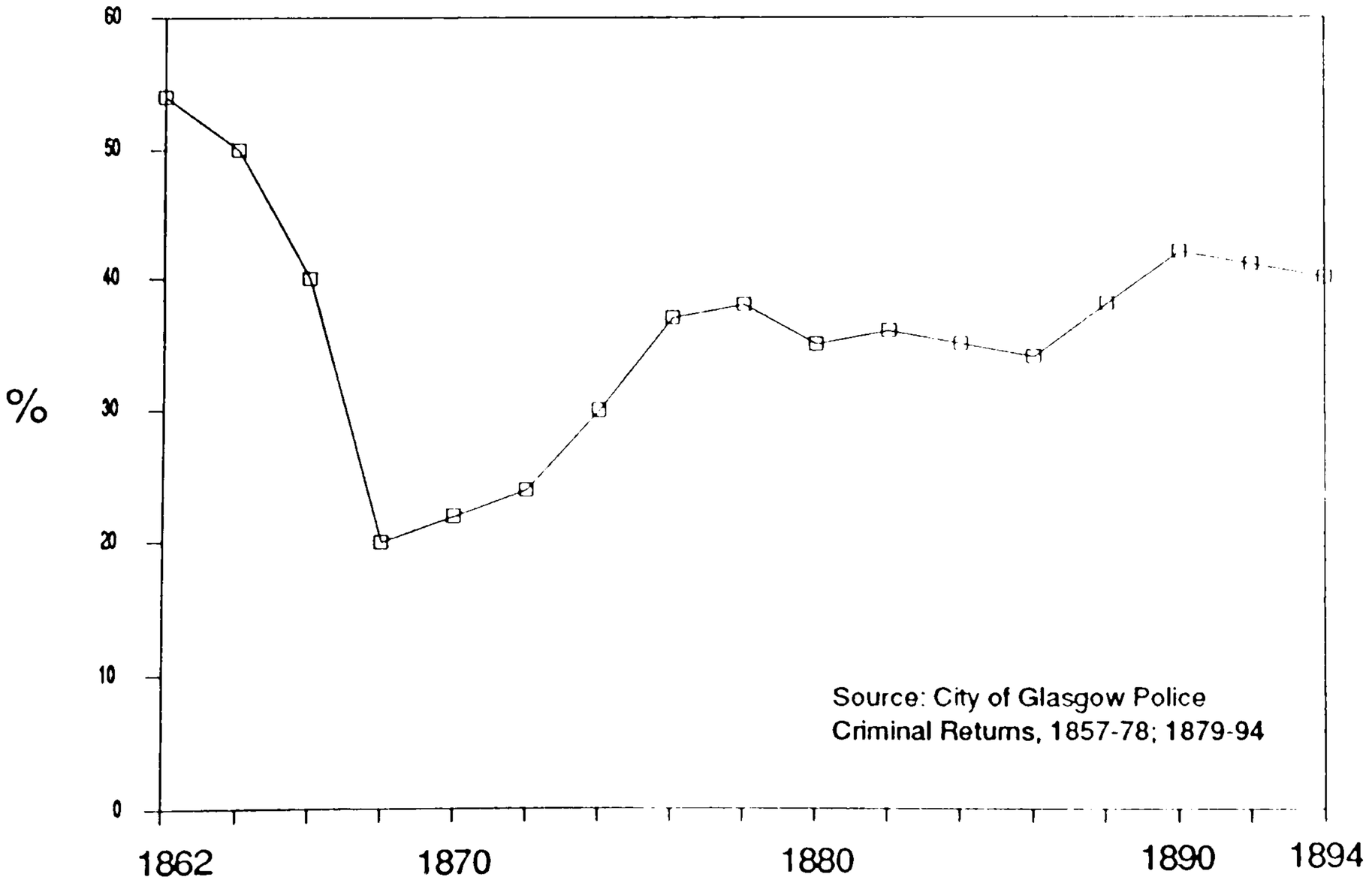


Figure 2.2 Drunkenness Arrests, Glasgow 1862 - 1894

(Percentage of all arrests)



Lighter and perhaps more popular ballads draw on a similar theme. The author of the ballad below (Figure 2.3) while 'puzzling' over the implications of the 1854 Sunday Beer Act, acknowledges the benefits for 'many a poor married woman' and 'hungary child'.

Figure 2.3 A ballad on the introduction of Sunday closing of public house

The Publican's
New Sunday Act

Now what do you think of this wonderful Act,
It has puzzled us all, sir, indeed 'tis a fact,
All day on a Sunday folks feel very queer,
And the publicans' ladies are trembling with fear.
When the clock's striking ten upon each Sunday night,
Up go the shutters and out goes the light.

* * *

Get ready, get ready, for out you must pop,
We are bound for to close, sir, at just ten o'clock ;
In the Commons and Lords they've passed a new Act,
To fine all the landlords, indeed 'tis a fact.

* * *

Now many a poor married woman 'tis said,
May have a new gown and a cap on her head ;
And many a hungry child his belly may fill,
'Cause his lushy old father can get no more swill.

* * *

In another six months, recollect what I say,
Public-houses through England won't open all day,
So on Saturday night you must all be complete,
And guzzle enough for to last you a week.

The era of legislative control

The passing of the Public Houses (Scotland) Act 1853 represented an important victory for the temperance cause in Scotland.[14] It was important not only as a signifier of official recognition of the social problem, but also because it illustrates a change of tactics on the part of the temperance campaigners. For the first time we see an attempt to make the drink-seller and not merely the drunkard subject to some degree of control. The Act closed ordinary licensed premises on Sundays - although so-called 'bona fide travellers' could still drink at hotels in (say) the neighbouring town - and introduced early closing (11pm) on weekdays. The Forbes-Mackenzie Act was reinforced by tighter regulations on the manufacture and sale of methylated spirits (Methylated Spirits Act 1855). The availability side of the equation was also tackled by doubling the duty on spirits and by giving the police greater powers to act against illicit distilling and the unlicensed sale of alcohol.

Building on its success with these initiatives, the temperance organisations established themselves as a political pressure group of some influence. Further confirmation of this influence, the ability to elicit a response from Government, came with the introduction of the 1872 Licensing Act. This Act, which set the pattern for licensing controls over the next hundred years, is often cited as the 'high water mark' of the Temperance crusade. Another goal of the Movement, permissive prohibition (local veto polls), however, was achieved on the eve of the First World War with the enactment of the Licensing (Scotland) Act 1913.

The pre-eminent expression of tee-total thinking - strict controls on the production, distribution, and retail of alcohol - was realised (for a brief moment) towards the end of the temperance era. Tee-total propaganda and organisational skill was no doubt important to the establishment of the Central Control Board. The crucial factor, however, was not Temperance pressure, but the unique demands of a nation at war.[15]

State control of liquor traffic

> Help the soldiers in their task ... Lord Kitchener suggests that in neighbourhoods where soldiers are stationed committees should be formed to educate public opinion on this subject ('treating' with drink), and bring home its importance to those who prevent our soldiers from being able to do their duty to their country in a thoroughly efficient manner.
>
> (Alliance News, November 1914:592)

Kitchener's appeal to the public to "refrain from the practice of treating" soldiers reflected the concern felt in many circles that intemperance interfered with the effective mobilisation of the nation for the war. The problem was felt to be particularly acute in areas around the National Munitions Factories. The "footloose and highly paid workforce" put considerable pressure on local amenities and, more to the point, greatly increased the patronage of local drinking establishments (Donnachie, 1982). Into a "quiet cities" such as Carlisle came thousands of "the navvy class whose hard drinking propensity is proverbial." As a result, according to at least one commentator, "the main thoroughfare of Carlisle was Bedlam" (Carter, 1918:200).

The Government responded by introducing measures to "extend the Defence of the Realm Consolidation Act 1914" and in May 1915 the Central Control Board (Liquor Traffic) was created under Lord D'Abernon. A system of limited nationalization and direct control of the drink trade was imposed in strategic areas. Carlisle and Gretna were joined in this 'experiment' by the naval base and dockyard at Invergordon on the Cromarty Firth and the area surrounding the Royal Small Arms factory at Enfield in Middlesex.

Under their powers of direct control the Board also suppressed licenses that were considered to be redundant or undesirable[16] and ordered the removal of alcohol advertising from outside public houses. The intention was that nationalised pubs should be simple, if not austere in appearance, with "plain windows with short green curtains and the name of the house set forth in simple white letters" (Donnachie, 1982:23).[17]

Public ownership was not limited to pubs. The demands of a wartime economy were used to justify not only State control of distribution and availability of alcohol, but also to direct control of production. As well as pubs and breweries, maltings, bottling stores, wine and spirits merchants' premises, and other properties were taken over (Brake and Williams, 1980:106). By the time the last purchases were concluded, in October 1916, 368 licensed premises of various kinds had been taken over - in the Carlisle area alone, 119 public houses and four breweries were taken into State ownership - and £883,265 had been paid in compensation.

What good did these draconian measure do? Smart (1974) has argued that the changes introduced by the Central Control Board had an immediate and significant effect on both the level of drunkenness and deaths from liver cirrhosis. This certainly accords with contemporary estimates of the situation. Lord D'Abernon, speaking in Paris in 1919 on the *Effects of War-time control on liquor traffic in England* (sic), offered the following statistics to support his claim that the restrictions had been a success:

Table 2.2 The effects of war-time licensing restrictions on indicators of alcohol related harm.

Indicator	Index 1913		Relative Index (1917) Male	Female
Convictions for drunkenness	100		22	34
Deaths from alcoholism	100		32	31
Deaths from cirrhosis	100		66.5	49
Attempted suicide	100		33	47
Cases of delirium tremens in certain districts	100		4.5	3
Suffocation of infants	100		57	
Absolute alcohol consumed	100	(1918)	40	

Source: Williams and Brake, 1980

The 1929 Royal Commission also supported the notion of public ownership. The Commission took the view that 'a prima-facie case of considerable strength' had been made in favour of public ownership and suggested that the 'Carlisle scheme' might usefully be tried in other areas of the country (Amulree, 1929-31:86). Although they never expanded beyond the immediate locality, many of the measures introduced by the Board were retained after the War. The last of the nationalised breweries in the Carlisle area only passed out of public ownership in 1971.

In the long term, as Smart acknowledges, the impact of the 'Carlisle scheme' is difficult to assess. Those who support licensing would no doubt take some comfort from the fact that the indices of alcohol harm never again returned to the pre-1914 levels, but there is no clear evidence that this trend is related to liquor control polices. As for the 'Carlisle scheme', perhaps the best that can be said is that its effects were 'moderate and transient' (Smart, 1974:119).

A natural history of Temperance?

The career of Temperance agitation can be made to 'fit' reasonably well with the natural history models that have been developed within the sociology of social problems. Take for example the most recent, the most sophisticated variant, that proposed by Spector and Kitsuse (1977). Their's is a four-stage model in which Stage 1 (emergence) and Stage 2 (recognition) parallel the development of the anti-spirits movement from its foundation in 1829 to the recognition of its legitimacy in the establishment of the Drunken Committee in 1834:

> Stage 1: Group(s) attempt to assert the existence of some condition, define it as offensive, harmful, or otherwise undesirable, publicize these assertions, stimulate controversy, and create a public or political issue over the matter.
>
> Stage 2: Recognition of the legitimacy of these group(s) by some official organization, agency, or institution. This may lead to an official investigation, proposals for reform, and the establishment of an agency to respond to those claims and demands.

Stages 3 and 4 represent for Spector and Kitsuse a kind of "second generation" social problem in which the response to previous claims or in this case the relative lack of response forms the basis for a renewal of claim-making activity:

> Stage 3: Reemergence of claims and demands by the original group(s); or by others, expressing dissatisfaction with the established procedures for dealing with the imputed conditions, the bureaucratic handling of complaints, the failure to generate a condition of trust and confidence in the procedures and lack of sympathy for the complaints.
>
> Stage 4: Rejection of complainant group(s) of the agency's or institution's response, or lack of response to their claims and demands, and the development of activities to create alternative, parallel, or counter-institutions as responses to the established procedures.
>
> (Kitsuse and Spector, 1977:142)

Stage 3 (re-emergence) could clearly be identified with the activities of groups like the STL and the UKA Stage 4, however, is much more problematic and indeed Spector and Kitsuse clearly intend that any move to Stage 4 activities should be seen as contingent upon the perceived lack of responsiveness of existing agencies. Certainly in so far as the main thrust of Temperance agitation is concerned, there is no sense that group activities were developed in the belief that it was no longer possible to "work within the system". On the contrary, the activities of the prohibitionist wing in particular seemed to run in the opposite direction. Far from challenging the legitimacy of established institutions, they were demanding an expansion of responsibility and more official involvement in responding to alcohol problems.

The concept of natural history, if it does anything, provides a useful means of focusing attention on the claim-making activities of those groups which sought to promote habitual drunkenness as a social problem. It is important that we understand something of the process by which the problem we now call alcoholism was defined (constructed) as a social problem. And in part at least I have now covered that ground. I have provided answers to the when, where, and who questions, but I have not said much about the motivation that provided the impetus for the Temperance crusade.

Symbolic and instrumental aspects of Temperance

At the beginning of the industrial period there was no discernable widespread support for the belief that drunkenness was a major social problem. Less than a hundred years later, the Temperance Movement had been successful in promoting the issue and was, in turn, set to become the largest, most enduring reform movement of the nineteenth century. How are we to explain this transformation? Why did the Temperance cause find a receptive audience at this point in time rather than 50 years earlier, or for that matter fifty years later?

There are at least three ways of looking at the problem. The first and most straight forward approach is simply to take the problem as a given. Put simply, the Temperance Movement developed when it did because of objective conditions, specifically the increasing availability of alcohol, led to increases in both per capita consumption and drunkenness. In the context of an industrialising society experiencing major social, political, and economic changes, heavy drinking and habitual insobriety came to be seen as a legitimate cause for concern.

The second approach to the development of Temperance attempts to shift the focus of attention, to unpackage the 'given' and to look at the motivation of the claim-making group. This approach focuses on the symbolic dimensions of Temperance agitation and identifies Temperance with the interests, prestige and status of the rising middle class. Probably the best known example of the argument is that advanced by Joseph Gusfield in his classic study of the American Temperance Movement, Symbolic Crusade (1963).

Finally, there is an approach which sees economic and political interests as being of paramount importance. Unlike Gusfield's work, this approach focuses on the instrumental dimensions of the Temperance phenomenon. Social control and the demands of industrial production are seen as the key factors in understanding the development of the Temperance Movement. Let us consider each of these three ways of interpreting the rise of Temperance in turn.

The rising tide of whisky drinking

Let us start from a consideration of the 'objective conditions' which underpinned the debut of the Temperance Movement in the early nineteenth century. For the temperance reformers themselves, and for many later commentators, the increasing availability and consumption of alcohol was the major impetus for the foundation of the Temperance Movement. The crucial factor was the increasing availability and consumption of 'ardent spirits', particularly in the towns and cities of the industrial belt, and the deleterious effect this had on moral standards. Surveying the situation in Scotland after a visit to France in 1828, Dunlop expressed 'sceptical astonishment' that:

> ... there could be so little difference in outward morals between two countries, one of which (Scotland) so excelled the other in all religious privileges. How a nation of papists and infidels could vie in the duties of life with one which possessed not only a pure church and upright confession of faith, but with whom the Bible was in form at least received as the test and spring of all ethical purity.
>
> (Dunlop, 1932:59)

Secure in his belief in his nation's religious and moral purity, Dunlop had, nonetheless, to account for the "contaminating forces" which counteracted the "benefits of exquisite perception of right and wrong". The answer, as William Collins was to tell the 1834 Drunken Committee, was drink. Drunkenness, said Collins, though a growing problem of urban living:

> ... did not advance rapidly, however, till 1822, when the duty (on whisky) was reduced: at that period a great and decided increase took place ... We thought it would be only a short and sudden ebullition of drunkenness ... but in that we were deceived.
>
> (Report of the Select Committee on Drunkenness, 1834, vol VII:177)

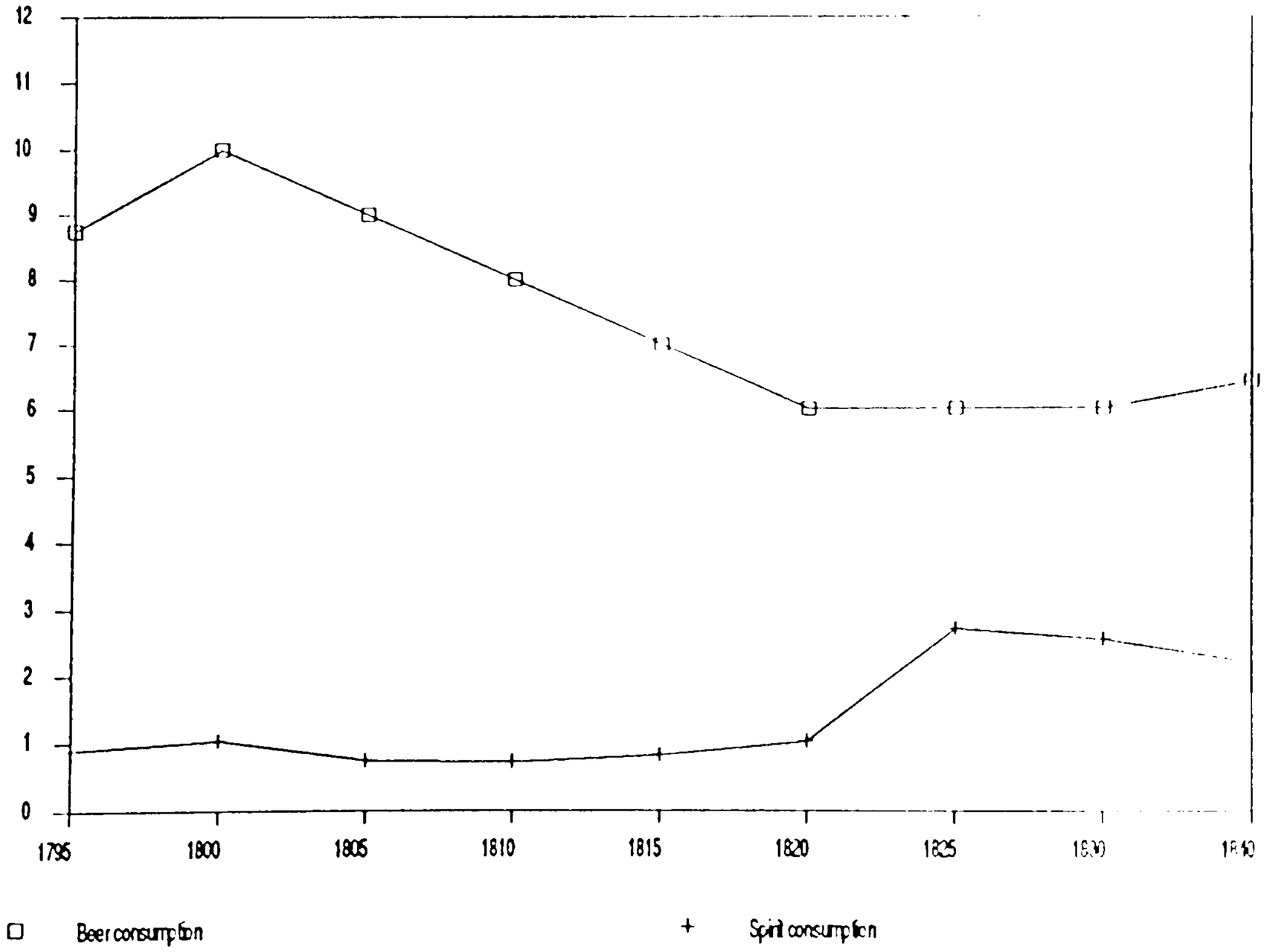
It is worth noting that the problem was not simply the drinking or even drunkenness of the 'lower orders'. For the temperance reformers, the drink question, the impact of alcohol on a developing industrial workforce, was dominated by concern about the emergence of whisky as the national drink.

Whisky drinking appears to have been popularised in Lowland Scotland sometime towards the end of the eighteenth century. The rise in population and the trend towards urbanisation stimulated demand for most foods and drinks. Whisky was no exception and, according to at least one historian, it is almost certain that a per capita rise in spirit drinking took place at this time (Devine, 1975).

By the end of the eighteenth century there seems little doubt that whisky was making considerable inroads (Figure 2.4). The increasing availability of cheap whisky, meant only that people drank more. At the end of the century for example, consumption of spirits was put at 3.6 million gallons or about 2.2 gallons per capita a rate over three times higher than that of today![18] Perhaps what is more important is this drinking was done in a context that was less controlled than it had been in the pre-industrial period.

Figure 2.4 Drink in Scotland, 1795-1840

(Proof gallons per caput)



A caveat must be enter at this point, however, regarding the evidence for the rise in whisky drinking. The trend shown in Figure 2.4 would certainly seem to support the claims of the Temperance Movement that the revision of the Excise laws which led to a reduction of the duty on spirits in 1823, occasioned a massive increase in the use of 'ardent spirits'. After that 'fatal year' the per capita consumption of spirits rose by over 160 per cent to around 2.71 gallons. Beer drinking which was generally considered less detrimental to the morals of the 'lower orders', was, by contrast, beginning a long term decline (Donnachie, 1979). The question is how far is this increase in spirit drinking attributable to other factors, such as illicit spirits being squeezed out of the market both as a result of lower taxation and by gradually more rigorous enforcement?

Beginning in 1822 with the Illicit Distillation (Scotland) Act, the government introduced a series of revenue measures, including a system of fines, with the explicit intention of illicit whisky production in Scotland. Whatever, Collin's reservations, the effect of the 1823 Excise Act in substantially reducing excise duty was to undermine the cost advantage which the illicit distiller enjoyed over his licensed competitor. The distilling industry itself was not slow to highlight the link between the level of excise duty and illicit whisky production. A spokesman for the industry had this to say of the Government's decision to increase excise duty in 1825:

> (H)ad this decrease (in spirit consumption) been a consequence of increased temperance in the use of spirits, it would not certainly have been a matter of regret, but such is not, by any means, the case, it is due to illicit distilling.
>
> (Parnell Commission, 1834, Appendix 24:146)

Whatever the truth of the situation, it is clear that concern was now being felt about the popularity of whisky drinking amongst the urban working class. More than one minister in the Old Statistical Account was wont to complain about the spread of 'dram shops' or 'tippling houses'. The comments of the Rev. James Sommerville, the minister for Stirling, are typical:

> The manners of the inferior ranks are also much hurt and debased everywhere, by the great number of tippling houses, and the low price of ardent spirits. Of these the number in Stirling has considerably diminished for some years past, but ought to be still more so. ... such a step would contribute much to prevent the growing depravity of the people.
>
> (OSA, XIII:293)

By the time the New Statistical Account of Scotland (NSA) was published, in 1835, the expressions of concern had greatly intensified. At that time it was estimated that in some Glasgow parishes the ratio of 'dram shops' to families was 1:12 (NSA, Lanark:195). The situation in other industrial parishes was no better.

Table 2.3 Spirits dealers in the West of Scotland, 1834

Location	Number of Spirit Dealers	Number of Families	Ratio of Families/Dealers
Dumbarton	71	804	1:11
Glasgow & suburbs	2,198	40,000	1:18
Greenock	327	6,353	1:19
Paisley	454	12,308	1:27
Port Glasgow	81	1,279	1:15

Source: Report of the Select Committee on Drunkenness, 1834:136-7
(Evidence of William Collins)

The existence of an objective condition, in this case the increased consumption of spirits, does not of itself explain why the behaviour came to be defined as a social problem, or why it was felt necessary to launch a campaign against it. Blumer (1971) reminds us that there are many issues vying for legitimation as social problems. Many, perhaps most of these "budding social problems" never make it and are "choked off", ignored, or avoided. Objective conditions, therefore, are necessary, but not sufficient, to ensure the definition of an issue as a social problem. To understand why the Temperance cause was successful we

must go beyond the rather narrow debate about the nature and extent of the problem, to look at the ideology of Temperance.

The concept of Symbolic Crusades

Gusfield's analysis of the American Temperance Movement, offers a more comprehensive explanation for rise of Temperance (Gusfield, 1963). The success of *Symbolic Crusade* - the term is now firmly established in the literature on both alcohol and social problems -was in focusing attention on the symbolic nature of rules and of the social processes involved in their creation. Gusfield draws on Weberian notions of status in order to explore the symbolic dimension of political acts and to explain how social issues such as Temperance have been used by one social group to assert its domination over another group(s). Temperance, so this argument runs, provided an expression of dominance that hinged on moral, ideological, or 'status' superiority, and not on exclusively economic relationships.

Taking as its example the conflicts surrounding Temperance and Prohibition in the USA, Gusfield's analysis attempts to distinguish between 'class politics' movements oriented in terms of "the material goals and aspirations of different social groups" and 'status politics' "movements whose appeal is to ... individuals or groups who desire to maintain or improve their social status" (Gusfield, 1963:17). The rise of Temperance, for Gusfield, is better understood in terms of 'status politics', rather than by more traditional sociological models of economic class conflict.

Status movements are expressive rather than instrumental. They seek symbolic evidence of social domination. Given that different norms relating to drinking and drunkenness operate in different social groups (classes), the possibility exists for one 'status group' to achieve domination over, and deference from, another group(s) by attempting to make universal its own drinking norms. The 'symbolic victory' of Temperance, according to Gusfield's analysis, lay in the achievement of that dominance. For the emergent middle

class of the Industrial Revolution, the promotion of abstinence became a status symbol, a means of distinguishing the middle class from the working class. The drunkenness of the latter was presented as a threat to the ascetic qualities of industry, discipline, thrift, punctuality, and of course sobriety, that served to validate the superior social position of the former. It was in defence of these values that the 'symbolic crusade' was launched. Put simply, Gusfield's argument is that the founders of the Temperance Movement got together and decided that "if they could not control the politics of the country ... they might at least control its morals" (Gusfield, 1963:5).

At first sight Gusfield's analysis seems to correspond with what we know of the career of the Scottish Temperance Movement. Certainly it is tempting to view Temperance as a straight forward 'symbolic crusade' in which the moral people, in this case the temperance reformers, attempt to 'rescue' the immoral people, the inebriated masses of the urban working class. And it is not difficult to marshall support for such a view. Dunlop's 'sceptical astonishment' at the morality of papist France, for example, suggests parallels with Gusfield's view that Temperance was an expression of Protestant-Catholic tensions. Gusfield's "disinterested reformers" saw the crusade against alcohol as a way of solving the problems posed by an immigrant, urban poor whose culture clashed with that of American Protestantism. Similarly, the founders of Scottish Temperance can be portrayed as having used Temperance legislation as one means of impressing upon the urban working class - no small number of whom were Irish or Highland catholic immigrants - the central power and dominance of Protestant morality.

The religious dimension is perhaps the most obvious theme that can be traced through the history of temperance agitation. Certainly in its initial response to drinking and drunkenness the movement drew heavily on the evangelical tradition in the Church of Scotland. A great deal of the support for the early Temperance Movement came from within the ranks of the Kirk, in particular from laymen of an evangelical persuasion who were

concerned about the perceived decline in moral standards with the advent of industrial and urban development.

That religious fervour in itself provides part of the explanation for the rise of Temperance we have already seen with Dunlop. Certainly, the founders of the anti-spirits movement saw their goal as nothing less than the moral and religious salvation of the Scottish working class. The leaders of the movement were associated with the leading evangelical minister, Thomas Chalmers, and doubtless shared Chalmers' conviction that the 'evils' of industrialisation could be ameliorated, and the urban working class rendered amenable to moral control, by what he called the Principle of Locality. In essence the Principle of Locality advocated the adaptation and extension of the traditional parish system to the towns and cities (Mechie, 1960:51).[19]

The association of Temperance with dissent and Evangelicalism that is evident in the anti-spirits movement is equally prominent, or is perhaps more strongly felt, in the later tee-total phase of the crusade. After the Disruption of 1843, the leaders of the Scottish Temperance were non-conformist, almost to a man, as Brian Harrison has pointed out:

> Eight English and Scottish teetotal leaders left the established church for dissent ... Of the Scottish teetotal leaders, only one came from the Church of Scotland, whereas the Free Church provided six. The United Presbyterians, the Scottish denomination closest to England's militant dissent in outlook, contributed five influential teetotal leaders.
> (Harrison, 1971:164)

There is, however, a world of difference between identifying Temperance with religious non-conformity and asserting that tee-totalism was the symbolic guarantor of the supremacy of bourgeois morality. For one thing, neither non-conformity nor tee-totalism were the sole preserves of the middle class conscience.[20] The significance of this fact was not lost on the rising bourgeoisie, many of whom were chary of what they viewed as the dangerous and seditious nature of working class aspirations. Here again France provided the model, but on this occasion it was as a warning. "It may not have occurred to our readership", wrote one

contributor to a temperance journal, "that temperance societies ... partake more of the spirit of 'Revolutionary France' during her worst times than of great Britain in 1831" (quoted in Paton, 1977:182). Temperance might outline the way to 'respectability' for 'lower orders', but there was no guarantee that working men would follow that path. Sobriety, like education and political suffrage, was seen by many to be a gift which could be put to a variety of ends, not all of which were sympathetic to the interests of capitalism.

Middle class criticism of the temperance crusade should direct our attention to certain tensions within Scottish society and counsel caution in drawing analogies between the Scottish and the North American experience of Temperance. What is evident in Scotland, and what Gusfield argues is unimportant in the context of the United States, is the centrality of class politics. Whatever ones' view of Gusfield's analysis of American society, no one would seriously suggest that nineteenth century Scottish society was characterised by "consensus about fundamentals" (Gusfield, 1963:2). It is this supposed consensus that is at the heart of Gusfield's analysis. This underlying consensus, he argues, created a vacuum that was taken up, in part, by moral issues that were contested, not along traditional lines of class or economic interest, but in terms of symbolic values, status and prestige.

In order to reconcile Scottish Temperance with Gusfield's model one has to be prepared a) to dismiss working class temperance as an aberration, a manifestation of false consciousness, and b) to credit middle class reformers with the prescience to recognize that their interests could best be served through a *symbolic* affirmation of status. Neither contention is tenable.

According to Gusfield's analysis, as heavy drinking became identified with a dissolute working class lifestyle, so the antithetical behaviour of abstinence signified a rejection of working class norms and values. For those workers with middle class aspirations, therefore, the advocacy of Temperance became as it were a "ticket of admission to respectability" (Gusfield, 1963:47). Working class involvement with tee-totalism, however, was a

complicated affair and, as we have already seen, it was often viewed with concern and suspicion by middle class reformers. The fear was not altogether unfounded since working class societies were often identified with political radicalism and, as Brian Harrison has pointed out, "teetotalism constituted a form of freemasonry among working men" (Harrison, 1971:133).

Working class support for temperance was not simply a manifestation of false consciousness. It did not uncritically accept middle class temperance propaganda, but recognised that brutal working conditions, poor housing, and many methods of paying wages, locked many men into a heavy drinking culture. The leaders of working class opinion in Scotland, men like Keir Hardie, embraced Temperance as a means of rising not *from* but *with* their class.

The objection to investing temperance reformers with an instinctive appreciation of how their status and prestige might be established through the enforcement of temperance legislation, is that it fails to recognize that whatever symbolic meaning Temperance possessed had emerged *out of the processes of the crusade*. We must be very careful here. It would be too crude to ascribe to the development alcohol control policies, straight-forwardly class interested motives. But to ignore the elements of economic and class politics and to characterize the temperance crusade as symbolic, is to confuse the end product, how things turned out, with the processes of which it is a part. Underlying such *ex post facto* explanations, as Schutz pointed out, is the unspoken proposition that the researcher (historian) "already knows perfectly well what the actor intended to do because he knows what he did in fact do" (Schutz, 1972:213).

The instrumental concerns of Temperance

As far as Scotland was concerned, symbolically oriented support for legislative control of drink existed, not only among the most vociferous proponents of abstinence, but also among

a significant section of the general population. In recognising that, in the course of its development, the drink question became imbued with symbolic significance, however, one must not ignore the centrality of instrumental goals. The precise nature of these aspirations and the extent to which they were realised may be a matter for debate. In the present context, however, the important point is that the temperance crusade cannot be seen in primarily symbolic terms. As Gusfield himself acknowledges, the interplay of economic and class issues has been "salient to European history" (Gusfield, 1963:1). It was in the context of this complex interplay of economic and class conflict that the shape and ultimately the fate of the temperance crusade was determined.

One of the principal thrusts of early anti-spirits campaign was directed against the social and symbolic functions of alcohol to be found in many crafts and industries (Dunlop, 1839). Dunlop himself catalogued many of these 'artificial usages'.[21] "In no other country," he concluded, "does spirituous liquor seem to have assumed so much the attitude of the authorized instrument of complement and kindness as in North Britain [Scotland]" (Dunlop, 1839:6). Dunlop clearly recognised in these rituals some kind of 'metaphysical agency' which in his opinion was related to the observance of manners of social etiquette and courtesy. The fact that he labelled them negatively, as 'artificial usages', however, would suggest that his interest was in the attenuation, rather than in the understanding of such practices.

From the paternalism of the anti-spirits movement to militant tee-totalism, Temperance can best be viewed as part of a more general campaign to reconstruct popular (working class) recreational patterns in ways that were more in tune with the demands of industrial capitalism (Bailey, 1976). Frequent opportunities (excuses) for imbibing, even for drunkenness, might have been tolerable in an agricultural society or in the more primitive forms of industrial manufacture.[22] The same could not be said of factory production, where the drunkenness of a machine-minder could inhibit productivity and perhaps endanger the

lives of the workers. Add to this the anxiety caused by the apparently imminent breakdown of social order occasioned by the economic, demographic, and social strains of industrialisation, and it is clear that the appeal of Temperance went far beyond the mere symbolic affirmation of status.

There were many people both inside and outwith the Movement who recognised that their vested interests could best be served by a sober and industrious labour force. Controlling the drink trade and drunkenness made sound economic sense. In fact, the political and economic advantages to be had from the control of drunkenness were recognized even in the early stages of the Industrial Revolution. The Report of the Parliamentary Select Committee on Distilling Duties (1798) formed the "general opinion that it is wise in the political as well as in the financial view", to increase the duty on spirits to a level that would "prevent the excessive use of it (alcohol) by the poor (xxi:12).

For the new urban bourgeois conspicuous abstinence might attest to the superiority of their moral values. More importantly, however, it was an opportunity which accorded well with their economic and political interests. By imbuing the drink question with symbolic significance the instrumental aspirations of the reformers could be presented in a more acceptable guise. Demands for social control, and in the final analysis that is what the crusade is about, could be presented as humanitarian concern or as a rational appeal for 'law and order'. "Every teetotaler," in the words of Thomas Spencer, "was a policeman engaged in repressing crime and preserving the peace" (cited in Harrison, 1971:96).

The analogy with the policeman is apposite. The new police force which was gradually established throughout the country in the years after 1829, was grudgingly accepted because it was felt to be necessary to control the burgeoning secondary economy that was threatening the commercial life of many cities. The operation of a secondary economy that served the working class an 'economy' of street peddlers, markets, pawnshops, betting shops, beer houses, lodging houses, and brothels did not coincide well with

bourgeois ideals or, indeed, the demands of commerce. Intemperance was deemed to be a inevitable by-product of the operation of the secondary economy and, therefore, by its emphasis on sobriety and industriousness, the tee-total movement lent at least tacit support to the activities of the police.

As long as the operation of this secondary economy and the conduct of working class drinking rituals and customs was confined to existing areas of working class settlement, it can be argued, the public order problem was ecologically manageable, or at least tolerable. The pressures of an expanding population, however, pushed the deviants and with them the threat of disease from poor sanitation and overcrowding over the boundaries into the commercial thoroughfares and, perhaps more importantly, into areas of middle class residence (Bunyan, 1976; Gordon, 1980; Brogden, 1982). At that point private troubles (to use C. Wright Mills term) such as drunkenness became public issues.

Whatever one's view of the motivation underlying the legislation - whether it is seen as an expression of humanitarian concern or as a way of preventing the combination of drinking opportunities with the possession of leisure and money - it is clear that the effect was to restrict access to drink as part of working class leisure.

Temperance & the disease concept of alcoholism

The translation of Temperance demands into action was influenced, if not determined, by two institutional approaches to the problem of habitual drunkenness (I hesitate at this point to call them ideologies) that emerged out of the Industrial Revolution. The approach that is most readily identified with tee-totalism, is the legislative response that we have been discussing and which finds its embodiment in the developing institutions of the criminal justice system - in the courts, the prisons, and above all in the new police of nineteenth century Britain. The other approach which can be defined as the medical or more broadly, and ultimately more accurately, as the therapeutic tradition.

The therapeutic approach offered a new way of understanding drunkenness. Whereas in the classical view habitual drunkenness was a problem, the advent of medical and in particular psychiatric interest defined it as problematic, in the sense that the behaviour required an explanation. In contrast to the popular sentiment that "drunkenness was a choice, albeit a sinful one, which some individuals made" (Levine, 197:165), medical opinion increasingly turned to the proposition that habitual drunkenness could be more usefully categorized as a disease. Such insights were not always welcomed by tee-totalers who held to the classical (punitive) view of the problem. Nevertheless, they made an important contribution to the ideology of the Temperance Movement and, ultimately - through the rediscovery of the disease concept in the post-war era - helped shape contemporary attitudes and responses to alcohol problems.

The nineteenth century disease model

The closing decade of the eighteenth century was a period of real transition for the medical profession and for psychiatry in particular. Psychiatry was emerging as a discipline in its own right. Madness was beginning to be differentiated from criminal deviance and attempts were being made to understand and treat mental disorders (Foucault, 1967; Rothman, 1971; Turner, 1987). It was in this context that the notion of alcoholism as a disease was born.

The earliest formulations of the disease concept were developed, independently but almost simultaneously, by two doctors on opposite sides of the Atlantic. First into print, in 1785, was the American psychiatrist Benjamin Rush with a treatise unprepossessingly titled *An Inquiry into the Effects of Ardent Spirits upon the Human Body and Mind with an Account of the Means of Preventing and of the Remedies for Curing Them.* The *Inquiry* defined addiction to ardent spirits as a "disease of the will". The cure, according to Rush, was abstinence from spirits, though not from all alcohol. Rush then was no tee-totaler.

On the other hand his suggested treatment which included beatings, cold showers, frights, threats, and even whipping, do not appear to the modern eye to be particularly therapeutic.

Thomas Trotter's *An Essay, Medical, Philosophical and Chemical on Drunkenness*,[23] was published in 1804. Trotter did not take Rush's benevolent anti-spirits stance, arguing instead that total abstinence was the only treatment. In other respects, however, he was much more in advance of his time. He recognised the importance of environmental factors. He also argued that the 'disease' had a psychological as well as a physical dimension, that "habitual drunkenness is a disease of the mind". In what is perhaps the clearest articulation of the nineteenth century disease concept, Trotter wrote:

> In medical language, I consider drunkenness to be a disease, produced by a remote cause, and giving rise to actions and movements in the living body, that disorder the functions of health.
>
> (Trotter,1941:586)

Like so many reforming innovations of the nineteenth century, however, the gradual acceptance of the disease model owed a good deal to North American influence. Without the example of a small group of medical men, mainly psychiatrists, who vociferously promoted the concept through their work with inebriates and in the pages of the *Journal of Inebriety*,[24] it is unlikely that the British medical profession would have become involved with the problem of alcoholism to the extent that they did. The medical profession, through the auspices of the British Medical Association, did, however, become involved in the struggle to win recognition for the idea that addiction to alcohol as a medical problem. They also made an important contribution to the establishment of State provision for the "care and treatment of habitual drunkards" (MacLeod, 1967; McLaughlin, forthcoming).

The treatment of inebriates

In Scotland, as in many other countries, medicine was emerging as an important and influential institution at the time as the revitalised Temperance Movement was looking for

new methods of addressing the problem. One route, as I have shown in this chapter, involved legislative control of the distribution and sale of alcohol. In terms more familiar to us today, it addressed the availability side of the equation. But those on the other side, the "pitiful victims of drink" were not altogether forgotten.

The latter half of the nineteenth century was the era of reformation through self-help and this was well reflected in Temperance ideas about treatment. In working with 'inebriates', as they now began to be called, the teetotal movement adopted a number of strategies that have in recent times come to be identified with self-help groups such as Alcoholics Anonymous. Local groups held regular meetings to help inebriates avoid their old drinking haunts, to provide support, and to offer fellowship in place of the companionship of drinkers that they had renounced. Visiting and regular 'pairings off' with reformed inebriates were also encouraged as a means of keeping the inebriate in good company and reinforcing the determination to remain sober (Harrison, 1971).

The Movement also began to use medical 'experts' and therapeutic imagery as a means of conceptualising deviant behaviour. Social Darwinism, national eugenics, and a generally materialist view of human behaviour led to the (re)conceptualisation of habitual drunkenness as a medical disorder the effects of which, if they could not be altogether eliminated, could at least be ameliorated by proper treatment. The 'alcoholic' gradually replaced the 'drunkard' as the appropriate object of intervention, as the disease concept gained acceptance. There is, however, a paradox in the relationship between medical science and Temperance reform. As Harrison (1971) pointed out, "the Victorians often failed to distinguish between alcoholism, drinking and drunkenness". Tee-totalers argued that drinking inevitably led to drunkenness, and that *all* drinkers were at risk not simply a few especially vulnerable individuals. Medical experts, on the other hand, were increasingly promoting the view that such a differentiation did exist. What follows is a description by a nineteenth century psychiatrist of what we today might call 'alcoholism':

> There are drunkards by intuition as well as by training. It is an instinct, a vocation. They plunge into intemperance so suddenly, it may be spasmodically, so thoroughly and irretrievably, that they must act in accordance with their original and not an acquired nature: with them there is no preparation, no degrees, no stages. With them there is no sipping, no dalliance, no bouquet, no glee, no song: they do not even court the excitement, the super-sensuous enlightenment experienced by revellers, but rush at once into wild delirium, or into an insensibility resembling coma. They seek not pleasure but oblivion.
>
> (Browne, 1860:4)

Browne was giving voice to a perceived need to do something about the problem of drunkenness. He was not simply identifying the problem. He was making an explicit claim that the appropriate response was part of a medical (psychiatric) agenda. Intemperance as pathology was defined in terms of the medical language of delirium and coma. In doing so, Browne was clearly operating with an idea of addiction that regarding some individuals as particularly vulnerable because of some inherent flaw in their make-up. In a sense the paradox remains unresolved. Contemporary responses to alcohol problems continue to draw on these two opposing (but overlapping) belief systems - alcoholism is a disease requiring treatment, drunkenness is a deviant behaviour to be controlled by legislative and criminal justice mechanisms.

The most tangible outcome of medical involvement in the drink question was the introduction, between 1879 and 1900, of a series of Acts - the so-called Inebriates Acts - that allowed for the establishment of 'retreats' and 'reformatories' for the treatment of alcoholism. The next chapter looks in some detail at these inebriate reformatories. It does so, however, within a wider frame of reference. The experience of the inebriate reformatories serves as a case study of the interplay between the two threads that run through the nineteenth century history of responses, the legislative and the medical. In the twentieth century the medical, or rather the socio-medical ideology has come to influence all institutional responses to alcohol problems. In the inebriate reformatories, however, we see the offender/client /patient caught up in a developing legal-medical nexus. An historical

explanation of the rationale which underlay the inebriate reformatories might usefully inform some of our contemporary ideas about responses to problem drinking, particularly in the context of diversion from the criminal justice system.

Conclusion

In this chapter I have argued that habitual drunkenness as a problematic issue, defined as a discreet entity that required (demanded) explanation and some form of official response, was only discovered during the nineteenth century. The initial appearance of the issue in the 1830's was dependent upon the promotional endeavour of the anti-spirits movement and (later) by the claim-making activities of militant tee-totalism. These developments took place against the background of a rapidly changing industrial-urban society and were influenced by social, economic, and institutional factors. The response to the problem was influenced by the needs of the capitalist economy for a sober, disciplined workforce. The major themes emphasized by Temperance were (increasing total) abstinence, moral reform, and legislative control of both the drink trade and drinking habits of the working class.

The simultaneous promotion in the U.S.A. and Scotland of the idea that habitual drunkenness was a disease, introduced a new way of understanding the problem and new possibilities for responding to it. Medical men such as Rush and Trotter put much greater emphasis on treatment and on the awareness of the psychological as well the physiological sequela of alcohol abuse. The two approaches - or models for explaining habitual drunkenness - were not mutually exclusive; rather they frequently overlapped. In practical terms, we are not dealing with opposing ideologies of punishment and treatment, but with a complex matrix of responses. It is in the context of this interrelatedness of therapeutic and legalistic approaches that we must now try and explain attitudes and responses to what we now call alcohol problems. Viewed separately, neither the legislative model nor the more overtly therapeutic explanation takes us to the heart of the question, which is about how the

problem was responded to historically and the relevance of this response in the contemporary context.

Notes

1. Much of this whisky was distilled illicitly, particularly in the Highlands, a factor which may have added to the attraction of the spirit. The number of illicit stills seized - over 1000 in 1782 - gives some indication of the scale of the activity. However, it has been suggested that since ratio of operating illicit stills to those seized was perhaps 20:1, the official figures greatly underestimate the scale of the activity (Devine, 1975).

2. Such omissions are perhaps the more surprising since Sinclair, the author of the OSA, specifically asked that minister comment on the "number of alehouses, inns, etc.," in their parish and on "what effect they have on the morals of the people".

3. The statute of 1436 restricted drinking hours in the burghs, but not in the countryside. perhaps because it was believed that the demands of rural life naturally required earlier hours. The statute also makes no mention of whisky or aqua vitae - ale, beer, and wine drinking merit specific mention - and this might to taken as an indication that spirit drinking did not usually take place in taverns.

4. In practice, Kirk Sessions found it very difficult to enforce fines, because many people would not (or could not) pay. During the latter half of the seventeenth century, the practice was first relaxed and later allowed to fall into disuse (Davies, 1980:129).

5. The jougs was a metal collar with a padlock and chain fixed to the wall by the door of the Kirk. Offenders were 'exhibited' in jougs throughout the period of church services for anything up to six hours. Examples of jougs, can be seen in the North Berwick Museum or in-situ at Garvald church, West Lothian.

6. John Galt's *Annals of the Parish* (1821) provides a fictitious, but nonetheless enlightening account of the eccentricities of the Scottish clergy at about this time.

7. The establishment of the 'Drunken Committee' was in reality more the work of one man, its chairman the radical M.P. for Sheffield, J.S.Buckingham than an official attempt to respond to the 'claim-making activities' of the temperance movement per se. The Report of the Committee makes interesting reading, not least for the 'evidence' given by the leadership of the temperance movement. Collin's evidence is typical in that present us not only with an analysis of the problem, but also the rationale for the foundation of the temperance movement. Another interesting feature of the Select Committee, in view of later developments, was the total lack of any medical representation on the Committee. Overall, however, one should bear in mind Harrison's injunction that the report should be only used with extreme care (Harrison, 1971:110-12).

8. There are at least two accounts of how the term 'teetotal' came into use. The version from the U.S.A. claims that in the early days of the Movement a 'T' was entered in the membership roll against the names of those members who had taken the 'total pledge'. The British version is a little more colourful and concerns a temperance zealot called Turner. This man, so the story goes, had a tendency to stutter when excited. Turner was addressing a temperance meeting one night and, elated in his enthusiasm for the cause perhaps, declared that he would have none of the "moderation and botheration pledge", but would be "tee-tee-total for ever and ever".

9. In a further split, the Scottish section of the UKA, unhappy about what was perceived to be the English domination of the Alliance, broke away in 1858 to form the Scottish Permissive Bill Association. The SPBA remained tee-total and it campaign for permissive prohibition through 'veto polls'. The SPBA amalgamated with the STL in 1922 to form the Scottish Temperance Alliance which, to the best of my knowledge, continues to the present day.

10. The alcohol industry, of course, enjoyed significant parliamentary representation through a loosely-knit group of (mainly) brewing interests (Mathias, 1959). This influence was mobilised in opposition to the demands of tee-totalism. Inside and outside Westminster the Drink Trade organised itself to challenge tee-total agitation at all levels of political action. The countervailing pressure of financial interest and parliamentary lobbying by the Drink Trade did not succeed in undermining the efforts of the tee-totalers, but it did enough to ensure that support for legislative control was often less than whole-hearted.

11. The experience of some Temperance societies seemed to calculated to reinforce the middle class fears. In Glasgow, for example, men belonging to 'the productive classes' left the Tradeston Temperance Society to form their own association dedicated to freeing working men from the present competitive and irrational state of society (Trades Advocate and Co-operative Journal, October, 1830), an ambition that can scarcely have endeared them to the capitalist man of business.

Middle class temperance advocates were equally hostile to any suggestion of collective, independent working class action and, indeed, were often patronising in their attitude to working class Temperance in general. Their attitude is typified by Hugh Miller, the evangelical churchman, in his commentary on the drinking mores of his fellow stone masons of the North-East of Scotland:

"(T)there are few working-parties which have not now their groups of enthusiastic teetotallers that always bind together against the drinkers, and mutually assist and keep one another in countenance; and a breakwater is thus formed in the middle of the stream, to protect from the grinding oppression of the poor by the poor, which, let popular agitators declaim on the other side as they may, is at once more trying and more general than the oppression which they experience from the great and the wealthy."

(Miller, 1854:321-22)

12. The objects of his Lordships fury included the Inebriates Bill (1898) and the (admittedly controversial) Contagious Diseases Acts of 1886. However, the clearest statement of his general position is contained in speech made during the debate on the Vaccination Bill of 1898:

"Some of the speakers seem to me to imagine that we live in an ideal state of things, where it is only necessary for Parliament to enact something, and it will be at once listened to, where there are pliant guardians and obedient magistrates and a submissive peasantry only waiting for the word of wisdom to be uttered at Westminster .... That, I am afraid has no correspondence to the existing state of things."

(Hansard, Fourth Series, 64: cols. 54-55)

13. Glasgow was in many respects the obvious barometer of the acceptability of Temperance activity during the latter half of the nineteenth century. The city, second only to London in importance, had been forged in the furnace of the Industrial Revolution and possessed in full measure all of the social problems that were attendant upon the rapid growth of an urban, industrial environment. Social commentators of the period tended to look upon drunkenness as a commonplace of inner city life and in this Glasgow was no better than the rest. One such commentator, Alexander Brown, provides an interesting account of working class life in Glasgow in 1858 one would hesitate to call it sociological, but Brown's technique would not be unfamiliar to some more recent researchers of the 'darker side' of Glasgow (Patrick, 1973).

Brown's *Midnight Scenes and Social Photographs*, published under the pseudonym 'Shadow', guides us through a 'typical' week in 1858 and shows us another side to the operation of the Forbes Mackenzie Act. On Sunday night, the pubs being closed, we are introduced to the "mysteries of the shebeen", where "a very good glass of ale" could be had for "a very good price". Monday night finds 'Shadow' in the Bridgegate witnessing "the idiotic jeer and senseless laugh of drunkards, ... the horrid oaths and imprecations of low prostitutes." As the account of the week unfolds the "poor pitiable victims of drunkenness" come and go. On Saturday the pubs "next to the house of God by far the most important institution in the city" are filled to overflowing:

"One can scarcely realise the enormous number of these houses, with their flaring gas lights in frosted globes, and brightly gilded spirit casks, ... with the occasional mirror at the extreme end of the shop reflecting at once in fine perspective the waters of a granite fountain fronting the door, and the entrance of poor broken-down victims, who stand in pitiful burlesque in their dirty rags, amid all this pomp and mocking grandeur! We have often thought, as we have seen these mirrors, that they must be the appropriate gifts of some benevolent institution, or a Total Abstinence Society, desirous of realising the sentiment of the poet,

'Oh wud some power the giftie gie us
To see oursel's as ithers see us."

(Shadow, 1976:98-99)

Thirty years on from Shadow's *Midnight Scenes*, the legislative successes of the Temperance Movement notwithstanding, social commentators could still be moved to express the opinion that:

"Glasgow was probably the most drink-sodden city in Great Britain. The Trongate, Argyle Street, and, worst of all, the High Street, were scenes of debauchery ... there

were drunken brawls at every street corner and a high proportion of the passers-by were reeling drunk."

(Oakley, 1947:233)

Glasgow's experience of Temperance was also somewhat unique, both in the sense that the Temperance Movement was a strong force in local politics and for the impact of a single piece of legislation passed by the city's corporation in 1890. By a resolution passed in that year, Glasgow Corporation prohibited the sale of drink on any property owned by the city. In the short term this bye-law did nothing to curb the drunkenness of the city, but it was to have a considerable impact on the lives of many of Glasgow's council house tenants in the mid-twentieth century. Until very recently, and in the case of Cathcart until 1983, this piece of temperance legislation meant that the vast new council estates, established on the outskirts of the city after 1945, lacked both public houses and, for the most part, suitable alternative meeting places.

14. The victory of course did not belong to Temperance Movement alone. As with any piece of legislation, the Act was the result of a complex interplay of factors. In the case of the Forbes Mackenzie Act, however, the crucial element seemed have been the pressure brought to bear by an alliance of teetotal interests with the sabbatarian sentiments of the post-Disruption evangelical Churches.

15. A case can no doubt be made for regarding State control as a victory for Temperance. Certainly, there were those at the time who saw reflected in the advocacy of State control a good deal of traditional Liberal temperance sentiment. Such people questioned the seriousness of the threat and argued that Lloyd George was being precipitate in subjecting the Drink Trade to such strong legislative control.

16. In the area of 'the Carlise scheme' there had been 340 licenses in July 1916, by 1920 there were 271 the Board having suppressed 123 all but 47 of which were under state control (Brake and Williams, 1980:107).

17. From their description, these pubs appear to be similar in style and operation to those operated under the Gothenburg system of municipal ownership. The Gothenburg system takes its name from a scheme set up in Sweden in the 1860's in which a company operated licensed premises for the benefit of the community. The profit from the enterprise were used to off-set the city rates. The scheme was first introduced to Britain in the 1890's and was taken up by a number of towns and villages in Fife. An interesting contemporary account of the operation of the Gothenburg system can be found in Kellog Durland's *Among the Fife Miners* (1904).

18. The precise nature of the measure is not specified, but if the report is referring to the old Scottish wine gallon, then a the figure would have to be reduced by one quarter (to about 1.6 gallons) to make it comparable with an imperial gallon.

    The strength of the whisky is also an important variable that is not specified in the report. Fynes Moryson, an Elizabethan traveller, describes three type of whisky 'usiquebaug', a double distilled spirit; 'testarig', a triple distilled spirit; and 'usiquebaug-baul' which was distilled four times. This last was reported to be so strong that two spoonfuls were reputedly enough to endanger life (Wilson, 1973:36).

Assuming the average strength of spirits was comparable with that of today, however, a per caput consumption of 1.6 gallons at the close of the eighteenth century is still very high by present day standards.

19. Chalmers was fully convinced of the probity of the traditional parish system. He was of the opinion that:

> "... nothing but the multiplication of our Established Churches with the subdivision of parishes and the allocation to each parish of its own church ... will ever bring us back again to a sound and wholesome state of the body politic."
>
> (Letter to Wilberforce, quoted in Mechie, 1960:51)

20. For all its anti-working class ideology, the temperance movement had a long, sometimes close, relationship with the Scottish Labour Movement. The average tee-totaler of the 1840's came, as likely as not, from the 'respectable working class' and might very well have been active in labour politics. Not until later in that decade did the middle classes have any sizeable involvement in tee-totalism. Some members of the working class no doubt looked to temperance as a vehicle of social mobility. For the majority of working class activists, however, concern about the harm which a drunkenness might do the Labour Movement and the pernicious effect it had on working class families, inclined them to see the advocacy of temperance was an part of the larger social struggle.

21. Dunlop writes, for example, of apprentices who were expected to pay a drink fine when being indentured and that other drink fines were demanded at the completion of apprenticeship. A joiner's apprentice might be required to pay the fine upon completion of his first window sash, or any other difficult operation. Although Dunlop cites an apparently exhaustive list of such examples, Collins claimed that it did not cover "a tithe of the customs and practices which induce spirit drinking in Scotland" (Select Committee on Drunkenness, 1834:139).

22. In the agricultural sector payment in drink was not unknown, though there were those who objected. Witness the OSA for Clackmannan (XIV:605-646):

> "... woman reapers get 1s. (per day) in harvest, and a glass of whisky in the morning; a very bad practice, and which frequently leads them on to habits of drinking whisky during all their lives."
>
> Nor was it uncommon, at least until mid-century, to find that men accustomed in heavy industries such as iron founding drank 4 or 5 glasses of whisky per shift. Some employers even profited by the custom. Selling whisky was, according to one works manager, "more profitable than iron or coal raising" (Paton, 1977:108).

23. Although published in 1804, the *Essay* was on a doctoral thesis submitted by Trotter to Edinburgh University some six years earlier. The development of his ideas, therefore, are contemporary with those of Rush.

24. Following the example of the United States, the *British Journal of Inebriety* was established in 1882 to promote the issue of in this country. The journal, renamed the *British Journal of Addiction*, has now been continuously active in the area alcoholism and addiction for over a century.

3 Asylums for Drunkards: Ideology & Practice in the Treatment of Inebriates

The period from the 1840's to the turn of the century witnessed the ascendancy in Britain of an institutional ideology that had its beginnings in the late eighteenth century. This was the age of the 'great confinement' with men and women flowing through the prisons, workhouses and asylums in their thousands. In 1849, for example, there were over 150,000 receptions into prison in England and Wales. In the same year some 24,335 passed through Scottish prisons (Dobash, *et al,* 1986). A substantial proportion of this prison population had been convicted to short terms of imprisonment for drunkenness offences. In the opinion of the chaplin of the Glasgow prison, quoted in the 1846 Report of the Inspector of Prisons:

> Of the many thousands annually imprisoned, I think it would not be possible to find 100 sober criminals in any one year. Even the youngest of them learn this ruinous vice, and, when they live by thieving, swallow astonishing quantities of whisky.

The good reverend no doubt exaggerates, but even in reputedly less drunken times, for which more reliable statistics are available, the numbers imprisoned for drunkenness remained very high. Of the 66,769 persons received into Scottish prisons in 1901, 27 per cent had been convicted of simple drunkenness.

The history of an institutional ideology is perhaps most readily understood in relation to prisons and lunatic asylums (Foucault, 1967; 1977; Ignatieff, 1978; Scull, 1979). The essential features, however, can be identified in many other institutional structures of the nineteenth century such as the inebriate reformatories. The promoters of "asylums for drunkards" clearly felt that the rationale that lay behind the development of confinement for the criminal and the insane could be (should be) just as readily applied to the habitual drunkard:

> Let the State once realise that the destructive influence which alcoholism exerts upon life and property is as curable as other diseases, and *asylums will be established for the treatment of it, and laws enacted to protect society* against a scourge which destroys more lives, ruins more souls, desolates more hearths, than cholera, small-pox, or typhus fever, for which such abundant provision is now made.
>
> (Dalrymple, 1872:116 my emphasis)

In framing the problem, and indeed the putative solution, in terms of both medical and legislative action, Dalrymple unwittingly draws attention to, what I consider to be, the most interesting aspect of what would otherwise be an unremarkable experiment in the treatment of inebriety. In the context of the inebriate reformatories, it becomes clear that the medical profession did not merely inform responses to problem drinking. It became deeply enmeshed 4in the processes of implementation. Medicine, like the legal and criminal justice establishments, became another part of the mechanism of social control.

Why study the inebriate reformatories? I am tempted to answer - simply because we know so little of the history of these institutions. It is true of the Scottish experience of Temperance in general that it has not been exhaustively researched. The published work on the topic is limited and has yet to rival Harrison's (1971) *Drink and the Victorians*, or attempt the kind of socio-historical analysis offered by Gusfield (1963). In terms of understanding the nature of the institutional regimes experienced by habitual drunkards, however, there is nothing.[1] The purpose of this chapter, in part at least, is to help fill that vacuum.

There were of course other reasons. Although it cannot be said that they were *central* to the Edwardian response to drunkenness - that dubious honour must go to the police - the inebriate reformatories do offer a unique flavour of the period. Moreover, the study of the past raises questions about issues such as coercive treatment, or the effectiveness/desirability of specialist treatment facilities, that are relevant today. Dalrymple's "Asylums for Drunkards" provide a practical example of the operation of the therapeutic and the legalistic nexus.[2]

Sober houses, reformatories, and retreats

The links between the medical profession and the Temperance Movement did not end with the work of Trotter and Rush. Some doctors and psychiatrists were active in the Temperance Movement throughout the nineteenth century. Initially, they did not attempt to define an expert role for themselves in responding to drunkenness. As the century progressed, however, some medical men became convinced that a more "rational system for responding to the problem of habitual drunkenness" was needed. This 'rational system' involved the setting-up of special asylums for the treatment of inebriates. The idea was not new. Rush had proposed the establishment of 'sober houses' which could provide inebriates with specialized medical care. Leading American psychiatrists had endorsed Rush's recommendation, at intervals, and inebriate asylums had been in operation (on and off) since 1841.[3]

The introduction of inebriate institutions into Britain was in no small part the work of one man, a Norfolk surgeon, Donald Dalrymple. Dalrymple was the proprietor of Heigham Lunatic Asylum and it was as a consequence of his work with the mentally ill that he became convinced of the link between alcoholism and mental illness. A visit to the United States and Canada in 1869 - during which he visited nine inebriate homes - reinforced Dalrymple in the belief that inebriety could be treated (MacLeod, 1967). Elected to Parliament in 1870, as Liberal M.P. for Bath, Dalrymple immediately introduced a private member's bill "to amend the law of lunacy and provide for the management of Habitual Drunkards". He failed. Over the next three years, he made two more attempts to introduce legislation along similar lines, but again his efforts came to nought. Dalrymple died in 1873 without having achieved his goal. What he had done, however, was to increase medical awareness of the issue and secure a role for the medical profession in responding to alcohol problems.

This new-found awareness prompted the British Medical Association to appoint a joint committee (with the Social Science Association). It was from this committee that the Society for Promoting Legislation for the Control and Cure of Habitual Drunkard was formed in 1876. In 1884 developments were taken one stage further by the formation of the Society for the Study and Cure of Inebriety. The ostensible aim of the Society was to increase awareness of alcohol problems by effecting closer cooperation between medical and 'lay' reformist groupings. From the beginning, however, it was clear that the central contribution, the governing ideology of the society was to be provided by the medical fraternity. Full membership of the Society was only open to "qualified medical practitioners". Associate membership status, which conferred no voting rights and relatively little say in the organisation of the Society, was available to "others interested in the work of the Association". The domination of the Society by medical interests is clear not only from the membership - in 1884 almost three-quarters (72%) medical professionals - but also from those who contributed to the *Proceedings of the Society*.

The point is well illustrated in the first edition of the *Proceedings*, published in July 1884 (Figure 3.1). The President, Dr Norman Kerr, was at the time Medical Officer of Health for St Marylebone. At least ten of the other contributors appear to have had a medical background. In addition to the doctors, the Society could boast an impressive list of associate members including reformers such as Lord Shaftesbury, social researchers (Rowntree and Sherwell were both members), clergymen and lawyers.

The articles published in the *Proceedings* and in its successor, the *British Journal of Inebriety*, provide valuable insights on contemporary perceptions of alcohol problems. Then, as now, the arena was characterised by a good deal of conceptual confusion and there were disagreements about such things as the nature of the problem and appropriate response strategies. The major theme which comes across, however, concerns the relationship between drunkenness and insanity and feeble-mindedness (McCandless, 1984). Many of those who

promoted the institutional option, particularly those who favoured coercive treatment, were sympathetic to the ideas of eugenics and hereditary degeneration. The socio-biology of Herbert Spencer and works such as Henry Maudsley's *The Physiology and Pathology of the Mind* (1867), were influential in adding to "the manifestations of pessimistic thought which affected Edwardian Britain" (Soloway, 1982:137). This influence was, as might be expected, reflected in the institutions they established.

Figure 3.1 Frontpiece of the edition of the *Proceedings*

NO. 1 JULY, 1884

PROCEEDINGS

OF THE

SOCIETY FOR THE STUDY AND CURE OF INEBRIETY.

CONTENTS.

		PAGE
I	Institution of the Society	1
II	Inaugural Luncheon	1
III	President's Inaugural Address	2
IV	Paper - Etiology of Inebriety. W.B. Carpenter. C.B. M.D. F.R.S.17	
V	Paper - Inebriety and Volition Axel Gustafson	29
VI	Discussion -- Dr Drysdale, Dr Brigdewater, Rev G.K. Villbert,Mr A. Oakley Hall	32
VII	Adjourned Discussion - Mr Jabes Hogg, Dr H. Rayner, Dr C.H. Francis, Dr Hart Vlpen, Dr Geo. Harley, Dr Hill Gibson, Surg-Major Poole, Mr Holthouse, Mr James Stewart, The President	33
VIII	Resolution on Habitual Drunkard's Act	42
IX	Future Meetings	42
X	Letters - Dr Joseph Parrish, Dr T.D. Grothers	43
XI	Rules	44
XII	Bye-Laws	46
XIII	Honourary Members	47
XIV	Members	47
XV	Associates	51
XVI	Officers	cover
XVII	Dalrymple Home for Inebriates	cover

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SIXPENCE

Licensed retreats and reformatories

The institutions introduced in Inebriates Acts between 1879 and 1900, were of two types:

> *Retreats*: " ... houses licensed ... for the reception, control, care, and curative treatment of habitual drunkards". Patients were admitted on their own application, although once admitted they could be forcibly detained. In addition to retreats licensed under the Act there were also a number of unlicensed institutions operated along similar lines.
>
> *Inebriate reformatories*: Institutions, not infrequently prisons, operated by the State or local authorities for the compulsory 'treatment' of inebriates. Referral was by the courts, on conviction of certain offences, for a term not exceeding three years.

The influence of the medical profession is most clearly evidenced in the provision of treatment facilities (retreats) where the 'alcoholic' could obtain help. The mainly private retreats offered facilities for the well-to-do. An advertisement for the Vaughan Private Sanatorium in the Dumbartonshire Hills gives a flavour of life in the private retreat:

> The House is a handsome stone building, containing large airy rooms, and every modern convenience ... The Reading and Smoking Room is particularly comfortable, while, for those patients who prefer a little exercise along with their pipe or cigar, there is a good Billiard Room ... (S)urrounding the House are 6½ acres in extent comprising wood, shrubberies, lawns, fruit and flower gardens, besides 700 feet of glass hothouses.

It was the proud boast of the private sanatorium that there was "no restrain on patients". The same could not be said for those less fortunate whose only hope of 'treatment' lay in being admitted to the public lunatic asylum, 'chargeable to the Parish' (ie., under the provisions of the Poor Law). They would certainly not find a place in a licensed retreats.

In Scotland in 1909, according to the Inspector of Retreats, there were only three licensed retreats:

> All three ... conducted by private enterprise, and all three ... designed to meet the requirements of the upper and middle classes.
>
> (Report of the Inspector for Scotland, 1910).

The few facilities which did cater for the 'lower classes' were operated by voluntary organisations, religious and quasi-religious charities for the most part who were more

concerned with moral, rather than medical well-being. In any case, there were never more than a handful of these 'unlicensed retreats' for working class inebriates. The majority of these unfortunates were sent to prison or to lunatic asylums, while others were accommodated in the reformatories where they were subjected to a regime of moral (re)education, liberally reinforced with hard work. This situation, it was clear to many people, did nothing either to reform or deter the persistent offender. Indeed, as the Inspector for Scotland under the Act observed, the recognition of this fact underlay the provisions of the Inebriates Acts:

> The intention of the (1898) Act is not explicitly stated, but presumably it is (1) To protect the community against inebriate offenders; (2) to provide facilities for their reformation. The implication from the terms of the Act, is that both these objects are better attained by relatively prolonged detention than by repeated committal, which has been proved useless by long experience.
> (Report of the Inspector for Scotland, under the Inebriates Acts, 1907:834)

How were these facilities for the reformation of habitual drunkards to be operated? Were they to be run on medical or penal principles?

The institutional structure

Without the active involvement of the medical profession the inebriate reformatories might well not have been established. The ideology which underlay the initiative - though it may seem today to reflect a strange blend of pious moralizing and enlightened observation - was undoubtedly therapeutic. Policy documents at least give the impression that the intention was to translate the medical ideology into practice. In a Scottish Office Circular of February, 1899, the Secretary for Scotland "earnestly hoped":

> ... that a fair and reasonable experiment of the Act may prove, not only that a large percentage of these unfortunate inebriates are capable under careful and humane supervision of reformation and restoration to useful lives, but that ultimately both the Imperial and the local Exchequer and local funds will in this way be relieved by a sensible decrease in the population now located in our prisons and poorhouses.

It is interesting (and curious) to note that - whether talking about inebriate reformatories or the current enthusiasm for community care - the equation financial savings with the adoption of a more humanitarian approach to social problems seems to be an enduring theme.

The first (and perhaps the only) "fair and reasonable experiment" was undertaken by the City of Glasgow. The City Corporation, concerned by the continuing problem of drunkenness, established a sub-committee "to enquire and report as to any available buildings which might be suitable for an Inebriate Reformatory of moderate size" (Glasgow Corporation Minutes, 15 May 1899). As a result, Girgenti Home was licensed as a Certified Inebriate Reformatory for the reception of fifty-eight women. The Reformatory opened for business in January 1901.

Girgenti Home was in fact a farm. It was situated in the Ayrshire countryside some twenty miles south-west of the city and four miles from the nearest town. The inmates - despite the avowed therapeutic intentions of these institutions, the objects of attention were invariably referred to as 'inmates', never as patients or clients (the favoured social work tag) - were housed in two buildings. The majority were accommodated in the 'Home' proper, but six places were provided in a separate building some distance from the principal part of the Reformatory. The intention being to provide selected inmates with an environment "more resembling home life" - a kind of limited parole.

The next reformatory to be licensed was established some twenty-five miles down river from Glasgow, at Greenock on the Firth of Clyde. In common with its larger neighbour, Greenock had long had a reputation for drunkenness, particularly among its ship-builders, fishermen, and distillery workers. The town, however, could also claim a considerable reputation in the area of temperance innovation. The earliest recorded temperance societies were founded in Greenock in 1818 and John Dunlop, "the father of the British Temperance Movement", was a well-known and respected citizen of the town

(Dunlop, 1932; Mechie, 1960). The Greenock Reformatory was also situated in the countryside, at a sufficient distance to discourage inmates from casual encounters with their former associates or lifestyles. Licensed in 1903 for the reception of thirty women, the buildings at Greenock were already well equipped for their purpose, having operated as a refuge for 'fallen women' since 1853. Although it received financial support from both Greenock and, on occasion, Dundee Town Councils, the Greenock Reformatory was run as a charitable society.

These two Certified Inebriate Reformatories formed the major provision in Scotland under the Inebriates Act. Girgenti was the largest and most innovative of the Reformatories and Greenock, while never as large as 'the Glasgow Home', was the longest-lived of the reformatories, being in continuous operation from 1903-1921. There were other reformatories, all located in much the same environment and run along very similar lines. The Lanarkshire Home at East Kilbride, eight miles south of Glasgow, operated from 1904-10. The Scottish Labour Colony Association provided facilities in the Border's countryside at Dumfries. The latest, and smallest, reformatory in Scotland was opened at Seafield, Aberdeen, in 1906. Seafield had space for just eight women. Between them these three institutions could provide accommodation for twenty-eight persons, including all the places for men. They were never fully utilised, however, and their overall contribution was minimal.

Out of the city & down to the farm

The decision to locate the inebriate reformatories in more or less rural surroundings was not in response to any articulated policy directive, but neither was it a fortuitous coincidence. The preference for country locations was a reflection of a strongly held belief in an association between deviance and the contaminating influences of urban living, particularly for those who were held to be socially and/or morally inadequate. Men (presumably women

too) it was felt could be driven to drunkenness by the very proximity of temptation in the town or city. This view was shared not only by the medical profession and middle class reformers, but also by the leaders of the Labour Movement. Ramsay MacDonald, the Labour leader, could rival the Shadow's *Midnight Scenes* (1976) with his description of the malignant influence of the city pub:

> ... the fearful and devilish temptation of the public house, with its flaring lights, its genial welcome, its boon companionship, and its abominable drug that makes the present unreal and throws an evil glamour over the minds of men.
>
> (MacDonald, 1909:45)

In similar vein, the Reports of the inebriate reformatories made not infrequent reference to the contaminating influence of the urban environment. Inebriates, according the 1902 Annual Report of Girgenti Home, "chafe under restraint":

> ... and long to return to the old life they misname 'freedom'. They are the means of leading away others who are morally weak, who know right from wrong, but have not the will power to do right. Started in life as 'inefficients', or having drifted to an environment where drink and immorality are inseparable, they turn to drink as an aid to their vicious life, and as a solace for all their ills.

The physical separation of inmates from these 'occasions of sin', and the beneficial effects of outdoor labour and recreation, were widely considered to be prerequisites for the reformation of habitual drunkards.

Theories about the contaminating effects of urban life were not new. They had been used widely, for example, in the United States to justify the rural location of both inebriate asylums and more general 'institutions of correction'. In Britain the Reformatory movement was certainly aware of, and no doubt influenced by, these developments. There was a good deal of cross-fertilization between the two countries. The Select Committee of 1872, for example, not only heard evidence from two representatives of inebriates institutions in Philadelphia and New York State, but also sent one of its members on a fact-finding tour of the United States and Canada.[4] So many of the ideas and innovative treatment modalities

were tried out in both societies that it is difficult to say with certainty where they originated. On the beginnings of the reformatory movement, however, Baumohl and Room (forthcoming) appear to have little doubt:

> (A) therapeutic prefigurement of the recovery homes appears to have been introduced during the Washingtonian Movement, or the Washingtonian Revival, which flourished in the U.S. in the early 1840's ... we will mark this as the beginning of a systematic approach to the treatment of inebriety.[5]

The State Inebriate Reformatory

In addition to the five Certified Inebriate Reformatories already mentioned, there was a State Inebriate Reformatory at Perth. This institution was in many respects quite different from the Certified Reformatories. It was established to respond to a different client group. The State Reformatory was intended to deal with two types of inmate (i) those convicted under Section 23 of the Act of an indictable offence, and (ii) those transferred, under Section 6 (d) of the 1898 Act, to the State Reformatory on account of their disruptive behaviour in Certified Reformatories. Perth was also unlike the other Inebriate Reformatories in terms of its environment. The State Inebriate Reformatory was located not on a farm, but within the walls of Perth prison.

The State Reformatory consisted of two 'divisions'- one division for male inmates, the other for women. The women's Reformatory was housed in the disused "female lunatics block" which provided, in the opinion of the Superintendent, "an ideal residence for female inebriates". Another part of the prison was converted for use by male inmates.[6] Both divisions had their own entrances and were intended to be quite separate from the prison proper. In practice, however, the separation of Reformatory life from prison life was less clear cut. Prison staff seem to have played an important part in the day-to-day routine of the institution; escorting the inmates on 'outings', supervising them at work, and so on. In

the final years of the Reformatory, this separation became even more blurred as a prison officer (a Store Warden at Perth) appears to have had effective control of the day-to-day running of the Reformatory. Finally, throughout the brief existence, the State Reformatory was operated subject to the rules and regulations of the Prisons (Scotland) Act, 1877, as if it were a prison.

The operation of the Inebriates Act

Under Section 23 of the Inebriates Act if an individual "convicted on indictment of an offence punishable with imprisonment of penal servitude" admitted to being or was proved to be an habitual drunkard the Court could:

> ... in addition to or in substitution for any other sentence, order that he (sic) be detained for a term not exceeding three years in any State Inebriate reformatory, or certified inebriate reformatory, the managers of which are willing to receive him.
> (Inebriates Act, 1898)

Section 24 of the Act covered the more general population. Basically, it provided that anyone convicted certain drunkenness related offences and who had at least three convictions for similar offences in the preceding 12 months, could 'agree' to go to a Certified Inebriate Reformatory, again for " a term not exceeding three years".[7]

The provisions of the Act, therefore, set-out the class of persons who could be sent to a Reformatory. What it did not specify was that these groups *had* to be dealt with under the Inebriates Act. The Act was simply a piece of enabling legislation. In practice, it was used against only a very select group of individuals. Dr Dunlop, the inspector for Scotland under the Inebriates Act and medical advisor to the Scottish Prison Department, carried out a survey in 1901 in which he estimated the number of offenders, then serving prison sentences, who might reasonably have been dealt with under the Inebriates Act (Table 3.1).[8]

From Dunlop's study one might get the impression that the reformatories would have received people from the broad spectrum of 'criminal life'. Cases which might have been

dealt with under Section 23, as numerous as prospective Section 24 cases. Men would seem to be more likely to be sent to reformatories than women. Dunlop's assessment, however, did not reflect the reality of the situation. Section 23, for example, was little used and the reformatories operated a virtual 'women only' policy.

Table 3.1 Dunlop's survey of crimes and offences relevant to the Inebriates Act, 1898

CRIMES		Number	Condition at time of offence: Drunk	Sober	Might have been dealt with under: Sect. 23	Sect. 24
Crimes against the person						
Infanticide	F	1	1	-	1	-
Assault	M	55	45	10	22	-
	F	10	10	-	5	-
Cruelty to children	M	12	5	7	5	-
	F	11	4	7	2	-
Indecency	M	10	8	2	5	-
	F	10	7	3	-	-
Total		109	80	29	50	-
Crimes against property						
Housebreaking	M	23	13	10	12	-
	F	3	3	-	3	-
Robbery	M	18	15	3	11	-
	F	1	1	-	1	-
Theft & Reset	M	98	67	31	50	-
	F	32	24	8	19	-
Uttering,fraud	M	11	5	6	2	-
	F	3	1	2	3	-
Total		189	129	60	101	-
Other crimes	M	7	3	4	-	-
	F	5	3	2	-	-
Prostitution	F	74	38	16	-	-
Total		86	44	22	-	-
OFFENCES						
Drunk in charge of child	F	2	2	-	-	-
Drunk & Incapable	M	72	72	-	-	18
	F	80	80	-	-	42
Drunk & Disorderly	M	29	25	-	-	15
	F	25	25	-	-	8
Total		208	208	-	-	83
Breach of the Peace	M	145	142	3	-	21
	F	93	82	11	-	62
Total		238	224	14	-	62
Obscene language	M	10	10	-	-	-
	F	20	16	4	-	-
Vagrancy	M	19	8	11	-	-
	F	6	6	-	-	-
Miscellaneous	M	18	10	8	-	-
	F	5	1	4	-	-
Total		78	51	27	-	-
Excluded (untried, etc)	M	44	-	-	-	-
	F	23	-	-	-	-
Total		67	-	-	-	-
Total crimes & offences	M	530	433	97	120	54
	F	378	303	75	31	91

Drunken women, appropriate objects of reform?

The most striking feature of the Inebriate Reformatories is the way in which they were created as unique institutions for dealing with drunken women. The Inebriates Act was differentially enforced against women, almost to the exclusion of men. The ratio of men to women in the Certified Inebriate Reformatories was about 1:32.[9] At Perth the ratio was nearer 1:3. After the closure of the male division of the State Reformatory in 1915, no more men were admitted to any part of the Reformatory system.

The emphasis on women is interesting not simply for the insight it provides on the operation of the Act, and indirectly on the role of these women in the society, but also because it goes some way towards explaining the problems encountered by the Reformatories in their attempts to contain these inmates. Carswell (1901) offers a simple explanation for the disproportionately high level of women - poverty. The usual method of dealing with drunkenness offences, then as now, was to impose a fine. Those who could pay the fine, or who were prepared to forfeit their bail,[10] escaped 'the system' comparatively unscathed. Those who could not usually faced no more than a short prison sentence. Carswell suggests that Sheriffs (judges) favoured this option for men because they were reluctant to separate a breadwinner from his family for a prolonged period of time:

> It is a serious matter to take a bread-winner away from his family. The worker who gets drunk on a Saturday night and pays his fine of seven shillings and sixpence on Monday morning is not a suitable man to take away and shut up for three years.
> (Carswell, 1901:7)

Habitually drunken women, however, had not infrequently severed their family ties and with them, in the eyes of respectable society, their right to be considered as 'real women'.

While these considerations may have influenced the decision of Sheriffs when referring people to Reformatories, they clearly do not provide a full explanation of why the Reformatories took so many women. Indeed, the near dearth of places for the reception of men would suggest that the 'women only' policy was not so much an unforeseen

consequence of the operation of the Act, as a conscious decision on the part of those responsible for administering the Reformatories and perhaps, Government. Such a response could not be justified by reference to the excessive drunkenness of women as compared with men. On the contrary, of the drunkenness related offences known to the police at this time only about one-third were committed by women. In Glasgow in 1906, for example, 23,712 drunkenness offences were reported and, of these, only 7,049 were committed by women.

What was perhaps more influential than the drunkenness of women was Victorian society's continuing preoccupation with (and fear of) women's sexuality. The family continued to be seen as the mechanism 'par-excellence' through which sexuality (i.e., women) could be controlled. In the popular imagination, drunkenness in women was equated with sexual promiscuity and prostitution and, as such was considered to be beneath contempt. Women who challenged this view of the world by their 'wanton behaviour' threatened the very fabric of the society and had, therefore, to be responded to. The control and/or reformation of habitually drunken women was just one aspect of this response.

The position of women in Victorian and Edwardian society also made them particularly vulnerable to the kind of 'voluntary psychiatric' intervention that was the Inebriate Reformatories seemed to represented. The procedure necessary to commit someone to an inebriate reformatory against their will was both cumbersome and expensive. It seems unlikely that the Courts would have been willing to evoke such procedures in dealing with cases of 'simple drunkenness'. Most admissions to Reformatories were, therefore, 'voluntary', in the sense that individuals involved would have been persuaded to agree to their committal. Even allowing for a relatively lax system of confinement within the Reformatory, is it likely that any but the naive and the desperate would have agreed to their being detained in such places for a period of 2-3 years? Some clearly were desperate. One inmate at Greenock made several applications for admission to the State Reformatory,

claiming that she "would like to be all her time in prison" (State Inebriate Reformatory, Inmate Files HH/19).[11] The majority, however, had no such perverse desire. They were in the Reformatory because they had been persuaded (or pressured) into agreeing to their detention, perhaps because they were led to believe that they would be helped there rather than simply treated as prisoners.

Women in general, and women of the 'lower working class' in particular, were more vulnerable to the kinds of pressure exerted by the Courts, if for no other reason than, as Carswell implies, they had often only very limited financial resources. Beyond these judicial considerations, there might have been another, more pragmatic reason, for the differential emphasis on women. It was more than coincidence that two of the Reformatories had earlier been Houses of Refuge for Fallen Women.[12] Could it be that, just in that moment as Victorian attitudes towards prostitution were becoming ambivalent - especially about the need to 'lock up' prostitutes (Walkowitz, 1980) - the Houses of Refuge saw in the Inebriates Act an opportunity for bureaucratic survival and, perhaps, for the continuation of the fight against prostitution as part of some 'hidden agenda'. At Greenock and Seafield they seized the chance. The Magdalenes made way for their drunken sisters.

Reformatory life and regimes of reform

The operation of the Inebriate Reformatories raises many questions. What was life like for the Reformatory inmates, what was their daily routine? What were the strategies adopted by these institutions in an effort to "care for and control", and reform, habitual drunkards? How successful was the regime in reforming those individuals committed to its care? And, crucially, where is the evidence of any meaningful therapeutic intervention? The description I have given thus far could - but for the dubious voluntary provisions of Section 24 - be just as readily applied to any penal institution of the period. The regime cannot be defined as therapeutic just because those who set it up say it was. So much of what differentiates

the punitive from the therapeutic has to do with subjective issues relating to the day to day practices of the Reformatories.

It is a fairly easy task to explain the routine of the institutions. The Secretary for Scotland issued Regulations for the management and discipline of Reformatories in Scotland,[13] and the Annual Reports of the Reformatories give a clear picture of how these guidelines were interpreted. The Annual Reports in particular, are replete with details about the inmates' daily routine, diet, work and recreation. From these reports, it seems that all the Reformatories, including the State Reformatory, employed very similar uniform, almost regimented, standards of institutional life. The reformatory time-table (Figure 3.2) provides a graphic illustration of a typical day in the life of a reformatory inmate.

The strategy of reform favoured by the institutions can be summed up in one phrase - 'prayers and piecework'. Even the fairly short period of recreation allowed to the inmates was given over to the demands of the factory or the pulpit. Recreation periods were generally times of self-improvement - learning the skills of literacy and numeracy in which many of the inmates were sadly deficient and which were increasingly important in the industrial world outside the Reformatory. Such free time as remained was taken up by visits from the ladies committee, lectures (usually on biblical themes), concerts, and "amusements, such as draughts, dominoes, ping pong, etc."

Medical care in the reformatories

The emphasis on 'moral treatment' (Carlson and Dain, 1960) which structured the institutional environment, reflects their origins in the asylums for the mentally ill. The lunatic asylum continued to be the principal location for the non-criminal treatment of inebriates. The ideology and the therapeutic practices of the psychiatrist (alienist) dominated thinking on institutional care from the mid nineteenth century through to the First World War. It is not too surprising, therefore, that when medical enthusiasts for inebriate

institutions thought about how they might construct the institutional environment, they turned to the model of the lunatic asylum for inspiration. The annual report of Girgenti Home for 1906 illustrates the point, bringing together what were seen as the essential elements of treatment:

> Treatment is essentially the same as that for mental disorders, because inebriety is closely allied to insanity in causation, etc. 'A healthy mind in a healthy body' is the whole aim of the treatment. To gain this we must have (a) total abstinence (b) the removal of predisposing and exciting causes (c) the restoration of the general tone of body and mind (d) full employment of body and mind. I believe in keeping the inmates in constant employment, and ... as much as possible in the open air.
> (Annual Report of Girgenti Home, 1906:19)

The 'treatment' offered in the reformatories had little to recommend them to the modern advocate of the therapeutic community. There was no counselling beyond the more or less constant religious exhortations which served mainly to impress upon the wrong-doer her 'guilt' in the eyes of both society and deity. Nor, curiously enough does there seem to have been a full time medical presence in any of the Certified Reformatories. The case of the first inmate of Girgenti serves as a tragic example. This women was badly burned in uncertain circumstances (accident or suicide attempt). Despite being only a few miles from the nearest town, it was two days before she was seen by the medical officer. Shortly afterwards, she died of her injuries. Had qualified medical staff been readily available, while she may not have survived, she would surely have been removed to hospital much sooner.

In general, the medical practices associated with treatment in the reformatories were simple and straightforward, relying on 'moral treatment' rather than medical science (Baumohl and Room, forthcoming). It is interesting that, for all the therapeutic ideology and despite the active involvement of some medical men, there was very little emphasis on drug therapy. It is a curious fact that, though they were willing to borrow from the experience of others with regard to management techniques, the Scottish reformatories stayed well clear of contemporary fads for so-called 'cures' for alcoholism. Medical opinion within the

Reformatories held that inebriety should not be considered a crime, or even a social evil per se, "but rather a distinct disease with well-known symptoms requiring treatment, like other diseases of the nervous system" (Annual Report of Girgenti Home, 1905:21). Yet there was a general reluctance about endorsing any of the available drug treatments.

The reformatory inmates, had they known anything of the plethora of 'cures', might well have felt inclined to be thankful for their doctors want of initiative in this area. These so-called cures ranged from simple nerve tonics, through the American 'gold cure' of Dr L.E. Keeley, to bizarre concoctions of fresh black spiders' webs in five grain pills of course! (Barrows,1979; The Lancet, 1829).[14]

Dr Cunningham, the medical officer at the Girgenti Home, did run one drug trial. On the recommendation of a medical friend, he gave twenty-two patients a daily dose of a mixture of quinine, ammonium and aloin, plus a tablet of 'atrophine sulphide'. The 'willing patients' suffered sickness, vomiting, general stomach upsets, and attacks of diarrhoea (aloin being a bitter and fairly strong purgative) during the month long experiment, but their general health and mental well-being was said to have greatly improved. Two years after this experiment, however, all but three of the 'patients' had relapsed. Trials of some of the other 'cures' showed them to be no more effective. Mary Gordon (1906) carried out a study of the available 'cures' and, having satisfied herself that of 153 testimonials she received contained no more than five cases cured, she concluded that:

> The fact that these drug treatments are pleasant to many patients, welcomed by them, adopted by them without discretion, taken with alcohol or with other drugs, and often made by them accessory means of their final destruction, shows I think very plainly that they can have no antidotal effect.
>
> (Gordon, 1906:140)

So it was back to the bible and reliance upon the therapeutic and reformative value of hard work. And the benefits of a well-balanced diet.

The controlled diet

The other factor - apart from prayers and piecework - that was taken very seriously was diet. For many reformatories (and even prisons) the control of diet was felt to be very important. In the Salvation Army homes in England, for example, a vegetarian diet was prescribed with, it was claimed, considerable success:

> It is now eight and a half years since a fleshless diet was introduced into our inebriate homes, and we are satisfied by the increase of permanently good result that it is a real assistance ... It is a very significant fact that in many instances, when the craving for stimulants is upon a woman, she longs for animal food. When once the truth has dawned upon her, when once she has seen that eating animal food she strengthens the desire to drink alcohol ... her cooperation is secured.
>
> (Booth, 1911:63)

Some measure of the interest in diet and the mutual 'borrowing' that went on within the reformatory movement is evidenced in the fact that the 'dietary scale and time table' adopted at Girgenti (Figure 3.2) was adapted from that use in the Farmfield Reformatory near London.[15] Diet, of course, was also used by the managers of the reformatories as a means of control - punishing 'bad' behaviour and/or reinforcing effort.

The Reformatory at work

The work regime of the Reformatories focused, perhaps predictably, on the domestic tasks that were necessary for the upkeep of the institution and which supposedly prepared the inmate to return as a useful member to society. Gardening, sewing, knitting, cooking, cleaning, making doormats, and doing laundry (especially doing laundry) these were jobs the women were set to do. Jobs intended to equip them for a role, as wife and mother, which many had already rejected in the most dramatic fashion. The records of the Reformatories had a penchant for obscuring this truth; entering most women (and therefore the majority of inmates) as married, a fact which is evidenced in Table 3.2.

Table 3.2 Characteristics of reformatory inmates by age, sex, marital status, and religion

	Certified Inebriate Reformatory (%)	State Inebriate Reformatory (%)
Age of Inmates:		
under 20	8	-
21 - 30	47	23
31 - 40	28	44
41 - 50	15	26
over 50	2	7
Sex of Inmates:		
Male	3	39
Female	97	71
Marital Status:		
Married	56	64
Single	42	28
Widowed	2	8
Religion:		
Presbyterian	64	67
Roman Catholic	35	33
Other	1	1
	N=338	N=122

Figure 3.2 Timetable for Girgenti Home

Corporation of Glasgow.

GIRGENTI HOME.

TIME TABLE.

6 a.m.—Inmates to be called.

7 a.m.—Breakfast and Prayers.

7.45 a.m.—Work.

12 noon.—Dinner.

1 p.m.—Work.

5.30 p.m.—Tea.

6.30 p.m.—Recreation and Time for Private Work.

8.45 p.m.—Prayers.

9 p.m.—Bed.

9.30 p.m.—Lights Out.

During Winter Months, Inmates may be called at 6.30 a.m., with Dinner at 12 30, and Tea at 5.

These hours may be varied in the case of Inmates who, for for the time, are engaged on household work, or in attending to cattle, &c.

WILLIAM KING. Superintendent.

Even the most cursory glance at the available inmate files, however, gives the lie to this official view, making it plain that many of these women had abandoned their families, or had been rejected by them, long before they entered the Reformatory. The husband of one of the State Reformatory 'incorrigibles' wrote in reply to a request for information about his wife's character, that it "would take me weeks to tell you all (that) the children and I have suffered through her nasty disposition". He went on to say that "she was always considered very quarrelsome and of very weak intellect", and was "full of brute cunning and deceit". The tone of the letter leaves one in no doubt that any domestic ties this inmate once had had long since been effectively severed (State Inebriate Reformatory, Inmate File HH/19).

The male inmates were employed in many of the traditional tasks associated with 'prison labour' mending nets, sewing mailbags, joinery work, and the heavier labour associated with the general maintenance of the institution. There is also some indication that at least a few men had been involved in public work, reclaiming bog-land and roadworks. It is not clear, in the case of the State Reformatory inmates, whether or not the roadworks were carried on in association with convict labour. In any event, it would seem unlikely that it was intended as a long-term venture, given that in Scotland the use of congregate labour on public works was not generally approved. As Dobash (1983) pointed out in his study of prison labour, such work was felt to be detrimental to public morale and industriousness.

> The Scots rejected the 'signifying spectacle' of convicts labouring for the public good, at least within their own country. They did, however, send thousands of convicted Scottish males to England to serve sentences of penal servitude in the hulks and 'convict prisons' such as Dartmoor.
>
> (Dobash, 1983:30)

Much as they may have favoured the idea, the managers of the Inebriate Reformatories in Scotland were not in any position to dispose of their charges to the 'warehouses' of the English system. Nevertheless, they were as determined as the prison authorities that their institutions should pay their way and to this end they involved the Reformatories in socially

necessary and useful labour.[16]

If we except Girgenti, which dabbled a little bit in just about everything, and the State Reformatory at Perth which operated under somewhat tighter security, two of the three remaining Reformatories were involved in business as full-blown commercial laundries. The Greenock Reformatory had been operating as a laundry before it was licensed, as had the Seafield Home in Aberdeen on a smaller scale. One of the first actions of the managers after the institutions were licensed was to increase the scale of operations by introducing new machinery.

The importance of these commercial ventures is obvious from an examination of the financial returns of the various Reformatories. Whereas the others, including the State Reformatory, were operated at a considerable loss (and were therefore heavily dependent on Government funds), Greenock and Aberdeen showed a tidy profit. Where the Girgenti Home could only earn a few pounds from the proceeds of inmate labour, Greenock could show a yearly profit from their laundry of nearer two hundred pounds. The importance of the business was also reflected in the costs of maintaining Reformatory inmates. It cost about £40 per head per annum to keep an inmate in the State Reformatory (approximately £10 more than the average cost of imprisonment); £80 per head at East Kilbride; £53.40 at Girgenti; but only £44.20 at Seafield, Aberdeen, and £33.33 at Greenock. The Government Inspector commented frequently, and favourably, on the success of the Aberdeen and Greenock laundries. In 1914, a year after it had extended its laundry operations, the Inspector had this to say of the Greenock Reformatory:

> A great improvement in the premises of the institution has taken place since my last report. It consists of the building of a large, airy, and modern laundry. As the majority of the inmates are employed at laundry work, this addition will be beneficial, not only from an industrial point of view, but also from a sanitary point of view. (Report of the Inspector for Scotland under the inebriates Acts, 1914-15:99)

The Inspector might have gone further with his benediction, adding that the laundry, and indeed work in general, was also beneficial from the management point of view. Institutional labour was used not only to impress inmates with the habits of industrial discipline, to prepare them for a useful life upon release,[17] to reform them, and to make a profit, it was also an important means of social control.

> So long as the inmates are kept fully employed they give little trouble, but when idle their management becomes difficult.
>
> (Report of the Inebriate Reformatory, Greenock, 1909)

Work and discipline

When there were 'difficulties', labour, or rather the deprivation of work for a period of time, could still prove to be a powerful weapon in the Reformatories' armoury of control. The Regulations forbade the use of corporal punishment and limited the use of the more severe forms of prison punishment.[18] The managers made full use of the punishments left to them. Deprivation of work, reduction of diet, and/or isolation, were the favoured techniques of punishment. On occasions those in charge of the Reformatories sailed a good deal closer to the punitive wind, as the following extracts from the journal of the superintendent at Perth testify:

> (S)he became very foul mouthed, abusive and disruptive of her clothing and had to be put in a canvass jacket, and put on bread and water for a time (two days).

> On admission she charged that the superintendent at Greenock struck her on the face till she was black and blue and knocked out a tooth. The medical officer reported no signs of bruising but a tooth had been broken, though he could not say how.

At another level the work, specifically the work in the laundry, accorded closely with the general concern with health and social cleanliness. The Reformatories practised few of the 'admission rituals' associated with entry into prison. Nevertheless, on admission inmates were subjected to a medical examination, bathed and dressed, as often as not in clothes

supplied by the Reformatory. This 'purification' was carried out for the explicit purpose of 'protecting the inmates', but to a lesser or greater extent it also served to humiliate them,[19] and to undermine their identity as individuals.

In the same way, the daily routine of cleaning both the institution and oneself was more than hygienic, it was a tangible expression of the power of the State, acting through its agents, to supervise even the minutia of institutional life. Within this generalised concern with sanitation and hygiene, the concept of laundry work might have seemed particularly reformative. Cleanliness was associated with inner order - 'cleanliness is next to godliness'. Dirtiness, on the other hand, was indicative of indolence and lack of discipline. If through their work in the laundry, the inmates should come to learn the value of cleanliness, it was believed they would also be impressed by the need for method and order in their lives.

The inmates' tale

The Reformatories may be fairly categorised as places where a 'reformative regime' of hard work and religious exhortation was applied to a group of people who were certainly not renowned for their ability to articulate grievances. From an investigation of the characteristics of those admitted to the Reformatories, it is clear that they constituted a fair cross-section of the most socially, politically, and economically vulnerable groups in the society. It might seem reasonable to expect that "devoid of will, resistance, requirements, and needs", such inmates would conform to the demands of the institution. After all, they were reasonably well cared for, well fed, and decently housed. The conditions under which they existed may have been spartan, but they were better than most were used to and far better than life under any prison regime of the day. That was the official view at least.

But it is a view that ignored the reality of the inmates as people, as individuals whose lives were necessarily located within the context of their own culture and community. Arrested by the police, processed by the courts, and in most cases imprisoned at some point

before being sent to a Reformatory, most of the inmates had experienced (were experiencing) intense personal crises. How did they view the life in the Reformatory? Did they see themselves as patients or as prisoners? The official accounts do not shed much light on the subject. What little information they do contain, however, tends to focus on problems of discipline and inmates' complaints and does not suggest that they (the inmates) were particularly content with their lot.

Patterns of resistance

From the admittedly limited information, it appears that there was a good deal of resistance on the part of the inmates. This resistance was expressed in offences directed against the fabric of the institution - breaking-up furnishings, tearing clothing, and so on - or were intended to disrupt the "good order and discipline" of the Reformatory.[20] Assaults, whether upon other inmates or against reformatory staff, were recorded fairly infrequently.

Those who were not being disruptive inside the reformatory appear to have devoted a good deal of their time to breaking out of it. Girgenti Home, for example, recorded over 120 escape attempts in its nine years of operation, nearly one quarter of which were successful.[21] Although for the most part they appear to be rather mundane, often no more than trivial expressions of individual angst, it is clear that these disturbances posed significant problems for the management of the Reformatory system.

The State Reformatory, being the *non plus ultra* of the system, bore the full brunt of these problems. Originally intended for the reception of individuals committed under Section 23 of the Inebriates Act, the State Reformatory received on average only seven inmates per year in this category.[22] The majority of inmates detained at Perth came from the ranks of 'the unmanageables' of the Certified Reformatories. This state of affairs pleased the administrators at the State Reformatory not at all. The Superintendent at Perth recorded his thoughts on the transfer of yet another unruly inmate from the Certified Reformatories thus:

> This is another of the Girgenti 'unmanageables'. I regret that we have been sent this class of inebriate as it prevents, in great measure, the adoption of proper reformatory principles in the Establishment. We cannot classify, and all must be held under almost penal restrictions for the sake of the one.
>
> (Superintendent's Journal, State Inebriate Reformatory, 1902)

This concern about the 'class of inebriate' being sent to the Reformatory was not peculiar to Perth. All the Reformatories, to a greater or lesser degree, complained about the 'clients' that were referred to them by the Courts. They all had an ideal 'client group' in mind, one that offered the institution (and the individual) the best hope of effecting a reformation. The ideal inmates, in Carswell's opinion, were:

> ... persons who, while habitual drunkards, are of such character and disposition that it may be reasonably expected, if cured of their intemperance, they would be able to take their places in society as self-supporting citizens.
>
> (Carswell, 1901:9)

> ... in my opinion ... unless patients come under the scope of the Act at an early age, the results of treatment cannot be satisfactory when they are admitted physical wrecks, with shattered constitutions and distinct evidence of mental weakness.
>
> (Annual Report of Girgenti Home, 1902)

The preference for young, reasonably uncorrupted, well-motivated inmates is easily understood, but it is in marked contrast to the actual pattern of receptions which favoured the admission of older, more chronic, offenders. The Reformatories, however, were either public institutions or were dependent on public funding. They were in effect required to accept anyone, even those whose prognosis was considered to be hopeless. In the opinion of many, the class of offender scheduled in the Act effectively limited "its operation to the street pest, drunken prostitute, and thief, and the drunken flotsam and jetsam of our towns" (Carswell, 1901:3).

To be treated worse than the very beasts

The implementation of the Inebriates Act proved difficult for those in authority. For those on the receiving end, the inmates, the experience clearly caused a great deal of resentment.

The idea that they were being treated as prisoners (contrary to some promise or commitment to the contrary?) was a common expression of this rancour. Peter Burke, the first male inmate of the State Reformatory, for example, complained bitterly about being treated as a "criminal prisoner", and about being "locked-up during the day when not employed outside" (Superintendent's Journal, Perth, 1901). Another Reformatory inmate in a letter to her mother, conveyed very strongly this feeling of having been punished and somehow cheated by the system:

> I am keeping in very good health I am thankful to say but I am very downhearted when I think of all I have to stand from day to day and from year to year and I have to say nothing whether I am right or wrong and for nothing I ought to be outside working and treated with kindness and respect and getting paid for my work, but to work hard from day to day and not even get a kind word I shall never forget this as long as ever I live, if I had done a crime I would have first taken it as a punishment and said nothing but to be ordered about and never anything to look forward to why it is even worse than the very beasts. My one prayer is to have my health and I will put up with the rest for it is an awful place to have anything wrong with you.
>
> (State Inebriate Reformatory Inmate Files HH/19)

As if to demonstrate the completeness of State supervision of her life, even this expression of despair was silenced. The woman's mother never received the letter which was suppressed by the authorities.

The ability of the State to direct people's lives is perhaps best illustrated by the movement of inmates within the Reformatory system and between the Reformatories and other institutions. Although this information does not offer any access to inmate consciousness per se, it does give some indication of the conflict that existed between the formal and informal control of even the most routine aspects of an individual's life. Nowhere is this conflict more obvious than in the almost arbitrary nature of movements within and between institutions. The 'revolving door' which has proved such an evocative image in the context of contemporary discussions of alcohol-related issues, was already spinning freely in the early years of this century. The poor, the mentally ill, the inebriate,

all were stigmatised and confined within a complex and expanding network of institutions.

The progress of individuals within this institutional network can be traced through the sparse entries in the inmate files. The following history of events in the life of one woman, Isobella Thompson, presents an extreme, but by no means atypical, illustration of the institution nexus between the hospital and the prison. Before being sent to an Inebriate Reformatory, this woman had been imprisoned on twenty-nine occasions for periods ranging from three to thirty days. On 16 July 1901 she was sent to Girgenti Home and here her journey through the institutional network begins:

10 October	-	transferred to State Inebriate Reformatory, Perth.
1902:		
4 April	-	"The P.C. (Prison Commissioners) have the honour to report that Isobella Thompson, at present an inmate of the State Inebriate Reformatory at Perth, has become insane".
21 October	-	Removed to Woodilee Asylum, Glasgow, where, "Beyond a slight blunting of the finer intellectual and moral faculties", the psychiatrist at Woodilee could find "no sign of insanity."
1903:		
10 June	-	Returned to State Inebriate Reformatory.
14 September	-	Readmitted to Woodilee Asylum, Glasgow.
1904:		
16 July	-	Liberated.
18 July	-	Arrested (drunk and incapable) fined 2/6d (15p) or 3 days imprisonment.
8 November	-	Transferred from Duke Street Prison,Glasgow (sentenced 7 days for using obscene language) to Woodilee Asylum.
5 December	-	Discharged from Woodilee Asylum.
1905:		
28 June	-	Sentenced to 7 days imprisonment (drunk and incapable).
30 June	-	Transferred from Duke Street Prison to Woodilee Asylum, Glasgow as "insane and dangerous".
5 July	-	Discharged from Woodilee Asylum on expiry of prison warrant. Readmitted same day "chargeable to Parish".

From Court, to prison, to lunatic asylum, to Inebriate Reformatory, and back to the Court. The progression does not seem to be explicable in terms of any socio-medical diagnosis, or even some crude classification, rather it was related to the perceived failure of the individual to come to terms with the demands of institutional life. The story of Isobella

Thompson and a good many other Reformatory inmates is one of refusal - sometimes explicit, sometimes tacit - to be institutionally managed. The comments of one prison governor vividly portray the despair and frustration of the authorities faced with what many saw as an intractable problem with chronic inebriates. The concern is obvious, but so too is the pessimism about the ability of the medical profession - and, by implication the Reformatory system - to do anything about the problem:

> (She) commenced at 5 this morning (before the prison was open) to smash all furniture ... without doubt an insane person. No jury would convict her, in face of her history, if one of her outburst resulted in a serious or fatal inquiry ... She has proved over and over again that she is unfit to take care of herself but she is regularly dismissed (cured?) from Asylums ... Is it not time this farce ended?
>
> (Governor Journal, Duke Street Prison, Glasgow, 1904)

Disinterest and decline

For Girgenti the 'farce' ended on 7 March 1907 when Glasgow Corporation approved a recommendation to "discontinue, at the earliest possible date, the use of Girgenti Home as an Inebriate Reformatory". Girgenti finally closed in 1909, to be followed within the year by the Lanarkshire Reformatory at East Kilbride. Greenock and Aberdeen, being to some extent protected from the financial hardship that so affected the others, carried on throughout the years of the First World War, only to go into decline in the confusion of the post-War period. By 1921 all the Reformatories, including the 'rump' of the State Reformatory, had closed and the 'experiment' had come to an end.

Why did the Inebriate Institutions fail? The procedural complexities of committal, the difficulty of "attracting a better class of inebriate", properly motivated and with a good chance of reformation, the lack of any proper system of 'after care', and of course the shortage of resources, have all been cited in an attempt to explain the less than successful operation of the Inebriates Act (Radzinowicz and Hood, 1986). Certainly, the Reformatories came under increasing pressure to justify their considerable expenditure. But how were they to justify themselves? In terms of their supposed therapeutic ideal perhaps? Could the

Reformatories provide evidence of success in rehabilitating problem drinkers? In the light of what has already been said about the 'chosen client group' and the practical limitations of the system, it should come as no surprise to learn that the answer is no, they could not, as even to their most vociferous supporters had to acknowledge. The position in the State Reformatory was predictably worse, as a Report of the Prison Commissioners makes clear:

> It is worthy of note that out of 50 inmates received from Certified Inebriate Reformatories there have been only two cases of reformation, which emphasizes the fact that real reformatory work, ... can have little or no success with such cases, the majority of whom consider their detention a gross injustice instead of appreciating the great efforts made for their reformation.
> (Report of the Prison Commissioners for Scotland, 1914)

To judge the Reformatories on their success, or lack of it, in the rehabilitative field, is to accept perforce that the therapy was the main institutional aim. I am aware that the Inebriates Act has been seen as a testimony to the seriousness of medical interest in the problem and that it cleared the way for the eventual acceptance of the medical model of alcoholism and so on (Orford and Edwards 1977). Viewed from this position, the history of the Reformatories appears as an essentially benign series of events confounded by unfortunate, or unintended, consequences. However, having explored the detritus of the official record, I would suggest an alternative explanation.

Widening the carceral net

The Inebriate Reformatories formed part of a much broader interlocking carceral network. Although they were not penal institutions, the Reformatories had a good deal in common with the new prison system. The regime, the emphasis on 'prayers and piecework', the system of release on licence, even the concern with diet and 'moral treatment', all find parallels in other areas of the carceral world. The Reformatories were adjuncts to, rather than a radical departure from, the extant policies of the criminal justice system. And, whatever the fine phrases about "fair and reasonable experiments", this was clearly meant to

be the case. Outlining the history of the Inebriates Act, the Inspector for England and Wales presents the rationale of the Act in the following terms:

> (H)ow necessary it was that some curative or restraining power should exist capable of direct application to the drunkards themselves ... something applicable to inebriates more powerful than mere temperance teaching; something stronger and more physical, something that could make them reform, or, failing reform, could ensure their detention and care for the benefit of the community.
> (Report of the Inspector under the Inebriates Acts, 1908.)

The juxtaposition of the concepts of 'reform', 'punishment', and 'containment', was a recurring theme in the social commentary of the period.

The Inebriate Reformatories made a bid, albeit a rather late bid, for recognition as a legitimate element within a modern network of social control. The acceptability of the 'institutional option' had already been confirmed by the establishment of separate institutions for juvenile offenders, asylums for the mentally ill, and, most forcefully by the ascendancy of the prison, whose towering presence had become the ultimate symbol of the power of the State. But whereas these other institutions were gradually absorbed into the taken-for-granted fabric of society, to become part and parcel of our institutional inheritance, the Inebriate Reformatories disappeared. Like so many other 'contenders', they succumbed to the vagaries of philanthropic style and public policy.

The problem, then, was not simply a matter of a little local difficulty concerning the practicability of implementation. There were wider difficulties which related not only to the attitudes of society in general but also (and more significantly) to the 'reformers' themselves and their inability to clearly define the problem, its fundamental causes, or the precise nature of the putative solution. The disparate groups that were involved with the 'system' included doctors, legislators, administrators, and temperance reformers (in themselves a very mixed bag), and of course those involved in operating the Reformatories at a local level. All of these groups had ideas about what the problem was and about the mix of punitive and therapeutic treatment that was necessary for success. Consensus about such issues

proved to be an illusive objective. The medical officer at Girgenti, for example could express the view that, "inebriety is a distinct form of mental disorder ... requiring medical care and treatment", while the Convener of Glasgow City Council who had ultimate responsibility for the Reformatory could express himself equally firmly of the belief that "inebriety has not been proved a disease" (Carswell, 1901:1).[23] It is unlikely, however, that the 'therapeutic ideal' foundered solely on the rock of definitional confusion (disagreement). Despite the best efforts of the reformers, medical and psychiatric interest in the area was not widespread. Working with inebriates still carried considerable stigma and was regarded as a low status activity by most doctors. A view that holds true even today.

The Inebriate Reformatories could have survived the ambivalence, even the hostility of the medical profession. After all, the penitentiary system survived equally severe criticism of its functional shortcomings. But prisons could attract the continued support, and the purposeful backing of the State. There is no evidence that Governments were willing to extend the same backing to the Inebriates Act. As Carswell observed (without any apparent irony):

> (The Act) ... was admittedly a bit of experimental legislation, and Parliament never puts heart into experimental legislation, except, perhaps, when it is legislating for Ireland.
>
> (Carswell, 1901:2)

Conclusions

The Inebriate Reformatories attempted to change, or at least to extend the repertoire of society's response to habitual drunkenness. They developed as part of a more general trend in favour of institutional options that had emerged out of nineteenth century thinking on social control. This institutional option was informed by the ideas of the social and medical sciences which seemed to offer new insights on the nature of individual deviance and innovative strategies to control it. The most potent symbol of this ideology was of course to be found in the penitentiary and in the new penology of reformers such as John Howard

and Elizabeth Fry. The Inebriate Reformatories, though part of the same carceral network, were by comparison relatively unimportant; worthy of no more perhaps than a footnote in the history of moral reform.[24]

For an historical explanation of this sort to make any contribution to the development of contemporary polices and ideas about responses to alcohol problems, it has to identify themes that are of continuing relevance. The story of the inebriate institutions fulfill this purpose in two ways: it emphasizes the issue of control versus therapy which if anything has become more import in the present day, and it points to the importance of understanding how implementation of policies at ground level can distort or subvert the intended goal.

The pros and cons of coercive treatment continues to provoke considerable controversy, as we shall see later in the thesis. At a more mundane level, however, the attempt to operate a therapeutic regime through the medium of criminal justice had a paradoxical effect for those involved. The concept of legality when married to the idea of 'alcoholism as a disease' resulted in a double stigma for the offender - "bad and mad" - and an outcome more punative than the criminal law alone, by detaining her in the Reformatory for anything up to three years. Recent proposals for reforming the management of drunkenness have not gone that far, but it is a salutory lesson to realise that the medicine offers fewer safeguards to our civil liberties that the criminal justice system.

From Reformatories to designated places?

The comparisons are most easily made with regard to the management of public drunkenness and in particular with the changes that were introduced in the Criminal Justice (Scotland) Act, 1980. Section 5 of the 1980 Act makes provision for the diversion of some drunkenness related offenders from criminal justice processing. The implications of this provision will be discussed later in the thesis. For our present purposes it is sufficient to

note that those involved in the administration and operation of initiatives such as Section 5 might benefit from an understanding of the previous 'experimental legislation' in this field.

There are, for example, issues relating to the implementation of diversion schemes, the chosen client group, the nature of the 'treatment regime', the utility (desirability) of coercive control, and so on, which can be identified in the earlier legislation. In many of these areas, the aims and objectives of contemporary policy initiatives are no more clearly articulated than those of the Inebriates Act. The conflict between organisational and individual goals, for example, is often unresolved. The opposing claims of the socio-medical and the criminal justice traditions have barely been recognised, far less satisfactorily dealt with. Another major obstacle to the successful implementation of an alternative strategy for the management of drunkenness is (and historically has always been) the lack of purposeful Governmental support. Lord Mansfield in introducing the 1980 Bill in the House of Lords, echoes the permissive sentiments of an earlier period. He described Clause 5 (Section 5 of the Act) as:

> ... an enabling power, for use as resources become available, permitting the police to take drunk offenders to a detoxification facility, instead of arresting them.
>
> (Hansard, 15 January, 1980)

Like the Inebriates Act before it, this is a piece of permissive legislation designed to allow greater involvement of the private sector in the management of social deviance. Again, there is a comparison with the Reformatory system in that the Government has allowed for only a minimal investment of public funds to help provide for the establishment and operation of 'detoxification facilities'. In the light of this and the fact that only one facility "designated for the reception of drunken persons" has been established since the Act was implemented in 1981, it is hard to believe that the Government has any more intention of allowing a "full and fair experiment" of Section 5, than earlier Governments had with regard to the Inebriates Act.

Beyond these difficulties, however, there is one other factor which can compromise the successful translation of policy into practice and that is attitude and behaviour of those most directly involved in the day to day workings of the system. The historical record does not provide us with any easy means of interrogating the supervisors of the Inebriate Reformatories, or the Edwardian policeman. Nevertheless, it offers enough 'glimpses' behind the formal administration of the Reformatories to alert us to the importance of such people. There can be no doubt that stated policy were modified and interpreted in ways which might have had significant impact not only on an inmate's experience of the regime, but also on the desired outcome of the process. Nor can there be any doubt that contemporary policy decisions are subject to a similar process of modification and (mis)interpretation. The difference is that we can talk to the present day frontline managers of alcohol problems. We can discuss with police officers, social workers, magistrates, (even) doctors, their attitudes, perceptions, and experiences of dealing with problem drinkers. In some cases we can observe the interaction between (say) the policeman and the public drunk, contrasting ideology with practice in a very direct way. And in the chapters that follow, that is just what I will be doing.

Notes

1. Information on the inebriate reformatories, particularly on the day-to-day operation of the system, was admittedly difficult to come by and this may have deterred researchers in the past. In addition, some of the information was restricted. The Scottish Home and Health Department Records, for example, which contain a great deal of detail about the regime and the inmates of the State reformatory, were 'closed', and permission had to be sought to gain access.

2. Scotland and England were separate nations until joined by the Act of Union, 1707. This treaty guaranteed the continuation of distinct Scottish institutions in the areas of religion, education and law, with separate, though frequently analogous, administrative arrangements. Therefore, although the provisions of the Inebriates Act, 1898, were virtually identical in both countries, the operation of the Reformatories differed considerably. For one thing the English Reformatories tended to be much bigger than

those in Scotland and, in fact, many were purpose built institutions which seemed to be designed very much along prison lines. Whereas the largest Certified Reformatory in Scotland, Girgenti, had places for fifty-eight women, the largest of the English Reformatories could boast three hundred beds and the average Reformatory over one hundred.

Inebriate institutions were also to be found in many other English speaking countries Australia, Canada, Ireland, and of course, in the United States and in several European countries, particularly Germany (Baumohl and Room, forthcoming).

3. The earliest recorded inebriate asylum was established in Boston in 1841 but was soon closed for lack of funds. After this false start, the asylum was reopened, in 1857 and, thereafter, the number of institutions increased to over fifty.

4. In the autumn of 1871, Donald Dalrymple, the chairman of the Committee, spent two months visiting inebriate institutions in the United States and Canada. He visited nine institutions in all (8 in the USA and 1 in Canada), and reported his findings before the Committee.

   In his account of these North American institutions, Dalrymple stressed both the voluntary nature of most admissions some ninety-four per cent of patients were self-referrals and the limitations this placed on successful treatment.

   "(The) patients being voluntary, may leave before they are fit to go, deeming and calling themselves cured though they are not so, because he (the medical officer) has no power to turn the key on them; if he had possessed this power many cases would have been saved that were lost."
   (Report of the S.C. on Habitual Drunkenness, 1872:81)

   Despite the force of Dalrymple's evidence and the recommendation of the Committee, no compulsory measures were introduced in the Habitual Drunkards Act, 1879, which was passed as a result of this enquiry.

5. The Washingtonian Movement was a therapeutic, self-help association for reformed inebriates. In style and content the Washingtonian Movement had much in common with A.A. and other modern day self-help groups. The movement was begun "by so-called drunkards" in Baltimore in 1840 and enjoyed considerable initial success. By 1843 the Washingtonians claimed a membership of over one million. Two years later, however, the movement had collapsed; most of the local groups had either disappeared or had lost their distinctive Washingtonian character (Blumberg, 1983).

6. The male division of the State Reformatory was 'lent to the Military Authorities' in October 1915 for use as a detention barracks. From that date the Reformatory system was employed exclusively for the 'benefit' of women.

7. If the offender declined to be admitted voluntarily, the matter could be remitted to a higher court with powers of involuntary committal.

8. Dunlop's sample included (i) all prisoners received into Edinburgh prison during a four week period in 1901, (ii) one hundred prisoners received consecutively into Glasgow (Barlinnie) Prison with long sentences of six months or more, and (iii) 198 women prisoners resident in Duke Street Prison, Glasgow, on 25 November 1901. In all 975 prisoners were surveyed but 67 were excluded because they were untried or for other reasons.

The term 'drunk', as used in the Table 3.2, indicates that the individual was distinctly intoxicated at the time of arrest. 'Might have been dealt with under Section 23' means that the person was drunk at the time of the offence and was considered to be an habitual drunkard under the terms of the Inebriates Act. 'Might have been dealt with under Section 24' indicates that the individual had been found guilty on at least three prior occasions in the previous year of offenses scheduled under the Inebriates Act.

9. Bretherton (1984) makes similar observations about the predominance of women within the Irish reformatory system.

10. That practice of forfeiting bail was so common as to be regarded as 'normal' the equivalent of an on the spot fine for drunkenness. Between 1900 and 1914, on average, approximately thirty per cent of those charged with drunkenness-related offenses chose to forfeit their bail in lieu of a fine (Carswell, 1901:7).

11. Dr Dunlop initially refused the transfer of this women to Perth, arguing that there was no necessity for such a move. Once at the State reformatory, however, and despite her good behaviour Dunlop advised against her release on license. On this occasion his argument was clearly based on 'psychiatric criteria'. "This is a neurotic woman whose case is almost hopeless," he wrote in December 1910. "I cannot advise her liberation on licence" (State Inebriate Reformatory, Inmate File HH/19).

12. Coincidentally these two institutions, Greenock and Seafield in Aberdeen, were also the ones which had most need of female labour, laundry work not being considered suitable for men!

13. The Secretary for Scotland issued various regulations and guidelines from time to time concerning the operation of the Inebriate Reformatories. The most important ones, the 'rules' by which the institutions were, or were supposed to be, run were:

General Regulations for the Management and Discipline of Certified Inebriate Reformatories in Scotland: 1905, Cmd 2437, 1xv, 189.

Regulations for the Rule and Management of the State Inebriate Reformatory, 1900 (92), 1xix, 193.

14. The Lancet reported the rather bizarre 'cure' involving black spiders' webs in 1829. The incident concerned "an intelligent young man" who fell into "a state of tremulentness and excitement", after having consumed several bottles of brandy. After three days:

"... he began to use fresh web (of black spider) in pills of five grains every hour. The effect was prompt and unequivocal. He calmed, even sensibly to himself with every dose."

(Lancet, 1829 (2):976)

15. The the files of the Girgenti Home contain a copy of the Farmfield timetable which bears the annotation of a (presumably) Glasgow official working on the draft regulation for the new reformatory.

16. There does not appear to have been any shortage of such labour, particularly after 1914 when the inmates to be set to work doing their bit for the war effort. The precise nature of the 'war work' that could be undertaken in the Reformatories is not mentioned in any of the Annual Reports, but, given the nature of the institutions, it seems likely that it would have involved the manufacture of items of uniform.

17. It is of course questionable as to whether or not the majority of Reformatory inmates would have been judged employable under any circumstances, but there is very little evidence that Reformatory 'training' improved their job opportunities on release. Of the few 'hopefuls' that were placed in employment after their liberation, most entered 'service', doing menial tasks around the homes of their middle class benefactors. There is only one woman inmate of the Greenock Reformatory recorded as having found work in a laundry, despite all their 'training' in this type of work.

18. The State inebriate reformatory at Perth was something of an exception to this rule since it operated under Prison Regulations to some extent. Thus, we find one male inmate 'restrained' by having his hands tied behind his back 'in swivel hand-cuffs' for a period of 24 hours for assaulting warders (State Inebriate Reformatory, Inmate File HH/12/75/1).

19. The medical examination might have proved particularly embarrassing or humiliating for many women because, in spite of a clear ruling that wherever possible the doctor in a female Reformatory should be a woman, virtually all of the medical officers were men.

20. From the records of the State reformatory it would appear that the most common 'offences' were "swearing or using insolent or threatening language" and "disrespect of officers or visitors". Inmates were also discipline for seemingly trivial offences such as singing and whistling.

21. In fairness to the institution it should be pointed out that, unlike prisons, there was never more than the minimum of staff necessary for the general training and supervision of the inmates. The Reformatories did not have the human or technical resources that would have been needed to prevent or discourage escape attempts. Girgenti, for example, was a forty-five acre farm and lacked even a boundary fence.

22. Most of the admissions to the State Reformatory under Section 23 were for child neglect (and habitual drunkenness). This contrasts sharply with the position in England where there were not only a great many more admissions under Section 1 (the English equivalent of Section 23), but also a greater variety in the crimes for which persons were admitted. An average of about 32 persons per year were sent to Reformatories in England and Wales under Section 1 and. although child neglect was again the single most frequent reason for admission, individuals had been convicted of crimes ranging from Manslaughter and theft, to attempted suicide.

23. The medical profession in general was similarly ambivalent about the status of alcoholism as a legitimate medical problem. Although the British Medical Association played its part in the agitation which resulted in the passage of the Inebriates Act, it would be an exaggeration to claim that there was within the B.M.A. any particularly strong interest in alcohol problem. The following figures might help put medical interest into some kind of perspective. In July 1884 the Society for the Study and Cure of Inebriety had 232 members 165 (71%) of whom were doctors. Compare this tiny membership with the support that the B.M.A. could muster to oppose an innovation that seemed to threaten the vested interests of doctors 27,400 doctors pledged themselves to oppose the introduction of Llyod George's State Insurance Bill (Turner,1958:256).

24. In a country which prosecuted, fined, and/or imprisoned thousands of people for drunkenness-related offenses, the Inebriate Reformatory usually confined no more than a few dozen. In the twenty years under review, less than 600 inmates were admitted to Reformatories. Even with these small numbers the Reformatories had virtually so little impact that it is difficult to give any functional explanation of their existence. Certainly, to view these institutions as major and/or necessary agencies of social control would be a gross distortion of reality.

Part Two

The Contemporary Context

Doctors were brought in from surrounding areas to deal with the epidemic and for some time panic prevailed during which the burly chargehand dismissed Sylvester for he thought there was something suspicious in the smirk he wore. Sylvester found his way back to the East End and his Granny, who welcomed him with open arms, agreeing that he had endured sufficient punishment.

As for the sufferers, they quickly recovered and from that day to this they have not uttered a single complaint and swear they never felt better, a fact which they attribute to the medicinal wine.

This then is the origin of the legend.

From *The Medicinal Wine* by Matt McGinn

4 Researching the Contemporary Scene

The success of the Temperance crusade in constructing alcohol misuse as a social problem - a success bound-up with the influence of the disease concept of alcoholism - may paradoxically have generated, if not the seeds of its own destruction, considerable barriers to the future promotion of the issue. The historical legacy of Temperance was to define 'alcoholism' as a problem for the 'experts', rather than for the public to deal with. 'Ownership' and 'responsibility' was devolved to the institutions of medicine, the criminal justice system, and (more recently) social work.

The paradox of course is that, while the phenomenon - drinking - occupies a significant place in both 'public' and 'private' arenas, we known very little about the nature of the institutional response to the problems it creates. Not a great deal of attention has been focused on the individual and institutional processes that inform perceptions of the problem and influence response activities. The research that has been done - whether it is concerned with the past, in the case of my discussion of the inebriate institutions, or with the present institutional framework - suggests that the relation between the stated policy in respect of a particular problem and what actually happens, as it were, 'on the street', is often problematic. In police work, for example, a number of researchers have pointed to the disjunction between those who make the policy decisions and the "officers who work on the street" putting policy into practice (Fielding, 1981).

The primary concern of the thesis up to this point had been to reveal the 'construction' of drunkenness as a social problem. When exposed, however, the processes by which the problem emerged, do not inform us about the work of those who effect the day-to-day management of alcohol problems. In order to explore these issues - the affect of attitudes, perceptions, and behaviours on the way alcohol related incidents are dealt with - a study of the contemporary scene was required.

This chapter then explains the background and design of a study of the contemporary management of alcohol problems and goes on to discuss the basic concepts used in analyzing the data. The research project - there were in fact two studies, a pilot study and the main fieldwork - involved interviews with a range of people who had experience of dealing with alcohol problems on a day-to-day basis. The interview itself was semi-structured and included both open-ended and closed items. In addition to the interviews, the fieldwork included group and informal discussions and participant observation. The sample included representatives of the criminal justice system, social work, and a few medical professionals. Three hundred and seven interviews were conducted in 27 research locations throughout four Scottish Regions - Central, Grampian, Tayside, and Strathclyde.

Aims of the study

The central aim of the study was to develop an understanding of contemporary responses to alcohol problems: to look at the ways in which problems are responded to by the agents of the criminal justice system, medical and social services. I felt that a study of the discourses and actions of those actually involved in the routine management of the issue (as distinct from policy-makers or politicians) would provide the best opportunity for going beyond institutional ideologies and uncovering the reality of the day-to-day work with alcohol problems.

Although previous researches had considered some of the issues and had in a sense set the agenda, these tended to focus on a particular group(s) or on specific aspects of society's response to problem drinkers: Archard (1973) followed the well-trodden path to 'skid row' (Weisman, 1970; Bahr, 1970); Cook *et al* (1969) focused on the experience of drunken offenders in our courts; and social work responses have been discussed by Hunt (1982) and others. By contrast, the institutional framework within which responses operate

and, more importantly, the experiences and behaviour of those who work in these institutions, have been largely ignored.

Recently policy makers have tended to put more emphasis on the role of the front-line agents - police, social workers, G.P. and so on. The potential of co-operative initiatives by these front-line agencies for helping problem drinkers has never been more widely acknowledged (Advisory Council on Alcoholism, 1978). The success of such policy initiatives, however, depends on effective inter-agency co-operation. This in turn is influenced by differences in the way agencies, and those who work in them, approach the issue of alcohol misuse.

Working methods

The research problem set - the parameters of the research area formulated - the next step was to decide on the method of investigation that would be most appropriate to the task in hand. What research technique(s) would best elucidate the processes that characterise contemporary responses to drunkenness? On the face of it, there is no shortage of choice. Indeed, the range of competing alternatives has always been a feature of the sociological enterprise. Not only in relation to research methods, but also as regards theoretical perspectives and conceptual schemes.

Various research strategies were considered and rejected as unsuitable at a very early stage in the research programme. Self-administered pre-coded questionnaires, for example, were considered unequal to the task of illuminating complex issues relating to attitudes, perspectives, and behaviour. Questionnaires are subject to all sorts of practical difficulties, such as the problems of achieving realistic response rates or controlling the administration of the questionnaire in order to minimise frivolous (even dishonest) responses. These problems, of course, are well known and allowances can be made for their possible impact on the research (Cicourel, 1964; Galtung, 1967).

There are, however, some more invidious implications attached to the use of pencil and paper questionnaires. The major problems with such questionnaires is that they tend to structure not only the stimuli that is presented to respondents and their response to the stimuli, but also the reality of that which is being studied. Implicit in the use of forced choice techniques is the assumption that the researcher already has considerable knowledge of both the existence of, and the variations in, the phenomenon under investigation. Of course, the formulation of the research questions themselves logically presupposes that certain assumptions have been made about the objects to be studied. The problem with the questionnaire is that it assumes that the researcher's understanding of the phenomenon has some relevance for the respondent. It is not enough that we, as researchers, "take a handful of sand from the endless landscape of awareness around us and call that handful of sand the world" (Pirsig, 1979:75), we expect (demand) that our respondents will share our definition of reality. Regardless of their interest in or knowledge of the research topic, mindless too of their possible ignorance of the questionnaire format itself, respondents are expected to provide precise answers to fixed questions.

Of the other possible strategies, experimental techniques were rejected as impractical, and large scale participant observation was ruled out on both practical and ethical grounds. In many ways participant observation was an attractive proposition. It would have afforded valuable insights, particularly into police work, that might not have been possible with other methods of investigation. Not that the possibilities offered by observations were entirely abandoned. Given that the routine of police work has not been well documented in this country, I had hoped to include an observational component as part of the fieldwork with the police. Accompanying officers on mobile patrol would have provided an opportunity not only to talk with the officers on their 'home ground', but also to observe at first hand how they dealt with drunkenness-related incidents. Unfortunately, this ambition proved difficult to realise in practice.

During the pilot study I did get permission to accompany officers on patrol, though not on any kind of regular basis. From this, admittedly limited, experience it was clear that the opportunities for observing police-public drunkenness encounters were in fact circumscribed by the distribution and relative (in)frequency of these incidents. Improving the possibilities of my observing police-drunk interaction would have meant giving greater emphasis to the 'peak periods' for such incidents - Friday and Saturday nights - thus adding considerably to an already labour intensive exercise. Although the experience was valuable for improving my understanding of the role of the police, it could not be considered a practical research method.

Whatever the practical difficulties or ethical problems, at the end of the day the researcher must come up with a working method which can be meaningfully applied to the subject under investigation. In this case the best, the most appropriate research method, was judged to be one which combined elements of both formal and informal modes of data collection.[1]

Designing the study

Given the limited relevance of existing literature for the research topic, it was decided that the project should begin with a pilot study. This pilot study involved a variety of people: specialist and (a few) generic social workers; doctors, psychiatrists and psychologists; and police officers. The major part of the pilot study was conducted in one Scottish District - Falkirk - over a period of six months from January to June 1982.

Falkirk District was chosen because it is fairly representative of other parts of the Central belt of Scotland. The population is concentrated in an urban-industrial area in the North-East of the District, around the towns of Falkirk and Grangemouth, but the area also includes a number of small rural communities, and coal mining villages. The area is also representative in that the incidence of alcohol problems was in no way exceptional. Table

4.1 shows that the indices of alcohol related harm in Central Region, which includes Falkirk District, are comparable with those of most other Regions.

The pilot study collected data using a variety of techniques. The favoured method - unstructured and semi-structure interviews - yielded 94 interviews that were analyzed and incorporated into the findings of the main study. The fieldwork at this stage also provided the major observational component of the research, principally with Central Scotland Police (B Division). In the initial stages of the study a list of orienting questions was used to probe respondents' attitudes to drink and alcohol problems - their knowledge, perception, and experiences of both extant and alternative policies and response strategies. As the project developed a more structured interview schedule was evolved which included both open-ended and closed questions. With some minor modifications, this was the interview schedule that was used in the extended study.

The pilot study then was not simply a preliminary to the main research activity, the sole function of which was to pre-test appropriate research techniques. It yielded a vast amount of elaborate, detailed, and comparable information in its own right. As such it was an integral part of the overall research enterprise. It provided a positive opportunity to learn about the research issue and the problems surrounding it. As part of a learning process I was able to familiarized myself with current research in the area and to relate these ideas to the 'real world', the world as seen by those most directly involved in dealing with alcohol problems.

Table 4.1 **Regional patterns of alcohol related harm**
Rates per 10,000 of adult population

Region	Admissions to Psychiatric Hospital	Drunkenness/ Drink-driving	Alcohol-related Mortality
Borders	2.84	87.6	2.13
Central	3.01	136.7	1.88
Dumfries and Galloway	3.05	113.2	1.61
Fife	3.57	370.0	1.07
Grampian	3.86	194.4	2.06
Highland	12.0	266.3	2.3
Lothian	4.05	131.1	1.6
Strathclyde	4.74	211.6	2.0
Tayside	4.94	154.1	1.89

Sources: Kilich and Plant, 1981; Scottish Abstract of Statistics; Scottish Criminal Statistics; Scottish Home and Health Department.

Through this dynamic process - through talking with police officers, social workers and so on, and observing them 'in action' - I was able to develop a better understanding of the issues and processes involved. In this way common themes could be identified and, perhaps more importantly, disparities and contradictions could be brought to the fore where they could be constructively addressed.

Let there be no confusion, I am not suggesting that I was in any way seeking to discover theory lurking within the data. This was not an exercise in what Glaser and Strauss have christened 'grounded theory'. I did not come to this study as some kind of *tabula rasa* innocent, naked of all preconceptions and armed only with the abstract hypothesis-seeking

tools for generating substantive and formal theory (Glaser and Strauss, 1967). It should be clear from earlier discussions not only that my research was guided by a general methodological/theoretical perspective, but also that I arrived at this study with preconceptions about the nature of response strategies, having already considered in some detail the historical development of the problem. What the pilot study did was to give me an opportunity to check these preconceptions against the perceptions of those who had first-hand knowledge of the issues involved. Not that the story told by police officers or social workers is to be regarded as some kind of revealed truth, or as necessarily better than the researcher's definition of the situation, but there were occasions when it was necessary to modify or reformulate ideas and/or research strategies in the light of information from those working in the field.

The Interview schedule

In order to realise the goal of the study, to provide information about the nature and pattern of responses to alcohol problems, the fieldwork had to meet three objectives, it had:

i. to provide an account of the perceptions, attitudes and experiences of those agency personnel involved in responding to alcohol problems and to locate these responses within the context of the overall functioning of the agency.

ii. to assess respondents' level of knowledge of alcohol, its attendant problems and of the local resources for tackling these problems.

iii. to provide information about the nature and pattern of interaction among the various groups as they respond to a common problem.

The interview schedule itself was divided into four sections: background details; drinking and drunkenness; alternatives in managing alcohol problems; the role of the agency. A copy of the interview schedule is included as Appendix II, but it might be useful to provide a brief outline of the major themes and the rationale behind specific items.

Background details

The interview opened with the fairly standard socio-demographic variables - age, sex, occupation, and so on - that experience suggests might be relevant to attitudes and/or experiences. I also asked about periods of residence outwith the local area and previous work experience, in an attempt to establish the range of experience that a respondent might have had in dealing with alcohol and/or its attendant problems. Other items covered the respondents' own drinking and any religious or moral objections they might have to alcoholic drink.

Drinking and drunkenness

The major part of the interview was taken up by questions which related to attitudes to drinking and drunkenness, and the individual respondent's experience of dealing with problem drinkers in their day-to-day work. These are the crucial issues for the study because they tell us about how those who effect the routine management of alcohol problems view the behaviours associated with alcohol use. They reveal something about the attitudes and about behaviour in particular situations. These are the sorts of issues that the institutional history finds so difficult to address. The sorts of issues that the available research suggests are important determinants of response activities (Sknolnick, 1966; Muir, 1977; Fielding, 1983).

Questions about respondents' perceptions of the seriousness of alcohol problems, were followed by a series of attitude scales about drinking and drunkenness. The items used in these scales were adapted from other studies (Dight,1976; Rix and Buyers, 1976). In the pilot study I found that giving respondents a chance to talk about why people drink was useful in supplementing the attitude items.

Details of actual police encounters with drunken individuals were exploreded in a fairly structured way, (i) to ensure that the information from different sources was

comparable and (ii) because I found during the pilot study that a some police officers found it difficult to answer the question when it was put in a more general, less directed way. Others involved in the criminal justice process were asked similar questions, but they were more open-ended to take account of the different range of experiences and responsibilities. The same was also true of social workers.

I also attempted to assess respondents' knowledge of the locally available services and facilities for dealing with alcohol problems. Social workers, it has been claimed, have a poor level of knowledge and very little training in dealing with alcohol problems: a state of affairs which gives rise to pessimism, poor problem recognition, and low priority being given to drinking problems (Cartwright, *et al*, 1975; 1977; Leckie, *et al*, 1984). Can we expect that criminal justice staff will be any better informed?

Alternatives in management of alcohol problems

In this third section of the interview I was concerned with exploring possible alternatives to the extant pattern of responding to alcohol problems. Proposals for reforming the management of alcohol problems, particularly public drunkenness, have been topical in recent years. A growing sense of dissatisfaction with the ineffectiveness and inefficiency of the traditional system of management has led to demands for a change in orientation from criminalization to a more effective, or at least more humanitarian, response (Advisory Committee on Alcoholism, 1978; Light, 1987). Most of the proposals assume (demand) a fairly high degree of cooperation between the various front-line agencies, but very little attention has been given to the view of those most directly involved. How do social workers or police officers, for example, view the possibilities and the problems of reform?

The most recent proposal - certainly the one that was being canvassed most vigorous during the period of the fieldwork - involved the setting-up of 'designated places' where drunken offenders could be taken by the police. How did respondents' view the usefulness

of such places? Unfortunately, for most respondents these were hypothetical questions because only one 'designated place' has so far been established in Scotland. Except for those in the immediate vicinity of Albyn House in Aberdeen, respondents had no direct experience of how the system might operate. Respondents were also asked to comment more generally on possible strategies for dealing with alcohol problems. The final question in this section attempted to put the issue into some kind of context, asking respondents about the priority they would give helping those with alcohol problems.

The role of the agency

This section was concerned with two issues: how respondents' viewed the work of other front-line agencies, and their perception of the appropriateness of their own agencies involvement with alcohol problems. The first issue is clearly important when there are so many proposals which advocate a closer working relationship between the various agencies, and between social workers and police in particular. How one perceives the role of one's own agency is of course important whether or not there is cooperation between agencies. Bittner's study of the emergency handling of the mentally ill, for example, suggests that role perception had an important (and in this case negative) effect (Bittner, 1967).

The appropriateness of police involvement was explored further in order to assess the possibility, or acceptability, that decriminalisation - the official view was that 'designated places' would be "an initial step towards decriminalisation" - might lead to transfer of responsibility for initial mobilisation from the police to some social welfare or medical agency. The interview ended with some general questions which were intended to give respondents an opportunity to expand on any points that they felt were important.

The structure of the interview

During the pilot study the advantages of an open interview strategy, in the sense that it was fairly informal, over more structured procedures such as a questionnaire, was very obvious. The informal nature of the interview seemed to reassure respondents. Respondents talked freely about a wide range of issues relating to the general topic and displayed a willingness to express their own attitudes and opinions, as opposed to the 'approved version' that was (or might be perceived to be) favoured by their particular agency.

Invaluable though they were, these unstructured exchanges could not be used in the main stage of the fieldwork. To have undertaken to conduct a large number of interviews in this way would have been excessively and unjustifiably time consuming. Transcribing, coding and analyzing the detailed information generated by such interviews would have been an overly ambitious and wholly unrealistic project.

The finalized interview schedule attempted to hold on to the richness of the unstructured sessions while, at the same time, focusing on the most relevant issues. It was for this reason that both open-ended and closed questions were incorporated into the schedule. Where the interview was dealing with issues that were well suited to straight forward responses (details such as age, sex, length of service and so on) closed, pre-coded items were used. When the focus was on behaviourial and attitudinal variables, on the other hand, it was important not to inhibit informants too much by forcing them to choose from a pre-determined category of responses. On such occasions, open-ended questions were preferred. For the most part, the open-ended items took the form of what Galtung calls 'systematic stimuli':

> By systematic stimuli we mean that the stimuli are kept constant when the objects are changed, in the sense that all units are exposed to the same stimuli systematically.
> (Galtung, 1967:109)

Although the interviews were not as open as some of the more informal discussions that were conducted during the study, only the questions were standardised - the responses were not. It was always possible to probe in order to clarify the informant's views of a particular issue. And in many cases, particularly where closed items were used to explore attitudinal variables, responses were routinely probed.

Informants were encouraged to discuss, amplify, or qualify their responses as they felt it was necessary. That they did so is reflected in the fact that whereas the interview typically lasted for one to one and a half hours, in some cases this stretched to two or three hours.

The sample

It was proposed to conduct interviews with a representative sample of social workers, uniformed police officers, and other criminal justice professionals in Scotland. Four Regions were chosen as representative of the country as a whole: Central, for the pilot study; Strathclyde being the largest and most populous Region was an obvious choice; Tayside and Grampian were selected to give a sense of 'balance' both in terms of geography and culture. The research locations are shown in Figure 4.1. The survey area included three of the four major cities of Scotland and approximately 70 per cent of the population. Lothian Region excepted, the remainder of the population tends to be located in smaller centres of concentration either in the Borders countryside or in the Highlands and Islands. Constraints of economy and time made it impossible to include such areas in the study. The difficulty of getting access, particularly to the police, was also factor that had to be taken into account. Of the eight Scottish police forces, four were not prepared to grant any access. In two of the others, it was the granted only after a lengthy discussion and in one case, Strathclyde, the decision was later rescinded.

Because of the importance of understanding the everyday reality of responses to problem drinking, it was essential for the sample design to focus on the street level management of the problem. Coverage was therefore weighted in favour of those who had direct contact with drink related problems, such as basic grade social workers and police constables. Thus, the ratio of uniformed police constables to sergeants was about 5 to 1, while that for constables to inspectors is closer to 10 to 1. Similarly, basic grade social workers were represented significantly more than senior social workers or managerial grades (again the ratio was about 5 to 1).

Sample size

It was estimated that a sample size of about 400 individuals, inclusive of the numbers interviewed in the pilot study, would be sufficient to provide a representative sample and guarantee an acceptable level of precision in the interpretation of the data. A sample of this size would have provided a two and a half per cent sample of uniformed police officers and a four per cent sample of main grade social workers. The achieved sample for police and social workers were one and a half per cent and four per cent respectively.

Sampling frame

Having settled on the Regions to be surveyed, the sample was selected using a three-stage process: first, towns and cities were selected as the primary sampling units; second, research locations (agencies) within the selected primary sampling units were identified; and finally, a sample was drawn from the people working in these locations.

The primary sampling units were purposefully selected to reflect, as far as possible, the cultural, social, industrial, and geographic diversity of the country. The areas selected included: rural and coastal communities; urban and inner city areas; areas in which

traditional industries predominated and others where service or 'high-tech' development was the norm.

The choice of primary sampling units was also influenced by the reported (alleged) level of alcohol related problems. Table 4.1 shows that different Regions can have different experiences of alcohol problems, as measured by the conventional indices of alcohol-related problems at least, and this view is supported in the alcohol problems literature (Plant and Pirie, 1978; Kilich and Plant, 1981). Consequently, the sampling strategy reflected the possibility of similar variation in patterns of response.[2] The primary sampling units, therefore, included some areas which enjoy a reputation for heavy drinking - such as Inverclyde, Clydebank, and the whisky producing areas around Speyside - as well as more temperate parts of the country.

A total of 15 primary sampling units were selected in this way and from these 27 research sites were chosen. Within each primary sampling unit it was possible to identify a number of research locations, such as social work areas, police Divisions, non-statutory social service facilities. In some cases the range of options was limited particularly with regard to the non-statutory agencies. In other areas, in the cities for example, there was more diversity. As far as possible, therefore, research locations were selected so as to reflect the nature and scale of provision in the particular area.

Having identified the research sites and negotiated access, the final stage in selecting a sample was to decide who should be interviewed. In the pilot study it had been possible, over a period of four months, to interview virtually every uniformed constable in Falkirk. Although this was again possible with some of the smaller non-statutory agencies, where the question of who to interview effectively decided itself, in the majority of research locations a probability sampling procedure was used.

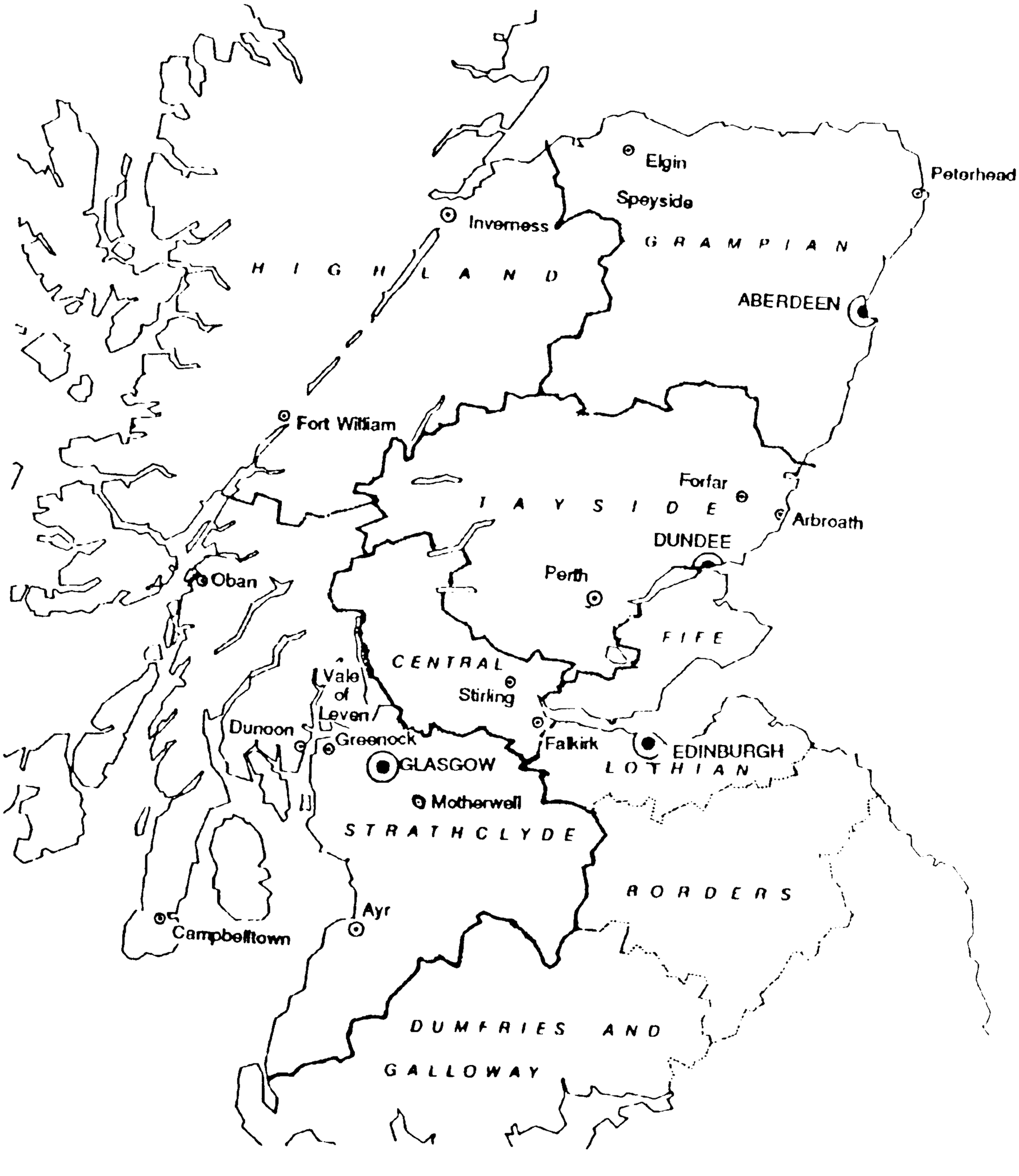
Some details of the procedure had to be adapted to suit the operations of the particular agency, but the same basic features applied to all. Take, as an example, the

sampling of police officers. Police officers make up the largest single group in the overall study and they were, in some respects at least, the most difficult sample. The final stage of selection was carried out at the police office. Having agreed access and decided - usually after consulting with a 'liaison officer' - which of the local offices I wanted to include in the study, I arranged to visit the station on a particular day(s). The numbers of uniformed constables, sergeants, and inspectors to be interviewed had been pre-determined and it was simply a matter of selecting officers for interview at random from those available. In most cases this was done by taking the first officer who was free from other duties.

The simplest method would have been to select all the officers from the same 'shift'. However, in some of the larger stations this could have given interviewees an opportunity to discuss the interview beforehand. This was felt to be undesirable as it might have led some people to alter their responses to particular questions or to refuse to participate in the study. Instead, interviews were spread over two or more shifts. This minimised the possibility of 'contamination', since only three or four officers would be selected from any one shift. Other criminal justice agents, such as lay magistrates, sheriffs, and procurators fiscal, were approached on an individual basis. In this particular case, persons to be interviewed were selected because they were responsible for the administration of justice in the area and/or because they had a specific interest in alcohol problems.

Social workers were usually sampled with reference to their area teams, but here again no more than two or three individuals were selected from any one team. A small number of doctors and health care workers were also selected in a non-random way based on their acknowledged expertise.

Figure 4.1 Map showing research sites



Fieldwork and representativeness of the sample

The fieldwork for the study was carried out in two stages: the pilot study was conducted from January to June 1982 and the main phase of data collection took place between November 1983 and May 1985.

All interviews were conducted on a one-to-one basis, typically lasted for one to one and a half hours, and were tape recorded in all but a very few cases. A total of 320 persons were selected, 307 (96%) of whom were interviewed. The distribution of the sample by agency and Region is shown in Table 4.2.

Table 4.2 Distribution of research interviews [3]

	Central		Grampian		Strathclyde		Tayside		Others
Agency	Expected	Actual	Expected	Actual	Expected	Actual	Expected	Actual	Actual
Police	50	50	60	59	100	-	40	40	11
Other criminal justice	3	3	4	4	12	8	8	6	-
Local Authority social work	8	8	10	9	30	30	12	12	5
Non-statutory social work	2	2	8	7	30	27	10	10	16
TOTAL (N=307)	63	63	82	79	172	65	70	68	32

Data gathered from a small sample such as that outlined above cannot adequately represent the entire population of police officers, or social workers, or whatever. There are limitations in all sampling frames, even in the most sophisticated, which make it unlikely that the sample is completely representative of the population from which it was drawn. Apart from these inherent sampling errors, other features of the achieved sample can affect its representativeness, such as non-response bias and under-reporting. Table 4.2 shows that, with the notable exception of Strathclyde police, the achieved sample was very close to the design targets. The non-response rate was exceptionally low; only 13 per cent in the worst case. I was also fortunate to be able, in all but a few cases, to know the reasons for non-response. This suggested a random, non-directional pattern of non-response and, therefore, non-response bias is not a problem.[4]

Strathclyde police, as I have already indicated, proved to be the exception. The problem, however, was not one of non-response since police officers in this area were never given the opportunity to participate on the same basis as had been agreed with the other police forces.[5] Reluctantly, I decided that fieldwork interviews would not be conducted with Strathclyde police. As a consequence, no information relating to Strathclyde police, other than that available from official sources, will be presented in this study. While it would be iniquitous to suggest that my experiences with Strathclyde were in any sense typical of the response I received from other police forces - happily the reverse was true - the reluctance of Scotland's largest police force to participate in the study highlights some of the difficulties in undertaking this kind of research.

In order to assess the representativeness of the achieved sample, it is usual to make comparisons between the sample and the population from which it was drawn. The loss of Strathclyde police with over 50 per cent of the Scottish force makes proper comparisons difficult in this case. Moreover, detailed information on the characteristics of the population I was dealing with, such as distribution in terms of age or gender, is very limited. As a

rough guide, however, Table 4.3 shows the composition of the main sample groups (social workers and police officers) as compared with that of the population as a whole.

There are some differences between the distribution of the research samples and that of their respective populations. Perhaps the most striking feature of the distribution is the small proportion of women in the police sample. Women police officers, however, were in fact somewhat over-represented since about five per cent of the police establishment in Scotland are women. Overall, the differences are not so marked as to call into question the representativeness of the sample.

Analysis and presentation of findings

Although the interview involved both open-ended and closed questions, the interview format was predominately open-ended. This informal approach allowed a good deal of scope for elaboration and discussion. It did have the 'disadvantage', however, that the more sophisticated statistical techniques could not be applied with any confidence to much of the data collected. It should be clear from the discussion of methodology in chapter one that this was never intended as an exercise in quantitative research. Much of the evidence was of a qualitative nature and, naturally, the overall presentation has that feel about it: direct quotations and non-empirical data are used freely throughout the thesis.

There are of course exceptions to this general rule. Although the interview format was open-ended, it did include a number of pre-coded items that could be presented in tabular form. Factual information about drunkenness arrests is a typical example. Even with some of the more open-ended questions there was a sufficient degree of consistency in the themes and concerns expressed in the course of the interviews to justify categorising the responses and presenting them in summary form. Throughout the thesis where tables have been constructed from an analysis of qualitative data, a note will appear to that effect.

Table 4.3 **Comparison of achieved sample with police and social work populations, Scotland 1983**

	Police		*Social workers*	
	Population %	Sample %	Population %	Sample %
Sex				
Male	94	92	52	
Female	6	8	48	
Age				
under 21		1	-	
21-30		41	19	
31-40		23	49	
41-50		30	27	
over 50		5	7	
Length of service				
less than 2 years	7	5	2	
2-4 years	16	16	33	
5-9 years	26	23	34	
10-14 years	16	20	11	
15-19 years	14	11	6	
20-24 years	12	14	14	
over 24 years	9	11	-	
Total	N=12,726	N=150	N=1,468	N=60

Police reports, official statistics, and other documents

One additional source of data that has yet to be discussed concerns the use made of official documents. A considerable amount of detail about responses to problem drinking can be derived from official sources, such as Parliamentary Reports and Criminal Statistics, and of course the study does draw on these sources. However, the use of official data was not

limited to the publications of local or national government agencies. The study also drew on a variety of unpublished statistics.

Prior to the pilot study, for example, I was given access to computerised information about drink-related reports made by Central Scotland Police to December 1981. This helped me both to expand my knowledge of the area and to determine the most efficient (productive) use of fieldwork time. After identifying all the appropriate cases from the police reports,[6] I extracted as much information as possible about the various incidents. Typically, reports of drunkenness -related arrests are very brief, but they did provide some information about the socio-demographic characteristics of those arrested: age, sex, residence, and (sometimes) occupation, were all recorded. Some details about the structural factors relating to the arrest were also recorded (e.g., time and location of the incident). When taken together with the data gathered in the interviews and from the observational study, the details gleaned from police reports allowed me to construct accounts of the role of the police in responding to alcohol problems. The information derived from the police reports was also important because it provided a check on previous estimates that suggested a high proportion (45%) of arrests for breach of the peace involved drunkenness (Hamilton *et al*, 1976). The police reports seemed to provide reasonable confirmation of this estimate and, therefore, I felt confident about including questions about breach of the peace in the interview schedule.

The use of official statistics in social research, and the use of police reports in particular, has been the subject of a great deal of discussion and not a little controversy. The debate about the production of official statistics and about the nature of the 'reality' they are taken to reflect - what Singer (1971) refers to as "the vitality of mythical numbers" - has been well documented and I do not intend to contribute to this literature.

Nevertheless, official statistics did play a part, albeit a small part, in the research enterprise and it is important, therefore, that we recognise the limitations of such data.

Official statistics should be treated as essentially problematic. Whether recorded as criminal statistics, by the police, or as social statistics, recorded by social service staff, or whatever, official statistics are subject to limitations and should only be used with care and for clearly defined purposes.

Recognising that official statistics are socially produced and that the calculation of absolute crime rates, for example, can be viewed as organisational processes rather than as indices of the incidence of certain forms of behaviour (Kitsuse and Cicourel, 1963:136-7), does not mean that we should eschew the use of such statistics entirely. However, it is important to be aware of the context in which the statistics were collected and the limitations this places on their usefulness. Official statistics have never been gathered for 'objective' or 'scientifically neutral' purposes, but always with some ulterior motive(s) in mind. Douglas (1971) pointed to this bias in the work of the social survey movements of the late nineteenth century:

> When we look at the early works in moral statistics ... we find that, with hardly an exception, they are concerned with the use of official statistical information and of statistical methods of analysis to get at the causes of social problems and, hence to show that certain solutions are better than others.
>
> (Douglas, 1971:62)

The motivation was clear. It was rooted in concern about the social and moral condition of society. Many of these early works were carried out by researchers who were either officials themselves, or were involved in official work. This fact of course influenced not only their data collection, but also the nature of the theories of deviance and society that were derived from that data. Similar reservations must be entertained about the applicability of contemporary social statistics.

Defining the limits

Although there are a great many agencies and organisations with an interest in the treatment and/or control of alcohol problems,[7] this study is concerned with only four groups. These will be: sheriffs, fiscals, and lay magistrates; social workers; doctors; and police. Within these groups the focus is further reduced so that the police and social work that provide the main institutional forum. The police because they are - and for the foreseeable future they will continue to be - the most significant front-line managers of the problem. Social work because as the importance of medical expertise declines and counselling becomes more important, it seems likely that 'responsibility' for that area of the problem will fall to social workers. We know very little about how either of these groups deal with alcohol problems and it is vitally important that we know much more.

In defining the limits of the research in this way, I am in no sense denigrating the work of other groups such as A.A. or the local councils on alcoholism. Nor do I question the necessity of providing a wide range services to meet the needs of the very diverse group people who are incorporated in the phrase 'problem drinkers'. I have simply chosen to focus on those elements of the institutional response that seem to me to be of continuing importance.

Part Two of the thesis concentrates on developing a better understanding of the factors that influence the day-to-day management of alcohol problems. The next chapter considers the ideologies (beliefs) that inform practice in this as in many other areas. Chapter 6 examines the nature and extent of contemporary alcohol problems, both from the official statistics and from the point of view of those who have to deal with them. Chapter 7 outlines the continued involvement of the medical profession. Issues of professional status and 'dirty work' are seen to be important factors in explaining the reluctance of doctors to become involved in the treatment of problem drinking. Chapter 8 documents the role of

social work, exposes the ambiguities in that role and suggests that the social work contribution is likely to expand.

In chapters 9 and 10 it is the criminal justice system that is exposed. The attitudes, perceptions, and experiences of the police management of public drunkenness are explored, particularly as they affect arrest decisions. The process of prosecution and the possibility of diversion (for those who are arrested) is discussed in chapter 10. The concluding chapter examines the some of the alternative response strategies that have been proposed, and considers some of the policy implications of the study.

The main findings are presented here using both statistical analysis and verbatim quotations from the interviews to illustrate the nature and pattern of responses to alcohol problems.

Notes

1. The advantages of applying diverse research techniques to the study of social phenomena have been widely discussed (Douglas, 1976; Filstead, 1979). Douglas, for example, argues that:

> "Since all research methods have costs and benefits, and since they differ greatly in their costs and benefits, a researcher generally finds it best to use some combination or mixture of methods."
>
> (Douglas, 1976:30)

The combination of research techniques is a strategy which if used in a careful and reasoned manner will improve our understanding of the research issue. However, it should be stressed that combining techniques does not imply, nor it is tended to support, the 'mixing' of methodological perspectives.

2. In the event, the findings of the study did not indicate any clear regional differentiation of attitudes to, or perceptions of alcohol problems. A shared occupational orientation (ideology), a professional 'world view' fostered by training and 'on the job' experience, seemed to be the central variable in this respect.

Local factors, however, seemed have importance for many respondents as explanatory tools and this 'local flavour' lent colour to many of the interviews. In the Speyside, to take as an example Scotland's best known whisky-producing area, the drinking culture fostered by the traditions of the whisky industry was often charged with responsibility for the drinking problems the area. Sitting in the shadow of the locally distillery, one local policeman assured me that 'that', the distillery, was to blame for

most of the alcohol problems in the area. Drunkenness and drink- driving had been encouraged by the habit (now discontinued) of allowing the workforce 'a wee dram or two during the day'. But, according to my informant (who had himself worked for time in the distillery), it didn't stop there:

> "They're allowed one or two (whiskies) and they'll take maybe two or three more. Now, your not taking about 'a wee half' (1 fl.oz.) ... [the respondent then went on to discuss ways of 'taking' whisky using an empty 'Smarties' tube which will hold about 2 fl.ozs.] ... so by the end of the shift they've had a good drink and then they go and drive home, or to the pub."

3. The figures in brackets in Table 4.2 relate to interviews conducted as part of the pilot study. The 'others' referred to in the Table include interviews with groups as diverse as the Scottish Police Federation, West Yorkshire Metropolitan Police, the Church of Scotland's Social Work Department, and the (now defunct) Federation of Alcohol Rehabilitation Establishments.

4. The most common reason given for not wishing to take part in the study was ill-health. Occasionally, the explanation was more dramatic, as was the case with one police officer who agreed to be interviewed, but then had to withdraw at the last moment. The police officer had been called to a serious incident which subsequently became a murder inquiry. In this case, however, I was able to select another person to interview from the same shift.

5. The stumbling block was Strathclyde's insistence that all interviews with police officers should take place in the presence of a senior officer. Obviously, the style of interview that had been envisaged could not be conducted under such circumstances. Nor could I agree to a method which would seriously compromise the validity and reliability of the resultant data.

6. There are a number of other Acts and Bye-laws that can be used against drunken persons in particular circumstances, but in the context of the present study drunkenness-related offenses generally refer to the two most frequently employed charges, 'drunk and incapable' and 'breach of the peace'. Of the 675 police reports studied, 102 related to charged of 'Drunk and Incapable', 386 to 'Breach of the Peace' arrests, and the remainder to charges of driving with more than the legal limit of blood alcohol. This latter group were not included in the analysis because of the difficulty in assessing the individuals' state of intoxication. Of the 386 incidents which resulted in 'Breach of the Peace' charges, 179 (46.4%) incidents, involving 247 individuals, were classified as drunkenness.

7. The Scottish Council on Alcoholism's Register of Alcoholism Services in Scotland lists over 120 'specializing' and some 60 'non-specializing' agencies which provide treatment facilities and counselling services for problems drinkers (SCA, 1981).

5 Thinking About Drunkenness: Problems of Professional Belief

This chapter considers the institutional rational and professional beliefs that inform attitudes and responses to alcohol problems. In attempting to discern the nature of contemporary responses it is useful to begin by outlining the main institutional traditions which underlay approaches to alcohol problems: the medical, the legal, and the social welfare models. I will also examine some of the implications, the pros and cons, of these main approaches as they have been applied in the area of alcohol abuse.

The contention here is that the beliefs of various professional groups hold about the nature of problem drinking (and problem drinkers) will affect, even if in the most general terms, the way in which they respond to any given situation. This might seem to be a truism, but it is one whose importance and consequences usually go unexamined.

Professional beliefs

Most of the approaches to the management of alcohol problems can be identified with one of three traditions. The medical model affects a scientific definition of the problem and focuses attention on issues of diagnosis and therapy. Where the problem is primarily behaviourial or social, the explanation (cause) is usually sought in the personality or family background of the patient. The medical approach to alcohol problems has been useful in many ways, not least in changing public attitudes on the subject (Kendell, 1979; Room, 1983).

Despite the benefits, however, a number of writers have expressed concern about the increasing medicalization of essentially non-medical aspects of deviance (Scull, 1977; Szasz, 1972; Zola, 1975). The introduction of medical expertise into the field of deviance and social control has caused concern because medicine - with its associated vocabulary of

'disease', 'treatment', 'contagion', 'diagnosis', and 'cure' - conjures up an image of moral neutrality. If alcohol problems *qua* alcoholism can be packaged in this neutral, scientific rhetoric, then, in the words of Geoffery Pearson:

> ... the uneasy consciences can be put to sleep; action taken against the misfit, which might in any other light appear morally ambiguous, is beyond all moral ambiguity when it is called 'treatment' or 'therapy'
>
> (Pearson, 1975:15)

A quite different palliative to "the uneasy conscience" in the form of a legal structure dedicated to the maintenance of social order, underlies the second important tradition in responding to alcohol problems. The legal or criminal model is perhaps the clearest representation of continuity with the Temperance backed legislation of the nineteenth century. The historical legacy of tee-totalism is nowhere more evident than in the Scottish licensing laws and the criminal prosecution of public drunks. Legislative control is based on the concepts of justice and individual responsibility, and holds that those who commit criminal acts should be answerable to society for their behaviour.[1] Viewed from this vantage point the legal system forms the main bulwark against drink related disorder.

Finally, there is the social welfare model. This model emerged, like the others, from the concerns of nineteenth century reformers, but its potential importance is only now being realised. As legal and medical professionals look for new directions in responding to alcohol problems, the possibility of developing a closer involvement with social welfare systems is being more actively promoted.

Although it assumes that behaviour is determined and owns a strong commitment to the therapeutic ideal, the focus of the social welfare model is on the nature of relationships, the family and social functioning. Problems are seen in terms of social disadvantage and the impact this has on those individuals who do not have adequate emotional, family or community support. Although this approach is most commonly identified with social work, some social workers, dissatisfied with the focus on the individual, have opted for a more

radical variant of the model in which, in essence, problem drinkers are seen as being no different from anyone else. The radical social welfare explanation focuses on two issues - (i) the processes by which groups such as social workers, health care professionals, and the police define some individuals as different (deviant) is seen as biased against the powerless and the most deprived groups in society; and (ii) the economic and social inequality within society puts sections of the population at greater risk of insecurity and poverty. From this standpoint, the root cause of the problem does not reside in individuals. They are not responsible. The responsibility lies with society generally, and, more specifically, with those who have the power to influence the social, economic and political system. The radical social welfare model implies that the solution to alcohol-related problems, and indeed to many other social problems, is related to fundamental social change and social reorganisation.

The essential features of these different approaches are outlined in Table 5.1. These approaches of course are not mutually exclusive. As has already been shown with the Inebriate Reformatories, there can be considerable functional overlap between the legal, medical, and social welfare ideologies. Its quite possible for organisations, for example, to 'borrow' from the different traditions. And, in fact, this may provide an important mechanism for change within the organisation. Recent initiatives on diversion from the criminal justice system, for example, raise the possibility (I would put it no stronger than that) that society's traditional allegiance to the legal model may be beginning to change as newer social welfare philosophies gain ground. At of the individual level too it is quite possible for professional intervention to be informed by selective 'borrowing'.

Table 5.1 Professional ideologies & approaches to alcohol problems

	Legal	Medical	Social Welfare	
Framework	Legal/rational	Scientific	Humanistic	
Pre-supposition	Individual has free will	Behaviour is determined	Behaviour is determined	
Attitude to deviance	Punitive: deviance is conscious defiance of rules; moralistic	Neutral: results of forces beyond control of individual	(a)*Traditional* compassionate: individual/ cannot cope with the situation	(b) *Radical* relativistic: results from social processes
Social rationale	Justice: due process; individual rights	Cure: treatment of needs of the drinker	Prevention: rehabilitation by re-adjustment	Social liberation via re-organisation
Focus of attention	Act of abuse: disorderly behaviour	Disease process, pathology syndromes	Individual: family, or social situation	Social processes, structural inequality
Tools	Legal code, courts	Medical expertise & technology	Counselling, therapeutic relationships social experts	Social change
Conception of problem drinker	Responsible	Not responsible	Psychological, emotional or social inadequacy	Socially victimised
Stated purpose of intervention	Punishment of guilt	Treatment of dysfunction	Individual rehabilitation	Equality and redistribution
Some practising groups	Police, judiciary	Doctors,some psychiatrists A.A. <- alcohol	Social workers: some doctors counsellors ->	Some social workers and sociologists

Source: Adapted from Carter (1974)

The medical model

The most influential of the contemporary theories about problem drinking has identified the problem as a medical issue, an illness. Beginning with the Alcoholism Movement[2] in the United States in the 1940's, a 'new scientific approach to alcoholism' was promulgated. The cornerstone of this 'scientific approach' lay in the refurbishment of an older tradition, the disease concept of alcoholism. The links between the Alcoholism Movement and the work of the early promoters of the disease concept such as Rush, Trotter, and Dalrymple lay in the concept of addiction itself and in the description of the addictive process through the popularisation of terms such as 'loss of control' and 'craving'.[3]

The precise meaning of the disease concept as it was used by the Alcoholism Movement, however, was never clearly articulated. Some commentators have suggested that the vagueness of the formulation, if not exactly deliberate, had considerable functional merit. It was if you like (to borrow Steiner's phrase) a "creative falsehood", a core concept around which participants could formulate some (apparent) consensus while holding very different ideas about what is going on (Christie and Bruun, 1969; Steiner, 1975). Through all the conceptual confusion, however, a number of propositions can be identified as being central to the formulation (Anderson, 1942; Pattison *et al*, 1977; Room, 1983):

i. There is a scientific solution to alcohol problems; a new approach which replaces the old moralistic approach.

ii. Implicit in this new disease model is the recognition of the existence of 'alcoholism' as a well-defined singular entity.

iii. Alcoholism as a singular entity should be thought of as a disease in itself and not as symptomatic of another underlying disease.

iv. An 'alcoholic' is a person who is exceptionally reactive to alcohol. Being ill the 'alcoholic' is considered, to some extent at least, not responsible for his condition.

v. "Sickness implies the possibility of treatment ... (and) that it is worthwhile to try to help the sick one" (Anderson, 1942:378). It follows from this that the 'alcoholic' should be responded to as 'a sick man' rather than as immoral or criminal.

vi. Providing services and facilities for the treatment of alcoholism is both an urgent (if not the most urgent) priority for and most efficient means of responding to this 'disease'.

The appeal of this new formulation reflects the positively enhanced position that medicine and medical science had achieved during the first half of this century. It reflects too the contemporary faith in the ability of scientific investigation to provide the answers to problems such as those of alcohol and alcoholism.[4]

For all its scientific pretension, however, the success of this new approach owed rather more to pragmatism of various sorts than to scientific rigour. The promoters of the disease concept were more concerned with getting the message across and winning a better deal for the 'alcoholic', than with satisfying the precepts of academic research in promoting scientific discoveries (Room, 1972).[5] Medical science, whatever other benefits it might produce, was not seen as an effective means of educating the public and interesting the public policy makers in the problems of alcohol misuse. Jack Anderson (1942), for example, argued forcefully that the ideas the Alcoholism Movement were promoting (ie., the disease model of alcoholism) had been repeatedly advanced in the scientific literature for more than a century without, as he put it, "penetrating the shell of public indifference". Anderson, a journalist with the *Saturday Evening Post*, clearly felt that what the Movement needed was a more general platform from which to promote its ideas:

> When the dissemination of these ideas is begun through the existing media of public information, press, radio and platform, which will consider them as news, a new public attitude can be shaped. It will not be difficult to use these media for publicization for this purpose because, no matter how often the idea may be repeated, it will remain news until its acceptance has become universal.
>
> (Anderson, 1942:378)

Although the optimism may seem a little strident there can be no doubt that the disease concept of alcoholism was successful, perhaps beyond the dreams of its originators. The statement 'alcoholism is a disease' is now so acceptable to many, including many

professionals, that it has become something of a 'revealed truth' (Bacon, 1976).

The success of the disease concept, however, has been attended by both advantages and disadvantages. In discussing the pros and cons of the disease model of alcoholism, however, it is important to realise that I am not talking about whether or not problem drinking ought to be defined as a disease - the precise definition of 'disease' is a very complex and controversial matter - but about the consequences which flow from the decision to regard it as such.

The advantages of the disease concept

No one would deny that those who struggled to have alcoholism recognised as a disease enjoyed considerable success. Perhaps the most important aspect of this success, as we shall see in later chapters, lies in the popularisation of the disease concept; in its ability to bridge the gap between the esoteric domain of the 'alcohologist' and the mundane arena of common sense and public policy making. By identifying alcoholism with a pre-existing set of concepts and attitudes that were appropriate to illness, its proponents were able to communicate to the non-medical professionals, the policy makers, and the lay public, the nature of the problem and to define the general outline of the appropriate response. The idea that problem drinkers (alcoholics) are sick has undoubtedly informed policy and influenced the way(s) in which they are seen by professional groups. The question for consideration is, has this influence been for better or worse?

The main advantage claimed for the disease model is that it changed society's view of problem drinking; that it succeeded in replacing the traditional moral/punitive view with a more humane vision of the 'alcoholic as sick'. This was after all the avowed object of the exercise and, at least in terms of treatment regimes, the change appears to have been genuine. There is no doubt that as a result of the struggle to have alcoholism accepted as a

disease, problem drinkers enjoy certain benefits that might well have been denied them before the struggle began.

Lessening the stigma that previously attached to deviant drinking behaviour, it is claimed, meant that problem drinkers (as alcoholics) had easier access to medical care and that they would be less likely to be imprisoned, or subject to other punishments as a result of public drunkenness. Acceptance of the disease model of alcoholism also implied that the sufferers are not responsible for their behaviour. It would therefore be expected that, with the success of the concept, moralistic attitudes to problem drinking would be greatly reduced. That may be true for medical and social welfare professionals. It might even be true of criminal justice agencies. The evidence of surveys and public opinion polls, however, suggests that, while the success of the disease concept may have moderated moralistic attitudes, it could not eradicate them (Mulford and Miller, 1964; Tolor and Tamerin, 1975; Dight,1976; Rix and Buyers, 1976). In Dight's study of *Scottish Drinking Habits*, for example, 84 per cent of respondents agreed that alcoholics were sick. A similarly high proportion, however, rejected the idea of spending public funds on "facilities for ... a few (perhaps undeserving) individuals" (Dight, 1976:191-94). A more recent survey of drinking patterns in Central Region produced remarkably similar results (McLaughlin and Scobie, *in preparation*).[6] It seems that for many people the perceptions of problem drinkers as morally weak, or criminal, or sick, are not mutually exclusive categories. The chimera of the nineteenth century Temperance Movement, the habitual drunkard, lies there still beneath the explicit assumptions of the disease concept and inhibits progress towards a more caring response to alcohol problems. In the meantime, however, the ascendancy of the disease model brought with it some important disadvantages.

> Until we stop regarding alcoholism as a disease, and therefore as a problem to be dealt with by the medical profession, and accept it as essentially a political problem, for everyone and for our legislators in particular, we shall never tackle the problem effectively.
>
> (Kendell, 1979:9)

In recent years there has been increasing criticism of the disease model both from the non-medical world and, perhaps more surprisingly, from those like Kendell who are actively involved with the treatment of alcoholism. Concern has been expressed in both camps that the basic tenets of the disease concept of alcoholism are not only fallacious but also a major obstacle to progress.

The introduction of more rigorous modes of investigation - controlled studies, household surveys, and follow-up programmes - has undermined the disease concept. It has become increasingly evident that, far from being founded on sound scientific knowledge, the disease concept was based on myth, the folk wisdom of alcoholics and the *ex cathedra* pronouncements of 'experts' themselves involved in promoting the concept. The data on which Jellinek's based his formulation of the disease theory has been exposed as "manifestly just a pile of papers" (Bacon, 1967:96). What is worse, a substantial body of evidence now exists which suggests that the efficacy of medical treatments of alcoholism is limited and that (in Kendell's words) "that of esoteric and expensive regimes are no more effective than quite simple ones" (Kendell, 1979:7). Medical opinion is increasingly coming to accept that the issues involved are much wider than the parameters of medicine. As one consultant psychiatrist with long experience of the alcohol treatment field commented, during a research interview:

> The disease theory, for all its vulnerability in scientific terms, has helped to put alcoholism on the map. It was an invaluable propaganda tool, but it has now outlived its usefulness. I would certainly bow to the fact that there is, undoubtedly, a very large social and environmental factor involved and I would like to see all of these agencies (G.P.'s, social workers, voluntary counsellors, etc) being more involved than they are at present.

A wide range of disadvantages can be ascribed to the disease model and in particular to its insistence that alcoholism is a discrete entity. The implication is that it is possible to distinguish between alcoholics and social drinkers. Such an assumption had important implications both in terms of how the problem was understood and in terms of what was done about it. The main effect of the disease model was to convince doctors and policy-makers that alcohol problems were increasing and that the appropriate response to this increase was to provide more treatment facilities. At the same time more research was needed to identify the 'cause' of alcoholism and, having pinned down the (presumably) singular 'cause' of alcoholism it would be but a short step to the 'cure'.

A great deal of money was spent in Britain, and even more in the United States, in providing specialized Alcohol Treatment Units (ATU) and in the search for some sort of alcohologist's holy grail. The specialist treatment units proved to be expensive but could demonstrate only limited success. The search for some bio-chemical abnormality or a so-called 'alcoholic personality' was a wildly expensive, entirely fruitless, and succeeded only in diverting research effort from more promising lines of enquiry.

By any rational system of accounting it would seem that the disadvantages of the disease model far outweighed any putative advantages. The concept may not be supported by the available evidence, it may have served to stifle attempts at primary prevention and inhibited meaningful research, but as Beauchamp (1980) has pointed out, the disease model continues to have powerful attractions and uses for the whole society. Put simply, the disease model provides an alibi for the majority of drinkers - a guarantee that their drinking is 'normal' - and disguises the part played by drink in the creation of alcohol problems. It does this by the tried and tested means of 'blaming the victim' and identifying alcoholism with the inadequacies or the characteristics of the individual. Rhetoric of this sort of course also serve the needs of the alcohol industry - allowing them to claim that they are promoting the harmless drinking of 'normal' drinkers and not the alcoholic excesses of the

deviant few - and of politicians because it allows them to avoid the electorally unpopular (albeit possibly effective) decision to increase the price of alcohol in order to reduce alcohol related problems.

Ironically, the nineteenth century tee-totalers avoided this controversy by their insistence that the essence of the problem lay not in the peculiar vulnerability of a some individual drinkers, but rather in the addictive nature of alcohol itself. For them, *anyone* who drank was in danger of becoming dependent.

The medicalization of deviance

In discussing the problem of definition in his disease concept of alcoholism, Jellinek made the following statement:

> Pointing out this lack of definition of disease by no means involves a reproach. The splendid progress of medicine shows that that branch of the sciences can function extremely well without such a definition. Physicians know what belongs in their realm. It comes to this, that *a disease is what the medical profession recognises as such.*
>
> (Jellinek, 1960:12)

The stress which Jellinek puts on the closing sentence leaves the reader in no doubt. What he is claiming is that the medical profession has exclusive jurisdiction over the label of illness and anything to which that label may be attached. This right presumably operates irrespective of medical professions ability to deal with (or even to define) the problem effectively. It is an extraordinary statement. One which should draw our attention to wider issues concerning the expansion of the medical responsibility to areas such as alcohol and drug addiction that are not *ipso facto* medical problems (Freidson, 1970; Pitts, 1971; Zola, 1972; Conrad, 1975). Why should this 'the coming of the therapeutic state' (Kittrie, 1971) be viewed askance? After all, medicine has a long history of involvement with social problems and it can be argued that the fruits of this participation have been essentially

beneficial. For many people, "the splendid progress of medicine" is seen as the victory of an objective and value neutral science over the forces of moral prejudice.

It is not quite that simple. The supposed value neutrality and status of the medical professions means that issue over which they claim responsibility tend to become depoliticised. This process of depoliticization operates in a number of interrelated ways. Firstly, it individualizes deviant behaviour. Conventions of medical diagnosis which identify illness with the individual body predisposes the medical professions to treat social problems in a similar manner. In Ryan's (1971) phrase, it is a case of 'blaming the victim', of seeking the causes of, and the solutions to, deviant behaviour in individual pathology while generally ignoring the relevance of economic or social factors. Having defined the 'victims' as medical problems, as patients, it becomes possible to treat them in ways that might not otherwise be countenanced. Brewer (1979) provides a contemporary illustration of the way in which the medical perspective can divert attention away from ethical questions pertaining to civil liberties and so on. By using the disease model and insisting that deviant drinking is an 'illness', he implies that any debate about coercive treatment regimes is illogical. In his view:

> ... a considerable amount of persuasion is justified. I would feel just as persuasive if I were treating a man with a life-threatening infection who was reluctant to take the antibiotics which I knew would have a good chance of curing him. Some people balk at the idea of deliberately using the threat of unemployment or separation as a means of securing compliance with treatment. ... Although the treatment ... is entirely voluntary, it could be applied in a penal context.
>
> (Brewer, 1979:25)[7]

The danger of course is that this kind of "persuasion" will compromise such guarantees as have historically attached to legal systems of social control. Unlike legal systems of social control, there are, as Roman (1980) has pointed out, very limited institutional means by which the operation of medical systems of social control can be monitored, evaluated, or criticised.

All of which brings us to a second point. Medicalization also depoliticises deviant behaviour by taking it out of the public arena. If deviance is 'illness', then it only remains for us to discover, or to decide upon, the most effective way of ameliorating the condition (Schneider, 1978). Lay society has virtually no part to play in this debate. The 'psycho-technologies' of treatment seem to many to offer a powerful and effective tool for controlling deviance, but it is a tool that is best left in the hands of the 'experts'. The problem is redefined and responsibility reassigned to the appropriate 'experts' be they medical, social, or legal. As traditional perceptions of drunkenness have been replaced by labels that are held to be both more 'scientific' and discrete, so the community at large has been encouraged in the belief that it lacked the requisite knowledge to discuss these issues, far less comment upon the implementation of control and/or treatment strategies.

Finally, medicalization closes off the possibility of discussing ethical questions relating to the meaning of the behaviour, about the toleration (perhaps even desirability) that might be extended to some forms of deviant behaviour. The popularisation of the disease concept of alcoholism has meant that few people are willing even to debate the desirability of heavy drinking. Illness is a cultural universal defining a pathological condition. Once the label has been successfully attached to a behaviour it seems in some sense illogical that we should attempt to understand the meaning of that behaviour in any positive way (Schneider, 1977). Drunkenness is *ipso facto* a negative aspect of any individual's persona and, because the drunkenness is viewed negatively, the antecedent conditions are also cast in negative terms. Medically defined, it seems deviant behaviour can have very little meaning except as an indicator of individual pathology. As Brisset has pointed out:

> Rarely does one read that people drink heavily because they feel good, because they are happy, because of high self-esteem or some other positive attribute. Rather, if one reviews the list of hypothesised causal conditions for heavy drinking, one encounters among them such deplorable conditions as anomie, status deprivation,anxiety reduction, inadequate personality, maternal alienation, parental antagonism, dependency needs, and confusion of self-image.
>
> (Brisset, 1978:5-6)

The medicalization of alcoholism was crucial to the development and recognition of the phenomenon as a social problem. The concept was useful to the medical professionals who had to deal with the problem. It lent prestige to the promotional activities of voluntary and self-help groups such as Alcoholics Anonymous. It informed both public policy and public opinion on the issue and contributed to the development of a bewildering array of treatment regimes (Wiener, 1981). However, it also paved the way for what may prove to be a much more problematic development, in that it began to identify more clearly the commonality of interests between the medical perspective and other, more obvious, agencies of social control.

Legislative control of drinking and drunkenness

If the disease model of alcoholism has been (is) the most influential in terms of theory and informing policy, legislative control of every aspect of alcohol (ab)use has been the most enduring legacy of the Temperance era certainly so far as practice is concerned. The legislation that was past in the period between 1870 and the end of the First World War formed the basis of the Scottish licensing system at least through to the mid-1970's. The basic rationale was one of social control, the need (desire) to minimise the incidence of drink related public disorder and to reform drinking patterns, particularly those of the working class. The legislation can be considered under two headings; (i) licensing laws and (ii) laws which make drunkenness an offence in certain circumstances.

The purpose of liquor licensing

Laws relating to the sale and consumption of alcohol have been in existence in this country for over five hundred years. The earliest example in Scotland, a statute enacted by James I in 1436, closed taverns at 9 pm and prescribed imprisonment (warding) for violators. The activities of the temperance lobby can, therefore, be seen as working within (or better

strengthening) this historical tradition. More recently, a report on the Scottish Licensing Laws stated that:

> Licensing has traditionally been regarded as the main weapon against alcohol misuse though ... it also serves other purposes such as the maintenance of public order and the prevention of public nuisance.
>
> (Clayson Report 1973:1)

No doubt Clayson was correct in his interpretation, but why licensing? Excepting Clayson's rather general statement, there is nothing in the existing legislation - certainly nothing in the legislation enacted during the nineteenth century or since - which gives any clear declaration as to the purpose of liquor licensing.

Nevertheless, some feeling for the principles of licensing is important to our understanding of contemporary responses to problem drinking. The alcohol related legislation, including licensing regulations, that was passed in the nineteenth century drew on variations of two historically constructed themes - the containment of popular dissent and the maintenance of labour discipline (Dorn, 1983:37). Although they might not be articulated with the same alacrity - the appeal is in terms of 'public order' rather than 'popular dissent' - the concerns of modern licensing are not too dissimilar. A review of contemporary legislation would suggest four main objectives of licensing: regulation, prevention of public nuisance, limiting exploitation, and preventative measures.

A. Regulation

While accepting that the use of alcohol is a legitimate activity, that it is under most circumstance a lawful pursuit, legislation is considered to be necessary in order to provide regulated conditions under which alcohol may be sold and consumed. One of the important functions of licensing, therefore, is to ensure that the trade is free to operate, within limits, and that people have reasonable access to alcoholic drink. Licensing authorities have a

responsibility to ensure that licensed premises are adequately maintained and operated according to the law.

B. The prevention of public nuisance

One of the most obvious functions or, better, one of the most routine functions of the modern licensing system is defined by Clayson as "the prevention of public nuisance". This also appears to be an aspect of licensing which the licensing authorities themselves find most perplexing. The difficulty is that it calls upon the licensing authority to balance what are often contradictory demands. On the one hand there is the pressure from the public, from "shoppers, tourist, young people, and shift-workers", to have access to licensed premises at times that are convenient to them this - pressure is often described in terms of 'social demand'. On the obverse side of the coin, there are the (not unreasonable) expectations of people living in the vicinity of licensed premise, that they should have some protection from the sorts of disturbances that is often attendant on drinking, particularly late night drinking.

C. Limiting exploitation

A third aim of licensing legislation has been seen as providing a break on the commercial exploitation of alcohol by the drinks trade. There have always been those opposed to licensing on the basis that it places the drinks industry at an unfair disadvantage vis-a-vis other commercial enterprises. The drink trade, they claim, should be subject only to market forces in the same way as any other commercial enterprise. In recent years, however, this view has found little favour and, indeed, there have been demands for tighter controls. In the modern world of aggressive advertising and persuasive promotional techniques, where there is an increasing level of concern about the personal and social impact of drink, it is not surprising to find demands being made for greater controls on (say) alcohol related

sponsorship in sport. Some groups have gone so far as to call for a complete ban on the public advertising of alcoholic drink (Strathclyde Regional Council, 1979).

D. Preventative measures

The final objective of licensing which is the prevention of excessive drinking and drunkenness, is perhaps the most controversial. Certainly it was the perceived threat to their civil liberties of these sorts of measures that exercised many of the critics of nineteenth century legislation. Even today there are those who would argue that licensing authorities should not take upon themselves the role of 'guardians' of public health or moral standards. Adults, it is argued should be free to regulate their own consumption and make decisions relating to their private drinking habits. Others see licensing, and, indeed, the criminal law more generally, as a potentially important factor in alcohol prevention programmes. De Lint and Schmidt, for example have argued that -the initial (historical) legal, moral, and economic rational notwithstanding - "the overriding concern reflected in control policies of recent date has been social welfare" (de Lint and Schmidt, 1982:149)

Clayson and the reform of Scottish licensing law

The move towards a greater emphasis on the 'social welfare' aspects of licensing control - in Scotland, as yet, we cannot claim it as an "overriding concern" - is perhaps best illustrated in the deliberations of the Clayson Committee.

Following the appointment of the Erroll Committee to review the licensing system in England and Wales in 1971, it was felt that the situation in Scotland - where there had been no general review of licensing since 1929[8] - also warranted some review to assess the necessity of adapting the licensing system to modern social and economic circumstances. The Scottish Office, therefore appointed a Committee:

> To review the liquor licensing law of Scotland and to make recommendations on what changes, if any, might be made in the public interest; and to report.

The Departmental Committee, chaired by Dr Clayson, began taking evidence in April 1971. By the time it had reported to the Secretary of State two years later, the Committee had received written submissions from "about 250 groups, organisations, and individuals and heard oral submissions from almost 50 organisations representing a very wide range of opinion and from a few individuals" (Clayson, 1973:4).[9] An indication of the tenor of the Report is given in the opening paragraph of its first chapter:

> Over a hundred years ago Dean Ramsay succinctly summarised what we can regard as the essence of our enquiry by recalling the famous words of a loyal servant who was defending his master's reputation "I canna say I've seen him the waur o' drink but nae doubt I've seen him the better o't".
>
> (Clayson, 1973:1.01)

There is no sense here of the advocacy of strict regulation. Certainly, the Committee is prepared to accept that a serious problem exists in Scotland, but considered that "the great majority of the people in Scotland who drink do so in moderation".

The Report of the Clayson Committee made over ninety recommendations concerning such issues as official procedures, licensing courts, courts of appeal and, of course permitted hours. In the cause of brevity, I shall outline only the main proposals:

i. The existing licensing courts should be replaced with tribunals to be called 'licensing boards' appointed by district councils and consisting of district councillors.

ii. The permitted hours on weekdays in hotels, public houses, and refreshment houses, should be from 11 am to 11 pm. Afternoon breaks, if any, should be at the licensee's discretion. These basic permitted hours should apply throughout the country.

iii. Public houses and refreshment houses, in addition to hotels, should be permitted to open on Sunday. The permitted hours of Sunday opening should be from 12.30 pm to 11 pm.

iv. It should continue to be an offence to allow children under the age of 14 in a bar during permitted hours. Special certificate's (a "children's certificate") should be able to be issued, however, to allow children into a specified part or parts of the premises.

v. There should be no change in the present age limit of 18 below which it is an offence to buy alcohol.

Many of these recommendations were incorporated into the Licensing (Scotland) Act 1976.[10]

Clayson firmly believed that a more liberal licensing regime would help to 'civilise' Scottish drinking habits. The intentions are clearly consistent with a broad "social welfare" orientation. It has to be said, however, that a significant minority of the people I interviewed were not impressed by some of the *consequences* of reform, particularly the advent of all-day and late night opening in many areas. Certainly the enactment of the 1976 Act radically transformed the Scottish licensing system. For some of its critics, it also sacrificed the last vestiges of Scotland's unique contribution to the Temperance cause - permissive prohibition[11] and Sunday closing of public houses (Paton, 1977). It can of course be argued that the 1976 Act represented a retreat from the 'successes' of tee-total legislation (King, 1979:25), but one could also point out that the it effectively ended some of the worst iniquities of prohibitionist licensing.

The physical environment of licensed premises, for example, has changed beyond all recognition. Muir's "pubs for the overdue", depressing places for purely perpendicular drinking where the solitary drinker was not inclined to stay long after the drink was over his throat (Muir, 1901), have given way to a variety of premises catering not only for drinkers but also providing food and various forms of entertainment and, increasingly, non-alcoholic drinks. The change is well reflected in the nature of the licenses granted. A comparison of the number and range of licensed outlets now and at the time of the Clayson Committee inquiry, reveals that there has been an across the board increase in licensed premises (Figure 5.1).

Whether or not these changes would have come about without the impetus of licensing reform is obviously a subject for debate. The desirability of such changes has also generated a good deal of heat. The 'modernisation' that has seen the pub metamorphosed as the wine bar, the cocktail bar, and the disco bar, has not been to everyone's liking. Hugh MacDiarmid's epistle on 'The Dour Drinkers of Glasgow', written more than a decade

before the Clayson inquiry began its work, may still strike a chord with the aficionado of the old-style Scottish pubs, institutions in which:

> ... at their most typical, the rule is 'men only' and 'no sitting' you stand at the counter with your toes in that narrow sawdust-filled trough which serves as a comprehensive combined ash-tray, litter-bin and cuspidor.
>
> (MacDiarmid, 1968)[12]

Another example of the change in drinking habits is the disappearance of shebeens, the illicit drinking dens that were for the temperance advocate the epitome of the evils of drink. The shebeen was, in a very real sense, the inevitable result of the restrictive licensing of the 1853 Forbes-Mackenzie Act. Only a few years after the Act was introduced (Anon, 1857) Edinburgh City Police estimated that there were some 242 premises being used as shebeens in their area. In Glasgow in 1857 there were 223 convictions for 'shebeening'. Although the activity seems to have declined in the years after 1945 - there were barely 100 arrests on average in Scotland throughout the 1960's - shebeens continued to be part of working class drinking culture. Writing of his life in Glasgow in the mid-1960's, Jimmy Boyle describes a shebeen he was involved with in the Govan area of the city:

> Govan was an ideal district for rackets as it took in all the shift workers coming in for booze to the shebeen. We used a two apartment house run by a friend. One room would be filled with crates of booze, and some women would sit in there throughout the night and sell it while we lay in the other with the birds. One room full of booze the other with mattresses. That way we were always handy for any trouble that arose...
>
> (Boyle, 1977:114)

The implementation of the Licensing (Scotland) Act 1976 obviated the need/rational for shebeens and for 'out of hours' drinking generally, and they are now pretty much a thing of the past.[13]

How far the reform of the licensing laws has been effective in its avowed aim of preventing alcohol related harm, is an issue I shall discuss in the next chapter. For the present, however, the discussion of shebeens rather conveniently leads into the other major

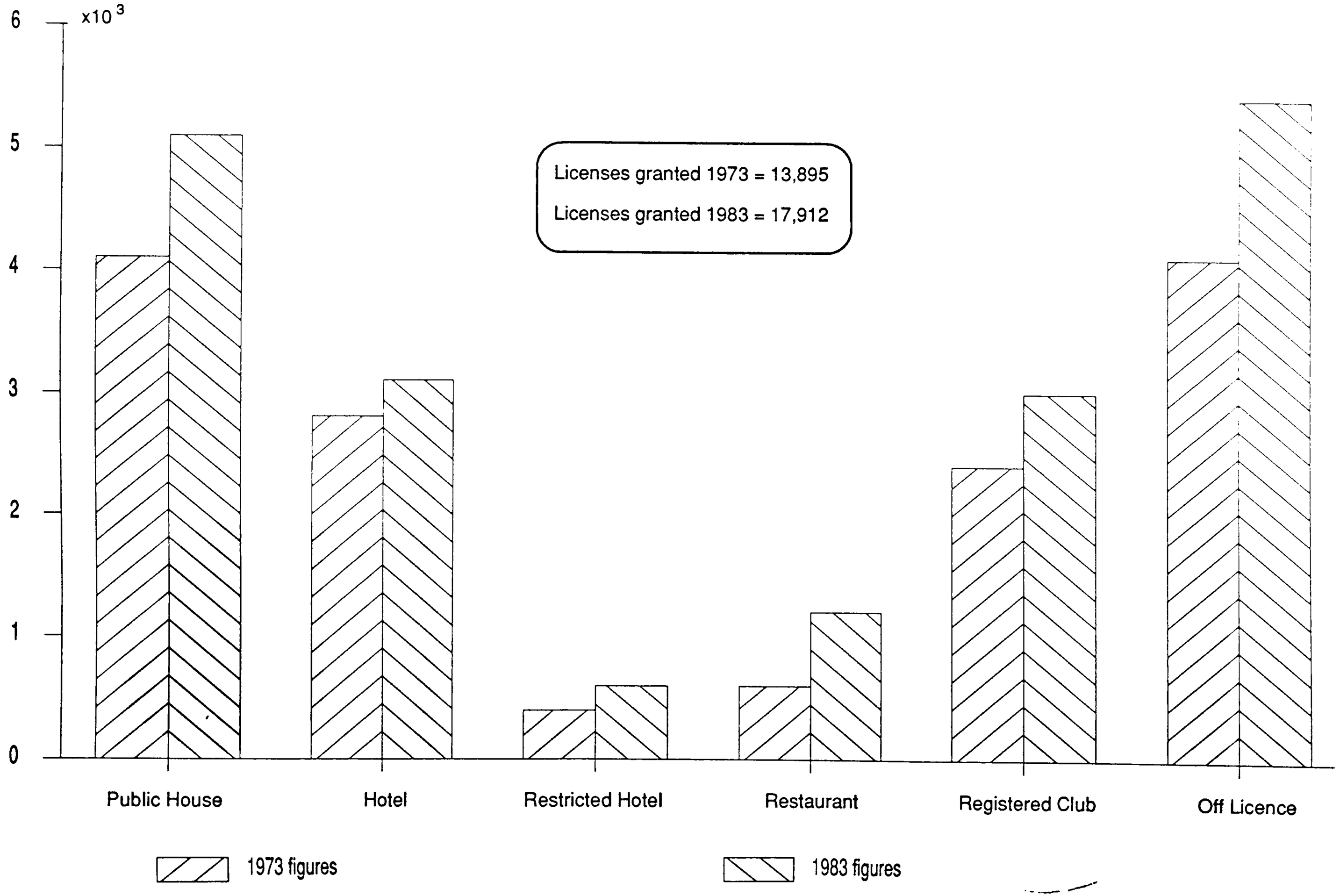
present, however, the discussion of shebeens rather conveniently leads into the other major dimension of legislative control - the criminalisation of public drunkenness.

The drunkenness offence

Underlying the two alcohol control mechanisms that are being examined here - licensing and criminalisation - is the notion that the State, through the medium of the law, is an appropriate vehicle for regulating and transforming drinking habits. The mechanisms by which this control was made possible (no, more than that, conceivable), the legal system and the police, evolved in the same era and were informed by the same ideological environment as the Temperance crusade. The concerns of this period - the focus on discipline, self-help, industriousness, social order and the seemingly countervailing emphasis on individual liberty and individual responsibility -are clearly reflected in the way the legal control of drunkenness has developed.

The law itself is straightforward. Drunkenness *per se* is not an offence under Scots Law except where it is combined with certain *species facti*. In general these aggravating circumstances relate either to being unable to take reasonable care of one's self - being drunk and incapable - or behaving in a disorderly manner to the annoyance of others. This latter charge, being drunk and disorderly, was little used in Scotland - disorderly drunken behaviour being more usually dealt with as breach of the peace - and has recently disappeared with the consolidation of legislation in the Civic Government (Scotland) Act 1982. There are a number of other Acts and Bye-laws that can be invoked in respect of drunken persons in particular circumstances. In the present context, however, drunkenness offences refer to the two most frequently used charges, drunk and incapable and breach of the peace.

Figure 5.1 Number and type of Licenses Granted in Scotland in 1973 and 1983



Legislation relating to public drunkenness, unlike liquor licensing, has changed little since the early part of this century when the Licensing (Scotland) Act 1903 made it an offence to be drunk and unable to take care of oneself in a public place. In recent years, some modifications have been made and others promised. The Criminal Justice (Scotland) Act 1980, to take the most recent example, abolished direct imprisonment as a punishment for simple drunkenness and held out a promise of an alternative to prosecution in the shape of the so called designated place. For the moment, however, most drunken offenders continue to be dealt with under legislation that was first passed in the early years of this century, albeit legislation now incorporated in a modern Act. Section 50(1) of the Civic Government (Scotland) Act 1982 states that:

> Any person who, while not in the care or protection of a suitable person, is, in a public place, drunk and incapable of taking care of himself shall be guilty of an offence and liable, on summary conviction, to a fine not exceeding £50.

That then is the law. The ideological picture of the relationship between the institutions of the law and civil society is more complex, not least because it is bound-up with an abstract view of the law as a non-partisan guarantee of justice. For many commentators, certainly for those who subscribe to a functionalist world view, the source of legal authority is the society itself. The institutional agencies of the law, most notably the police, have made good use of the language of consensus and accountability to *the law* in defending their own position. Witness the statement of Sir Robert Mark that:

> ... the fact that the British police are answerable to the law, that we act on behalf of the community and not under the mantle of government, makes us the least powerful, the most accountable, therefore the most acceptable police in the world.
>
> (Mark, 1977:56)

Police work, and indeed the work of the criminal justice system in general, is more than the simple process of law enforcement that is often presented. Appeals to high flown principles of justice and individual responsibility do not explain why the police proceed against

drunkards, why fiscals prosecute them, or why the courts convict. The stock phrases about "protecting property and lives" that trip so readily off the tongue of every police officer may be closer to the true purpose of the law in capitalist society (why is property always first), but do drunks really pose a serious threat to social order? "The average alcoholic," according to Glatt, "is not a criminal and does not come into serious contact with the law" (Glatt, 1958). The analysis of police reports undertaken as part of the present study would seem to support this view; it was found that only 6.5 per cent of those charged as drunk and incapable had 'other offences' (mostly minor) recorded against them (Table 9.1, p.218). In arresting drunks the police are not 'the thin blue line' protecting the rights of honest citizens against the growing forces of criminality. It seems much more likely that they are acting as 'the guardians of public morality'. Whether or not the police (or indeed criminal justice agents in general) see themselves in this way, it seems currently fashionable to stress the 'welfare' rather than the 'law enforcement' aspects of the job (Young, 1975:12). Just how well this "24-hour social service" (a favourite phrase of at least one Chief Constable) responded to alcohol related problems is something that will be discussed in due course.

Social welfare

The social welfare model differs from the conventions of legal or medical intervention principally by its focus on individual needs rather than on behaviour or pathology. Although historically this welfare orientation has been identified most closely with social work, doctors and (some) criminal justice professionals have taken an increasing interest. The notion that social work *ought* to be involved in the development, implementation and operation of services for clients with alcohol problems emerged only slowly and, initially at least, was associated with a very limited range of techniques borrowed from the mental health field and from psychoanalysis in particular. Indeed, the received wisdom of the social

welfare model was for a long time informed by medical rather than social models of society. Medical men could of course be relied upon to make the point with their customary alacrity:

> It is essential to make it clear from the outset that the social worker is part of the medical organisation. She is one means of diagnosis and treatment. She is not to pursue independent sociological or statistical enquiries. She is not to be the agent of any other non-medical society.
>
> (Cabot, 1919:3)

Cabot was, of course, commenting about hospital-based medical social work and he was writing at a time when the social work profession was in its infancy. Clearly things have changed over the intervening years. The restructuring of social work in the 1960's and the trend away from the 'disease model of alcoholism' in favour of (re)defining the issue as a major social problem would suggest to many people (not all of them social workers) that social workers have an important role to play in responding to social problems such as those associated with alcohol misuse. What is perhaps less clear is whether or not social workers, as a profession, have sufficiently loosened the strictures of the medical model to be able to articulate an independent view of alcohol problems and of the sorts of strategies that might be appropriate in responding to these problems.

Local authority social work departments have a duty under the terms of the Social Work (Scotland) Act 1968 "to promote social welfare by making available advice, guidance and assistance". Social workers are deemed to have many of the skills necessary to help problem drinkers: they are able to influence clients by qualities of empathy and sincerity and their ability to involve them in a non-exploitive relationship. But this is not the holy grail. Social work counselling is not the answer any more than medical treatment or punishment. Indeed one of the problems of the social welfare model has been that the claims made by some practitioners for their services and resources have far outstripped their ability to deliver the goods.

There is little doubt that social service managers have, in recent years, become aware of the role played by alcohol problems in social work caseloads (Strathclyde Regional Council, 1979; Social Work Services Group, 1981). There is equally little doubt that the humanitarian concerns expressed in the social welfare model have considerable appeal, not least because the approach is designed to deal with people rather than things, be they 'diseases' or 'offences'. This suggests perhaps that the 'compassionate' response of social welfare might prove more effective in the management of alcohol problems than the alternatives - the technical response of the scientific-medical approach and the rationalism of the legal model. Certainly that was the tenor of a 'practice guidance' issued recently by the SWSG. *Towards Effective Practice with Problem Drinkers* (SWSG, 1988), while acknowledging that many social workers remain unsure of their role in relation to clients with alcohol problems, suggests that:

> Qualified social work staff already possess many of the skills necessary to help clients change their pattern of alcohol use ... There are some instances in which social work staff are uniquely well placed to promote healthy life styles and to prevent the development of alcohol problems.
>
> (SWSG, 1988:14)

It is interesting that the guidance differentiates between qualified and unqualified social work staff. Is the implication that 'unqualified' staff are somehow unprofessional, that they do not have the requisite skills? While this may well be the case, there is also a feeling that unqualified staff - in this context that generally means alcohol counsellors - are too medically directed. But of course there can also be variations within the profession. There is some evidence to suggest that many social workers continue to conceptualise the problem in medical terms. They see alcohol misuse as an illness that is chronically difficult to treat (Cartwright *et al*, 1975). Going in the opposite direction, there could also be a tendency for some social workers - perhaps those with a particularly heavy supervision or probation oriented caseload - to rely more on statutory powers than on counselling skills. In either

case, this has obvious implications both in terms of their willingness to intervene and on the success outcome of any intervention.

Conclusions

Three professional ideologies have been presented in this chapter. Although there is a certain vagueness and some inconsistencies in these positions, in broad terms they exhibit distinctive characteristics. The legal model emphasises responsibility and retribution. The medical model is more interested in the 'disease' than in the individual, and the social welfare model in its traditional garb, identifies the problem with the individual at the expense of a wider social perspective. These overall conceptualisations of the problem can have considerable influence on decision making and perceptions. This of course does *not* mean that irrespective of other factors, especially individual attitudes and experiences, professional ideologies *determine* methods of the way a problem is dealt with. However, they do reflect a congruency of certain beliefs, a kind of operational philosophy, which help professional groups to conceptualise the 'problem' and helps justify their decisions about what should be done about it (Smith, 1977).

The consideration of professional ideologies brings the discussion to the micro level of analysis. How and why do doctors, social workers, police and judiciary, react to the problems that come their way as a result of alcohol misuse? It part of course they will be guided by what they *perceive* to be the nature of the problem. The analysis might usefully begin by reviewing the current situation, looking at the nature and extent of alcohol problems today.

Notes

1. The idea that we are all equal before the law is central to the maintenance of this framework of justice and individual responsibility. So far as drunkenness is concern, however, this is (and historically always has been) little more than a legal fiction. The reality is that at every level, from arrest to prosecute and sentencing, the operation of the rule of law discriminates against the working class, against the young, the poor, the homeless and the more socially visible offender.

2. There appears to be some confusion in the literature about the precise constituents of the Alcoholism Movement. Common usage would seem to included the triumvirate of the Yale Centre of Alcohol Studies, the National Council on Alcoholism and A.A. Some writers, however, have questioned the inclusion of A.A. as an institution (as distinct from individual A.A. members) on the basis that the emphasis of the institution is inward looking, focusing on self-supported self-help, rather than on the development of public services and facilities (Room, 1983). Individual members of A.A. and it might be argued the organisation itself through for example *The Grapevine*, an in-house journal were important to the development and promulgation of the 'disease concept' and it would be inappropriate to exclude them from the definition.

3. The concepts of 'craving' and 'loss of control' which are central to the A.A. view of alcoholism and which, as a result, found expression in the classical disease model, owe as much to nineteenth century temperance thought as they do to any 'new approach.' The following description of the habitual inebriate, penned by a temperance advocate would not look too out of place in a modern day account of 'loss of control':

   "In their sober moments they reason justly of their own situation and its danger; they know that for them there can be no temperate drinking: They resolve to abstain altogether, and thus avoid temptation they are too weak to resist. By degrees they grow confident, and secure in their own strength, and .... they taste a little wine. From that moment the nicely adjusted balance of self control is deranged, the demon returns in power, reason is cast out, and the man is destroyed."

   (Levine, 1978:147)

4. The claim that it was both rational and humane to treat alcohol problems as disease was no doubt given added credence by the development of a number of 'effective' therapeutic procedure. Such medical 'advances' included the introduction of aversion therapy and Disulfiram (Antabuse) into Britain in the 1950's.

5. In fact much of the scientific research that was used in promoting the new approach was done *ex post facto* and was motivated by a desire on the part of the promoters of the approach to gain some scientific legitimation for their views on the nature of alcoholism. The best known example of this borrowing process is to be found in E.M. Jellinek's early work on the disease concept (Jellinek, 1952). According to Bacon, it was "probably in late 1944" that Jellinek received some questionnaires from Alcoholics Anonymous. The questionnaires had been designed by members of A.A. and administered to other members. Even so the response rate was poor, possibly less than 10 per cent, and the result can hardly be described as scientifically rigorous (Bacon, 1976).

It was from the raw data of these questionnaires that Jellinek conjured up "a description of something called alcoholism." Jellinek's colleagues at the Yale Centre were apparently not too impressed by his initial analysis, referring to it as 'Jellinek's doodle'. Later, given the more academic title *Phases of alcohol addiction* and with the data greatly expanded, Jellinek's work was to prove a major impetus to the development of the disease concept of alcoholism.

6. The survey of 400 members of the general public throughout Central Region found that whereas 84 per cent of the sample defined 'alcoholics' as sick, 81 per cent of the same sample felt that problem drinkers lacked self control. The moral approbium was more marked in the case of women with 68 per cent of the sample agreeing with the statement that "a drunk women is a more disgusting sight than a drunk man".

7. In reality of course the 'threat' is not so much the loss of employment or personal relationships, as it is the possibility of incarceration. Until quite recently in Britain - and very recently in the case of Scotland - it was commonplace for sentence habitual drunkenness offenders to short terms of imprisonment.

8. Prior to the setting-up of the Erroll Committee, the licensing position south of the Border had been reviewed (and altered) on two occasions during the 1960's. In Scotland, on the other hand, there had been no such changes and, apart from a limited enquiry (the Guest Committee) in 1958, no review since the Royal Commission of 1929. Not that had achieved much. The Commission was unable to reach agreement and, at the end of the day, submitted both minority and majority reports. The recommendations of neither were acted upon.

9. The Committee took evidence from groups and organisations as diverse as the Scottish Temperance Alliance, the Educational Institute of Scotland (EIS), the Lord's Day Observance Society, and even the University of Stirling Staff-Student Club!

10. Some of the more controversial (imaginative) recommendations, however, were either not implemented or were given only limited support. The provision of family facilities is a case in point. The committee wanted to encourage the development of facilities that would allow young people to become familiar with licensed premises in a family environment, as Clayson himself explains:

    "What we wanted was a pub with family facilities where parents could take children who would be introduced to alcohol first by observation of its use in society. When they were old enough they could partake of it themselves, under parental guidance. That was the idea and it is possible under the [Licensing (Scotland)] Act.

    In 1980, there were only 58 such licenses in Scotland. Since then statistics have not been kept, but the impression I got from talking to interested parties throughout Scotland was that there numbers had not increased significantly.

11. Permissive prohibition, better known as the local veto poll, was introduced in the Temperance (Scotland) Act 1913. The provisions of the Act allowed local electors to vote on the issue of prohibition in their area. In order to hold a poll 10 per cent of the electors had to support the request and to pass, a "no licence" resolution required 55 per cent of the vote. In 1920, the first year that veto polls were held under the Act, 584 polls resulted in 41 areas voting for "no licence" and a further 35 for

limitation (King, 1979:24). As a result over three hundred licenses were lost, whole towns and large residential areas of Scotland's major cities went 'dry'. Kilsyth and Kirkintilloch, near Glasgow, and the Cathcart area in the south-east of the city, are perhaps the best known of these 'dry' areas.

Although it gave licensing boards some discretion in respect of granting licenses in previously 'dry' areas, the practical effect of the 1976 Act was to abolish veto polls.

12. This traditional image of the pub as an almost exclusively male preserve, "a masculine republic", has also undergone considerable change. Women are now going into licensed premises in greater numbers and, according to some commentators at least, this trend has contributed to the increasing incidence of drinking problems among women (Hunt, 1982; Hey, 1986; Hunt and Satterlee, 1987).

13. Shebeens of the sort described by Boyle may have disappeared, but one police sergeant I spoke to and who had worked for some years in the Licensing Division, could still cite contemporary instances of unlicensed drinking dens. One example concerned the recent prosecution of a hospital auxiliary who had set up a 'bar' in the boiler room of a large general hospital - a sort of illicit staff club. In another recent case the caretaker of a community hall ran "a wee bar on the premises, just for the auld folk, but couldn't be bothered" with the inconvenience of applying for a special license. Such colourful incidents are, however, very much the exception.

6 The Nature and Extent of Alcohol Problems

Over the last twenty years or so the various institutions of social control have been faced with what many *believe* to be a rising tide of alcohol misuse. Two Reports in less than ten years from the Royal College of Psychiatrists (1979; 1986) and a host of research material has drawn attention to the wide variety of alcohol problems and the heterogeneity of those who until quite recently would have been defined in more unitary terms, alcoholic. Clearly there is felt to be a problem to which society - and increasingly that meant all sections of society not simply the 'experts' - had to respond positively. The nature and extent of the problem, however, needs to be considered. Are we facing a rising tide, or simply (in Collin's words) "a short and sudden ebullition of drunkenness"? When Collins ventured that opinion, he had in mind the radical change in spirit duty that took place in 1823. For many of those who are concerned about contemporary drinking habits, the changes are linked to another 'fateful year' and the implementation of the of new licensing laws in 1977. This chapter will begin by assessing the situation in Scotland after a decade of more liberal licensing.

The main concern of the research, however, was that it should reflect the points of view of those who confront alcohol problems as part of their day-to-day work. In the interviews and discussions, therefore, I tended to use general terms such as 'drunkenness' or 'drinking problems' in preference to more value-laden one such as 'alcoholism'. Clearly this flexibility of definition will introduce a certain degree of inconsistency and ambiguity, with respondents tending to discuss the problem in terms that relate most directly to their own agency's work. The police and judiciary, for example, may be more exercised by issues that might be subsumed under the broad heading of 'public drunkenness', while social workers may focus on the consequences of excessive drinking at the expense of drunkenness *per se*.

The fact that the 'problem' means different things to different people, however, does not mean that it is any the less real and, in fact, as I have already shown, definitional confusion is a widely acknowledged feature of the 'expert arena'.

After Clayson: licensing reform ten years on

It is now fifteen years since Clayson submitted his committee's report on Scottish Licensing Laws (Clayson, 1973) and more than a decade since the Licensing (Scotland) Act 1976 effected major changes in the way in which controls on the availability of alcoholic drink operate in Scotland. The professed aim of the Act was to modernise and consolidate liquor licensing laws, to clarify licensing procedures and to make them more responsive to community needs. Denis Canavan, M.P., speaking during the closing phases of the debate on the Bill, expressed the views of many who supported licensing reform when he said:

> The more liberalised laws ... will, hopefully, lead to more civilised and healthier attitudes towards drinking and healthier drinking habits amongst the Scottish people, and will thereby fulfil the hopes of Dr Clayson and his committee.
>
> (Hansard 1976 [916] 585)

The liberalisation debate continues. Have Mr Canavan's hopes been realised? Has the implementation of the Act been beneficial, or have the less than optimistic prophesies of the (then) member for Glasgow Cathcart (Teddy Taylor) come to pass? In short, does licensing reform represent a step forward or backwards?

According to a System Three opinion poll published in the 'Glasgow Herald' (21-22 March 1985), both the public and the licensed trade have given the reformed liquor licensing laws a "decisive vote of confidence" - 85 per cent of the Trade sample and 66 per cent of the public felt that there had been no deterioration in drinking behaviour as a result of the changes. Even those who are critical of liberalisation are prepared to concede that there have been some beneficial effects such as the improvement in the general standard of license premises, the emphasis on food and non-alcoholic drink and the move away from

the "ten o'clock swill". A recent study for the Office of Population Censuses and Surveys also revealed a high level of public support for the new licensing system (Goddard, 1985). Seventy-three percent of Goddard's sample agreed with the statement that "the present licensing laws are an improvement on the old ones", while 51 per cent said that "these days you don't see as many drunks as you used to".

Many of those who work in the alcohol problems arena take a less optimistic view of the situation. Following the publication of the OPCS survey of public attitudes (Goddard, 1985), the directors of the Scottish Council on Alcoholism and the Alcohol Studies Centre at Paisley College penned a joint letter to the *Times* in which they declared themselves unimpressed by the support shown for the reforms and fearful of the long term consequences:

> As licensing law is a control measure it is not particularly surprising that its relaxation is popular. Whether it is good for the nation's drinking health is another matter ... The current licensing situation forms a sound base for an explosion of alcohol problems when the country recovers from the current recession.
>
> (Times, 11 June 1985:13)

One of the principal changes reflected in the "current licensing situation" was intended to reform the opening hours of licensed premises. This was to be achieved in two ways. Firstly, by extending the permitted evening period by one hour from 10pm to 11pm Monday to Sunday. Second, by allowing for extensions beyond the permitted hours subject to the discretion of the licensing board, thereby introducing a degree of flexibility into the system. The granting of these extensions on a regular, as opposed to an individual, basis has been the subject of considerable controversy, particularly in relation to late night drinking. One respondent, the Clerk to a local licensing board, summarised the issue from the legal viewpoint concerning the operation of the Act and the provision of regular extensions to permitted hours:

> Section 64 of the Licensing (Scotland) Act was never intended to be used to effectively alter the permitted hours. It was first used for that purpose to introduce afternoon opening which is now virtually universal ... Regular extensions were also not intended to be used ... as a matter of convenience instead of granting many individual occasional extensions. The fact that they are used in these different ways makes the legislation difficult to apply ... However, the main point is that regular extensions have been used to alter the permitted hours ... (which calls) into question the purpose and continued existence of permitted hours.

Table 6.1 gives some indication of the spread of regular extensions. In 1980, 24 per cent of public licensed premises and 40 per cent of registered clubs were granted some form of regular extension to their afternoon hours. The overall pattern of evening extensions, while not as pronounced, was nevertheless significant with 10 per cent of public premises and 22 per cent of private clubs enjoying regular extensions.

Table 6.1 Regular extensions of permitted hours granted, by period of extension, 1980.

Period of Extension	Public Houses		Hotels		Other*		Total		Registered Clubs	
	No.	%	No.	%	No.	%	No.	%	No.	%
Afternoons										
- daily	1516	20	896	25	106	10	2518	17	381	13
- part week	712	14	360	10	43	4	1115	5	762	27
Total afternoons	2228	44	1256	35	149	13	3633	24	1143	40
Evenings										
- daily	123	2	275	8	82	7	480	3	24	1
- part week	374	7	644	18	52	5	1071	7	613	21
Total evenings	498	10	919	26	134	12	1551	10	637	22

* Restaurant and restricted hotel licenses, introduced under the terms of the Licensing (Scotland) Act 1962.

Source: Scottish Civil Judicial Statistics

A survey carried out for the Trade journal *Brewing Review* estimated that "65 per cent of Scottish licensees have taken advantage of the new law" (*Brewing Review*, 1984:3). Perhaps not surprisingly, many critics have been less concerned with the problems of operating the licensing system than with the impact of these regular extensions on the incidence of alcohol related problems. For them the debate hinges around the question "Is what is popular necessarily good for the nation's drinking health?"

It is perhaps too early to answer the question, or to make any precise statement about the Scottish experience of liquor licensing since 1976. Nevertheless, when the situation in Scotland is compared with that in England and Wales where the reformed licensing system has *not* been introduced it would seem that the worst fears of the Act's opponents have not been realised. An analysis of the trends relating to the various indices of alcohol related harm does not suggest any marked changes in levels of alcohol related harm that might be specifically related to the events of 1976 (Figures 6.1-6.4).

Throughout the period 1970 to 1983, rates of alcohol related mortality were consistently higher in Scotland than that south of the Border (Figure 6.1). Recent studies, however, have attempted to 'uncover the myth' that lies at the heart of this disparity by demonstrating that levels and patterns of consumption of alcohol in Scotland are similar to those in England and Wales (Crawford *et al*, 1984; Wilson, 1982). It is suggested that the perceived difference in mortality rates are explicable, in part at least, by differences in recording practices as an artefact rather than a fact. Direct comparison of alcohol-related mortality rates in Scotland and those in England and Wales is complicated by possible differences in recording preferences. In England and Wales, until very recently, any death that was certified as alcohol dependence had automatically to be referred to the coroner for investigation. It has been suggested that this fact may have tended to discourage doctors from certifying alcohol dependence as cause of death. In Scotland alcohol-related deaths are not subject to the same routine investigation. Leaving these differentials to one side,

however, it is clear that in the years up to 1978-9, the general pattern in alcohol-related mortality in Scotland is similar to that in England and Wales, showing a fairly steady increase. After 1978 the rate for England and Wales drops sharply and then begins to rise once more. In Scotland the upward trend continues until 1979, but the trend over the four years is clearly downward. Where of alcohol related admissions to psychiatric hospitals are concerned the 'peak' a little earlier in Scotland, around 1974, and, thereafter, there is a steady decline in first admissions. South of the Border, by comparison the steady increase continues until 1981 (Figure 6.2).

Finally, a comparison of the trends in convictions for specifically drink-driving and drunkenness suggest a striking difference between England and Wales and Scotland over the period since 1976. In Scotland, convictions for alcohol-related motoring offences present a fairly stable pattern. South of the Border, on the other hand, a strong upward trend is in evidence (Figure 6.4). The same relative trend is revealed in convictions for drunkenness, with a sharp decrease in Scotland in contrast to a general upward trend in England and Wales (Figure 6.3).

Statistical trends of this sort, of course, do not prove that the Clayson inspired reforms have been a success. Indeed, such figures have been heavily criticised as notoriously unreliable, particularly in relation to the reduction in drunkenness offences. Douglas Allsop, Director of the Scottish Council on Alcoholism, argues that while:

> Much is made of the reduction in drunkenness figures in Scotland, which is consistently attributed to the 1976 Act, ... we also have to take into account the passing of the Criminal Justice (Scotland) Act 1980 which commenced the process of decriminalisation of drunkenness, and also include one other significant change in alcohol policy, namely, the banning of the consumption of alcohol on the way to and during sporting fixtures.
>
> (Glasgow Herald, 6 Jan, 1987:8)

Statistics relating to hospital admissions are also viewed with suspicion, not least because they do not reflect the increase in services that are now available to the problem drinker

outwith the clinical setting. One alcohol counsellor, for example, claimed that referrals to his local council on alcoholism had "risen by more than 200 per cent" in the ten years since the new licensing laws were passed. There is no doubt that information, advice and counselling services play an important role in responding to alcohol problems.It is, however, difficult to get any general information about levels of use. Admittedly hospital admission statistics cannot remedy this defect they cannot accurately reflect the instance of problem drinking in the community but they do help to illustrate general trends.

A final criticism that is often made by those who contend that increased hours will give rise to an increase in alcohol related problems is that the 'opposition' those who view the operation of the reformed licensing system as beneficial, or at worse neutral do not take into account the effect of the current economic recession on indicators of alcohol related harm. A recent survey of Drinking and Attitudes to Licensing in Scotland (Goddard, 1986) might lend some support to this view. Goddard found that between 1976 and 1984, the alcohol consumption of unemployed men fell by 28 per cent. Men in employment, on the other hand, increased their intake by over 10 per cent. This has suggested to some that an easing of the economic climate would result in a significant increase in consumption and, thus, in alcohol related harm. There are too many possible intervening variables allowing for too many selective (opposing) interpretations of the situation. On the evidence available so far, however, it seems reasonable to conclude, as the authors of a recent study do, "that, in relation to health, the new Scottish licensing arrangements may be viewed neither as a cause of harm nor as a source of benefit. They have in effect been neutral" (Duffy and Plant, 1986:39). That being the case, there seems little justification for rejecting liberalisation of licensing out of hand and, in fact, there is little likelihood of the Scottish experiment being abandoned in favour of a return to more restrictive licensing. The way forward, so far as licensing controls are concerned may be to recognise, as indeed the Clayson committee did,

that licensing is essentially a negative and restrictive process which has only a limited role to play in controlling alcohol related problems (Clayson, 1972:13).

Licensing as one form of control of alcohol misuse, will continue to exist and will, in all probability, continue along the same sorts of lines as those laid out in the 1976 Act. Licensing, however, represents only one side of the legislative coin. What most of the respondents were concerned about was the obverse - the use of the police and the courts to control alcohol related public disorder - continues to operate and, in doing so, to create problems for both the offender and the already overburdened criminal justice system. Alternatives to prosecution have been suggested as a means of reducing this burden. These of course have implications for the development of responses to alcohol problems in the future and, for that reason, will be considered later in the thesis.

Although the validity and interpretation of data such as that presented above has been subject to criticism and debate (Kilich and Plant, 1981; Ditton and Phillips, 1982), it *suggests* that - despite the best endeavour of 'claim-makers' over two hundred years to promote the issue as a social problem, and the considerable success of the disease model of alcoholism in more recent times - alcohol misuse in this country is still a problem of significant proportions.

The aim of the present study, however, was not to challenge these indices so much as to extend them: to go beyond the 'hard facts' in order to reveal something of the reality of the situation as seen by those who effect the routine management of alcohol problems.

Figure 6.1 Alcohol related mortality, 1970-1983

(Rate per 100,000 of adult population)

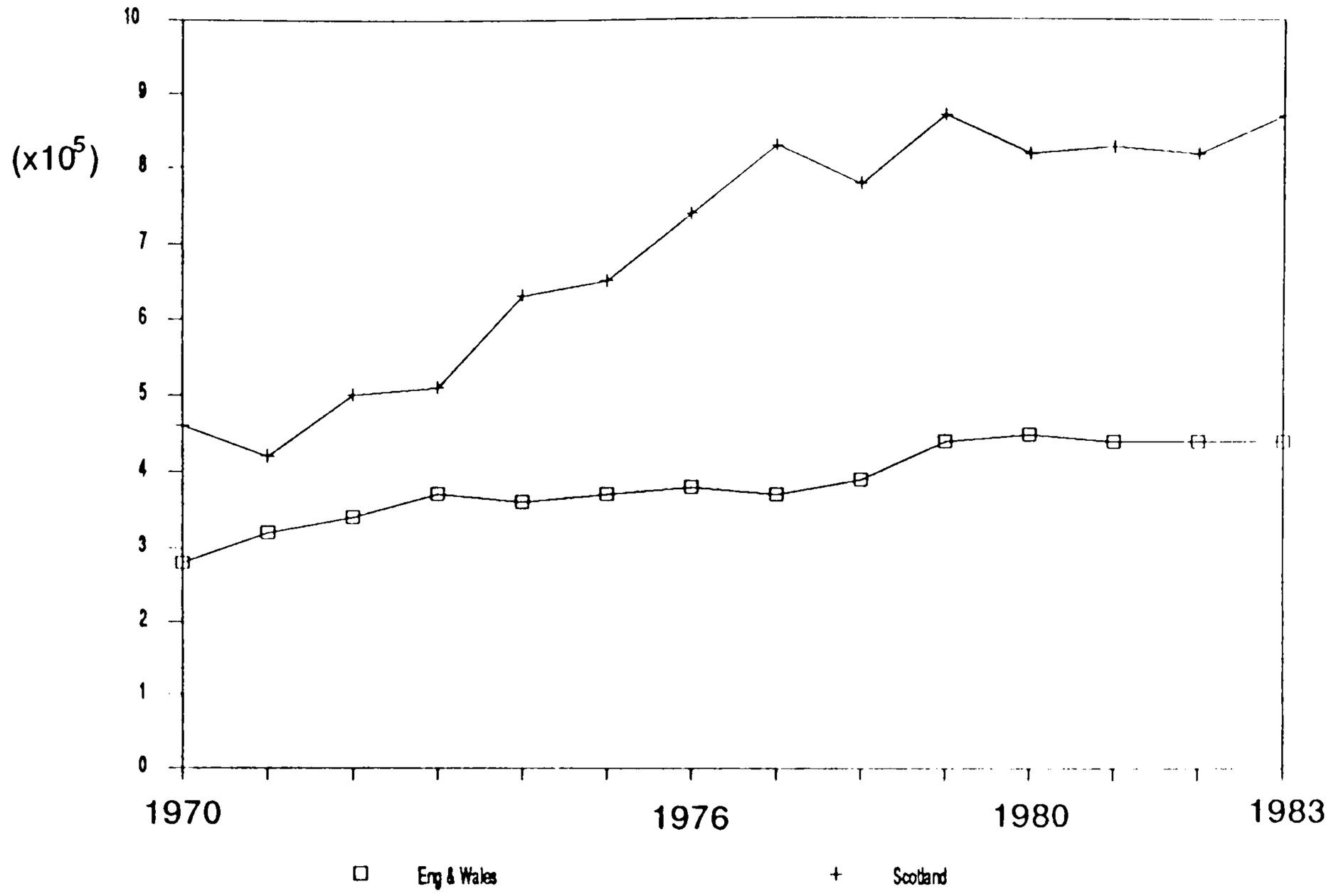


Figure 6.2 Hospital admissions for alcoholism and alcohol dependency, 1970-1982

(Rate per 100,000 of adult population)

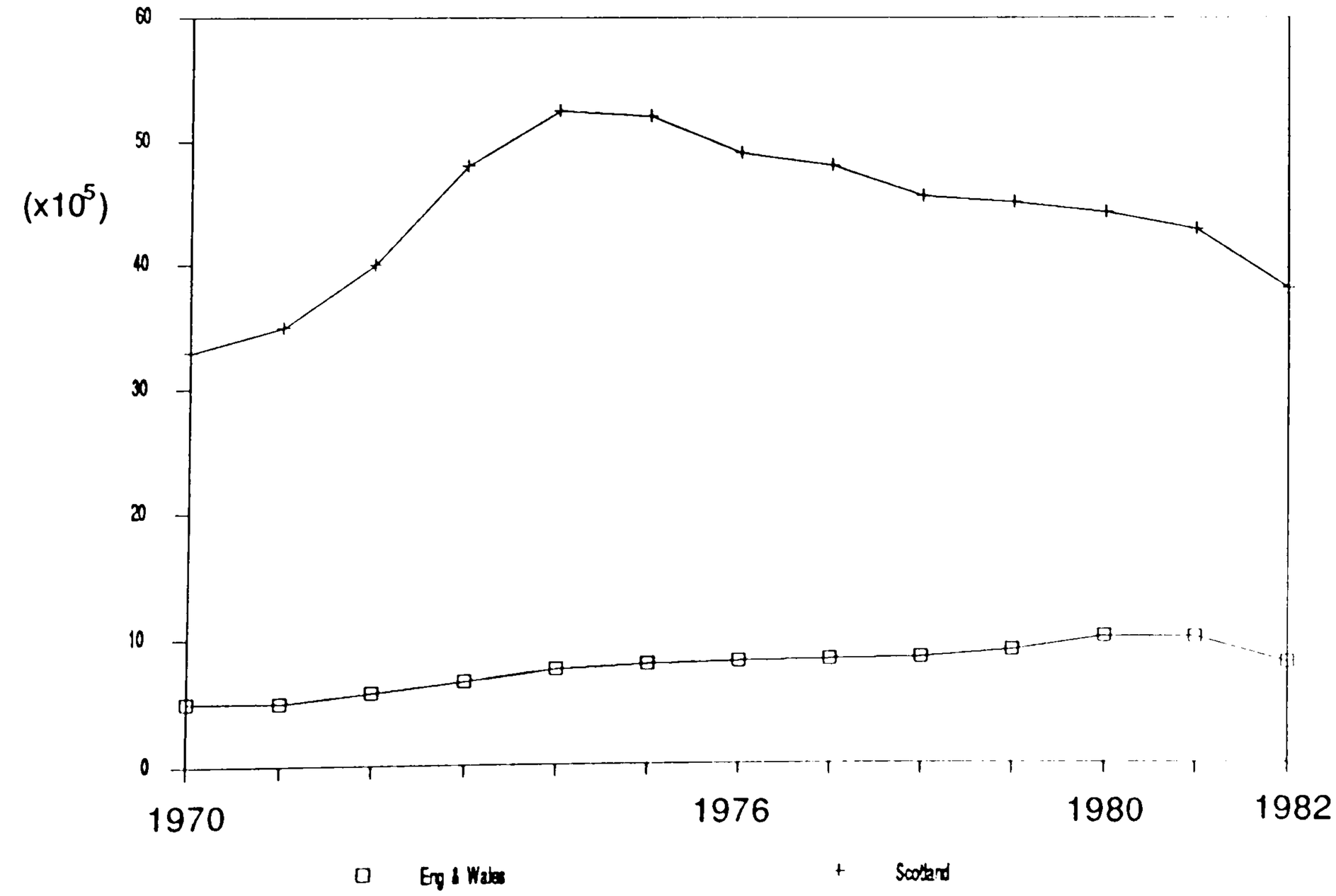


Figure 6.3 Drunkenness in Scotland and England & Wales, 1970-1983

(Rate per 10,000 of adult population)

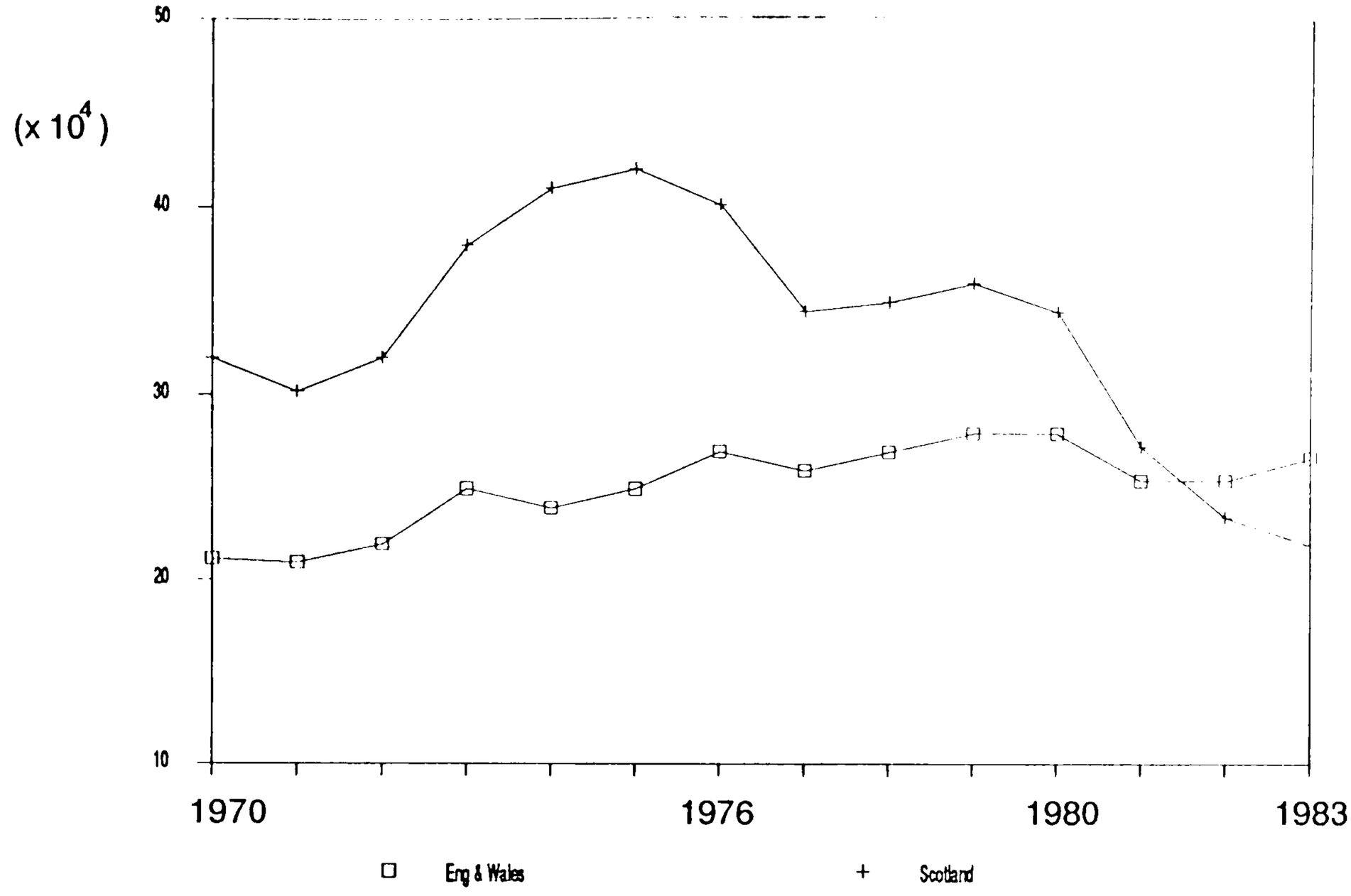
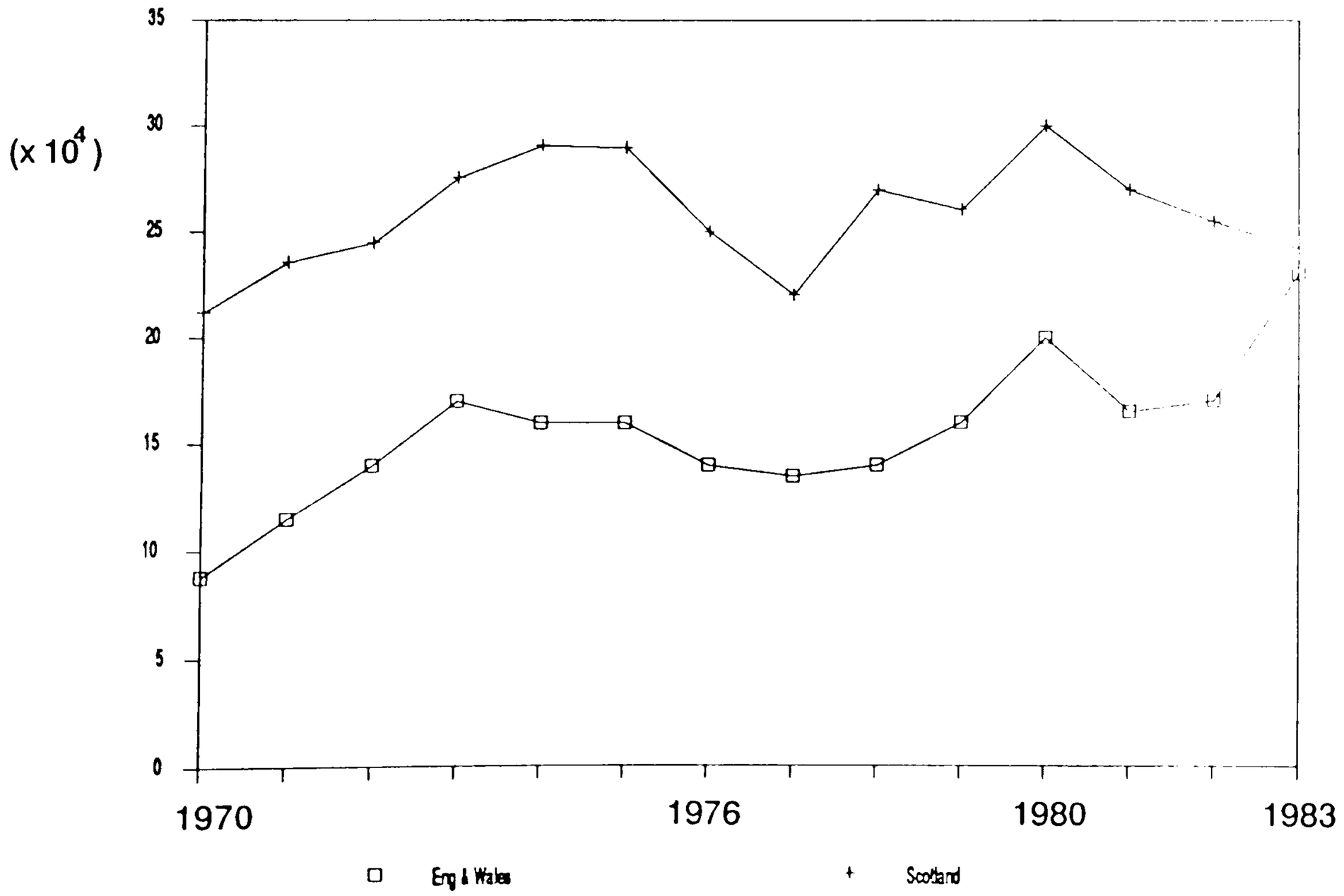


Figure 6.4 Drunk driving convictions in Scotland and England & Wales, 1970-1983

(Rate per 10,000 of adult population)



Perceptions of alcohol problems

Now might be an opportune moment to establish some kind of bench-mark for the study by the degree of support among respondents for the view that excessive drinking *does* represent a serious problem. The short answer to that question is that there was a very strong consensus on the issue. The vast majority of people agreed that there was a serious alcohol problem, but the strength of this consensus varied quite significantly across the sample groups - 92 per cent of social workers and 87 per cent of the medical and health care sample said that excessive drinking was a 'very serious' or a 'serious' problem, as compared with 67 per cent of the criminal justice sample and only 62 per cent of police officers (Table 6.2).

Table 6.2 Perceptions of the seriousness of alcohol problems

	Police %	Criminal Justice %	Social Workers %	Medical/ Health Care %
Very Serious	11	23	18	20
Serious	51	46	74	67
Not too Serious	32	32	4	13
Not at all Serious	7	-	4	-
Total*	101(N=160)	101(N=21)	100(N=111)	100(N=15)

* Percentages have been rounded to the nearest whole number and, therefore, the totals do not always add to 100.

Only a small minority of police - eleven officers in all - opined that there was no problem at all. It is interesting that those involved with the criminal justice management of the problem were *less* likely to see excessive drinking as a serious problem. Police work and, to a lesser extent, the work of the criminal justice system generally, places a premium on

speedy resolution of a problem. The offender becomes part of what one respondent called "a conveyor belt system of justice" and, as a consequence, there is no time to develop anything more than a superficial understanding of what is going on. The drunkenness offender is so much a part of this routine that the police have become inured to the situation and, therefore, tend to view problem drinking as unremarkable and immutable. On the other hand, many of those who thought that the problem was 'not too serious' seemed to feel that there had been an improvement in drinking behaviour, a general downturn in drunkenness offences, since the introduction of a more liberal licensing code in 1977:

> I think Clayson was a good thing. Certainly from our (the police) point of view. It's more civilised. You don't get the same ten o'clock swill and you don't get the same trouble with all the pubs turning out at the same time.

Licensing reforms not withstanding, there can be no doubt that the majority of those interviewed considered that there was a serious problem with alcohol. Moreover, when asked why they thought the problem was a serious one, most respondents focused on the difficulties that they experienced in dealing with the consequences of excessive drinking as part of their job. The question was open-ended and respondents were able to give as many reasons as they wanted. For the vast majority, however, the most important factor - the reason why they felt it was a serious problem - had to do with the way it impacted on their day to day work. Examples of the sort of reply given by almost three-quarters of all respondents were:

> It's part of a policeman's lot ... most of the work is drink-related ... most of your street crime, your violence. There's no doubt about it. Most violent crime, I would say 90 per cent is caused by drink.

> Alcohol abuse is a particular problem for social work. One of the big factors in reception into care of children is the abuse of alcohol.

> Oh, obviously, *the* problem. Well, I mean, from my work point of view. It isn't *the* problem from sort of my friends or anything like that, but from the work, it's much the most common factor ... in assaults, in theft or matrimonial things ... och, everyone's drunk when they come to court, or it has been drunkenness, or very nearly everyone.

Although there was substantial agreement across agencies about the seriousness of the problem, the different groups were in many cases describing a different problem. Doctors were mostly concerned with the sequelae of excessive consumption, in the sense that the consequences of alcohol misuse were seen largely in terms of physiological or psychological ill-health. Social workers, perhaps naturally, tended to see the issue more in terms of the consequences of excessive drinking for the individual and for his/her family. Child welfare was perhaps *the* orienting factor and indeed one social worker remarked that "social workers tend to tackle it (alcohol abuse) very much as a child care problem". Although social workers varied in their estimates of the prevalence of alcohol problems in their caseload, most were convinced that it was significant (Figure 6.5).

For the police, on the other hand, and for the criminal justice system the focus was on the more immediate and more visible manifestations of alcohol problems; drink driving, public drunkenness and drink-related disorder in general. Despite the changes in licensing controls and the introduction of alternative dispositions for drunken offenders in some areas, drink-related offences continue to play a significant part in the work of the criminal justice system. Figure 6.6 provides a graphic illustration of the trend in drunkenness offences before and after the implementation of the 1976 Act. The significant difference is not in the number of offences 'made known to the police', but in the proportion of those reported who are eventually 'proceeded against'. Whereas in 1972 90 per cent of those charged were prosecuted, ten years later that proportion had fallen to nearer 60 per cent. Different perceptions of problem drinking can, of course, be important not only in terms of the attitudes which group members have about drinking problems, but also for the way(s) in which they respond to these problems (if indeed they respond at all).

Figure 6.5 Social workers' estimates of alcohol related problems in their caseload

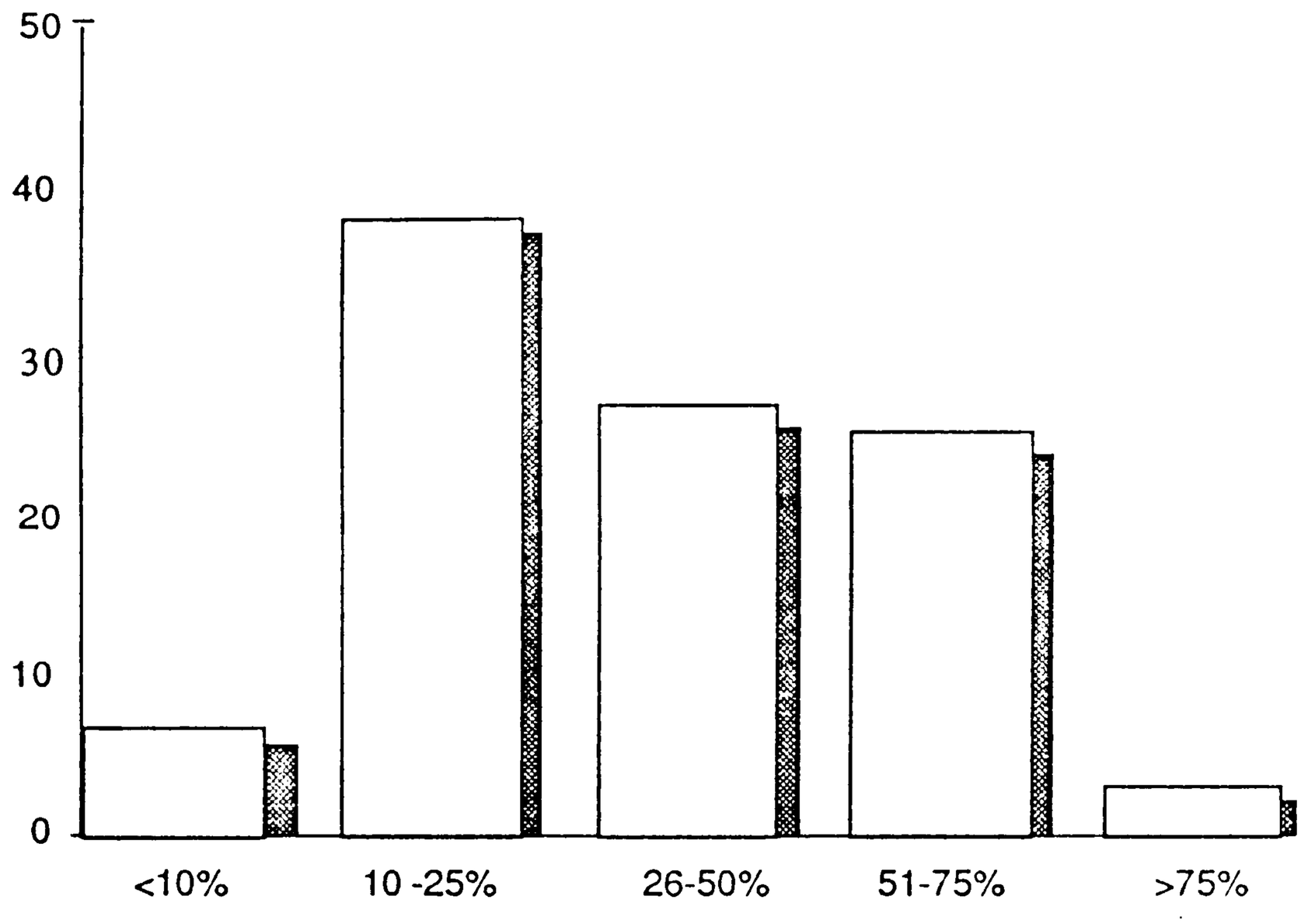
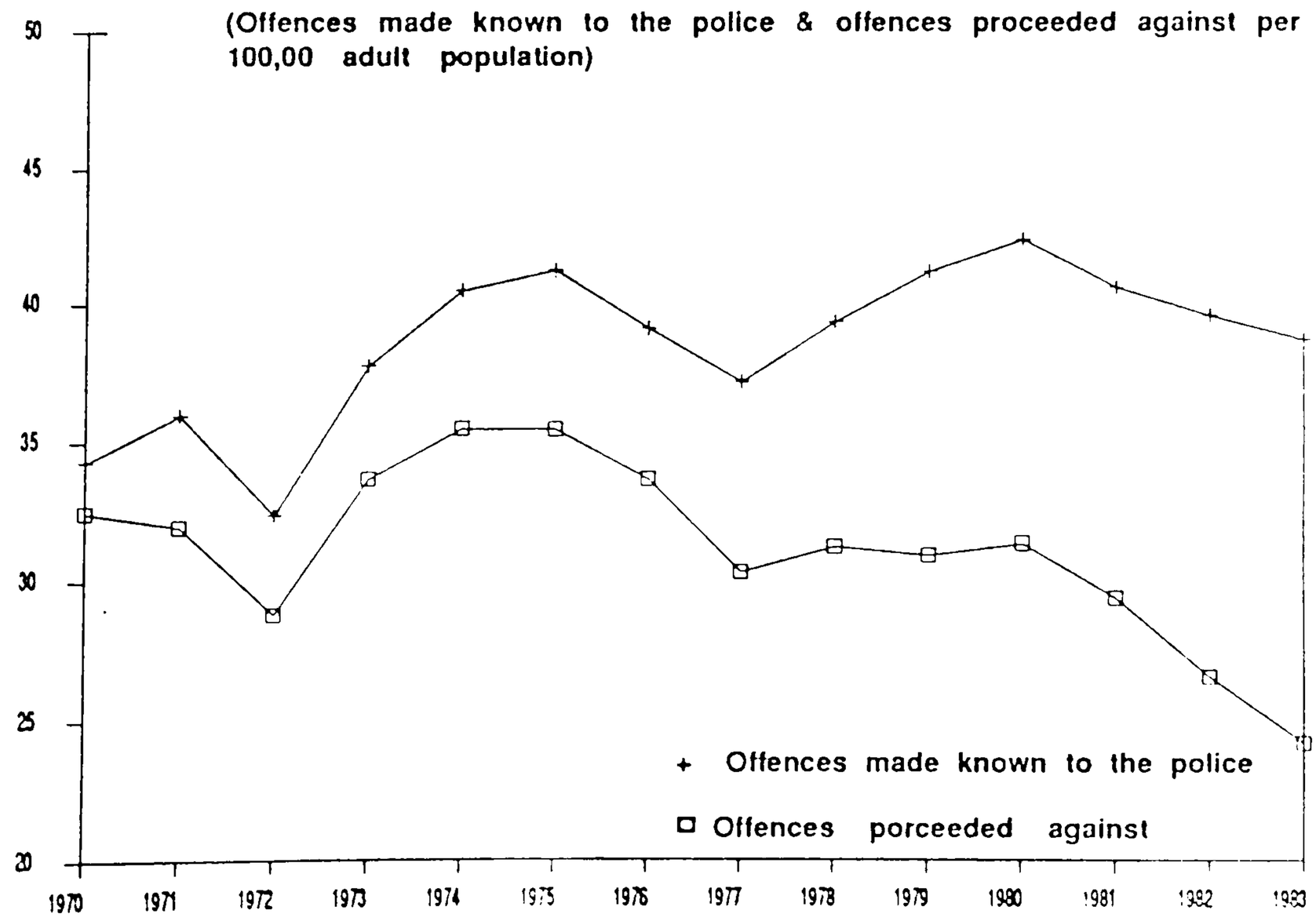


Figure 6.6 Drunkenness in Scotland, 1970-1983



Source: Scottish Criminal Statistics

Conclusions

In general patterns of alcohol related harm suggest that there has been very little sign of improvement in the extent of drinking problems over the last decade or so. There are many who would argued, to the contrary, that we are experiencing - or are about to experience - a dramatic *increase* in alcohol problems of every shade. There are problems with the official statistics - and, even more so, with the interpretation placed on them - and it seems unlikely that the debate will be easily resolved one way or the other.

In one sense, however, I am not concerned here with the accuracy of official statistics, or at least I am not interested in establishing the *precise* magnitude of the problem. I wanted to be able to point to something *out there*, to demonstrate that the incidence of alcohol related ill-health, or the trend in drunkenness offences, is unacceptably high, and despite all the reservations, the statistics make that point. However, more than that, I wanted to get to know how those who had to deal with the consequences of heavy drinking viewed the issue. Whatever the statistics may say, the central question was, do social workers, police officers, doctors, and magistrates, perceive drink to be a major source of problems? From their responses to interview questions and descriptive (sometimes graphic) account of their work the answer was clearly, yes. For *all* of the front line agencies, and police and social work in particular, problems caused by the misuse of alcohol was seen to be a serious problem which had a pervasive and disruptive impact on their day-to-day workload.

It is something of a truism to say that awareness of the existence of a problem is a prerequisite to doing something about it. However, in this chapter I have demonstrated that agencies are aware of the problem. In subsequent chapters, as I explore attitudes, perceptions, and responses to alcohol problems - we will see what they do about it.

7 The Limitations of Medical Response and Responsibility

The use of the term 'alcoholism' when applied to a variety of factors associated with the misuse of alcohol suggests a certain assurance, sanctioned by the medical profession, that objective criteria do exist by which the 'alcoholic' and the 'non-alcoholic' drinker can be differentiated. The reality of course is quite different, as Seeley (1962) pointed out.

> (T)he bare statement that "alcoholism is a disease" is most misleading since ... it conceals what is essential that a step in public policy is being recommended, not a scientific discovery announced.
>
> (Seeley, 1962: 593)

Alcoholism has become something of a social imperative that finds expression in a variety of institutions and forms of bureaucratic action. It is misleading to assume that "alcoholism is merely a word" (Mulford and Miller, 1959:705). The term 'alcoholism' has come to be seen as a feature on the landscape of response to the drink question and, as such, forms an integral part of the discourse which is being studied. Contemporary responses to the problems are, I would argue, *all*, to a lesser or greater degree, informed by the disease model of alcoholism. The landscape is dominated by the imagery of the medical and the therapeutic world.

In this chapter then I will discuss the continuing influence of the medical perspective in shaping responses to alcohol problems and the medical profession's perception of these problems. The concern is both with describing the background to the burgeoning of interest in alcohol problems in the last two or three decades and also with the role played by the medical profession (as distinct from medical ideology) in responding to the problem.

The decline in medical interest 1918-1945

The emergence of the nineteenth century disease concept of alcoholism established the medical professions right, alongside the more traditional institutions of control, to address itself to the major problems of human society. The inebriate reformatories provide us with a clear illustration of how the various strands religious, legal and medical coalesced around the control of habitual drunkards.[1] By the end of World War I, however, it was clear both that the "fair and reasonable experiment" had failed and that medical interest in alcohol problems generally was once more at a very low ebb. Small specialist interest groups continued their attempts to promote the issue, particularly in the area of psychiatry, and to provide some form of treatment. Private retreats and sanatoriums provided help for the better off patient. For the medical profession as a whole, however, the treatment of alcoholism held no appeal.

Not that the medical profession had been greatly enamoured of the subject in the first. place. The enthusiasm of those who promoted the disease model tends to blind us to the ambivalence of many doctors about the status of alcoholism as a legitimate medical problem. The British Medical Association (BMA), though it played its part in the agitation which resulted in the passage of the Inebriates Act, would have found it difficult to claim that there was within its ranks any particularly strong interest in alcohol problems. The following figures might help put medical interest into some kind of perspective. In July 1884 the Society for the Study and Cure of Inebriety had 232 members 165 (71%) of whom were doctors. Compare this tiny membership with the support that the BMA. could muster to oppose an innovation that seemed to threaten the vested interests of doctors, as when 27,400 doctors pledged themselves to oppose the introduction of Llyod George's State Insurance Bill (Turner,1958:256). Self-interest, of course, is not the only explanation of this comparative neglect. However, the availability of resources and the perceived need, or understandable desire, to focus these resources on areas that offered the best prognosis

undoubtedly contributed to the lack of interest. Habitual drunkards would have come very close to the bottom of anyone's list of priorities. Even those who had an interest in the general area of alcohol abuse preferred to concentrate on helping the 'well-motivated and articulate' private patient of the Licensed Retreat, rather than be involved with the 'incorrigibles' of the Reformatory and the prison. Dr Dunlop, the Inspector for Scotland and a medical adviser to the Prison Department, gives an indication of medical preferences in this area in his Annual Report for 1909:

> Retreats have been found to be of value as curative institutions for the treatment of habitual inebriety, and reformatories ... as places for the segregation and control of drunken pests and to some extent as curative institutions. The 'recovery' rate in well conducted retreats is found to approach fifty per cent, and that of the reformatories to be about seven per cent.
>
> (Report of the Inspector for Scotland, 1909)

The medical professions general lack of enthusiasm for the task was exacerbated by research carried out by the Francis Galton Laboratory for National Eugenics which could only induce a therapeutic pessimism about the possibility of achieving anything 'scientific' with chronic inebriates.[2] Doctors also found new, more 'scientifically' assured, areas of interest, particularly in the inter-war period as techniques of diagnosis and treatment became more sophisticated. Whatever the reasons, it is clear that drunkenness was no longer *the* problem and that the treatment of alcoholism figured very low on the medical agenda.

It has been claimed that the Inebriates Act testified to the seriousness of medical interest in the problem, that it cleared the way for the eventual acceptance of the medical model of alcoholism and so on (Orford and Edwards 1977). But it must also be clear that medical and medical interest in the area was not widespread. Despite the best efforts of the reformers, working with inebriates was regarded as a stigmatising, low status activity by most doctors. The acceptance of the modern disease concept of alcoholism might be thought to have transformed the situation, but has it? How has the disease model or the response

policies that developed as a consequence of been received by the medical professions as a whole?

Specialist treatment and general neglect: the medical response to alcohol problems 1948-1981

The developments of the inter-war period virtually eliminated the limited interest that had been shown in alcohol problems by medical or quasi-medical professionals. It was not until after the establishment of the National Health Service (NHS) in 1948 that the problem was rediscovered and some doctors once more began to promote vigorously the issue of services and facilities for those patients with alcohol problems. In Britain, the medical professions initial response to this new round of 'claim-making' could hardly be described as enthusiastic. There were still practitioners, particularly on the psychiatric/mental health side of things, who expressed an interest in the topic, but they received scant encouragement. The experience of one consultant has been offered as typical of the NHS response in the early 1950's. The consultant had applied for NHS support in attending a conference on alcoholism in Copenhagen which was being organised by Jellinek under the auspices of the World Health Organisation. The Ministry of Health in rejecting the application gave expression to what was (presumably) the official view that 'there was no alcoholism in England and Wales, and that the subject hardly merited the time of a consultant in the NHS' (Moss and Davies, 1967:1). Recognition of the problem improved gradually during the 1950's as first the British Medical Association and later the Ministry of Health officially endorsed the disease concept. A Ministry of Health memorandum on *Hospital Treatment of Alcoholism* recommended the development of specialised units throughout the country. The proposals were modest enough, emphasising in-patient care in specialised units, "one per region and increasing ... if the scale of demand makes it necessary", each unit having between 8 and 16 beds, "a convenient size for group therapy", and providing out-patient

care in cooperation with A.A. (Ministry of Health, 1962). The implementation of the proposals progressed slowly during the 1960's and 1970's. From the baseline of 1961, when there were no more than two or three specialised Alcohol Treatment Units (ATU's), their numbers had risen to thirteen by 1968 and by 1975 there were in existence 21 ATU's providing a total of 434 beds (Orford and Edwards, 1977:8). The Scottish Council on Alcoholism lists only seven ATU's in its 1981 *Register of Alcoholism Services in Scotland.*[3] With the size of the problem population estimated at anywhere between 75,000 to 150,000 individuals, it must be obvious that such specialised provision cannot cope with anything more than a very small proportion of those needing help.[4]

The limited development of specialised services and facilities can, in part at least, be placed at the door of Government. The increase in professional and public awareness of alcohol problems that has taken place over the past two decades has given rise to calls for Government to give "a strong and visible lead" in "developing a national corporate approach" to alcohol problems (CPRS, 1979; COSLA, 1981). Successive Governments, however, have firmly rejected the idea that they should be (can be) responsible for providing the lead on such an important and sensitive issue. The Government response can be adduced from its own publications as the following quotations from *Drinking Sensibly* (DHSS, 1981) make clear:

> The Government alone cannot secure responsible attitudes towards health matters throughout the community ... A strategy to achieve such action depends on better understanding of the issues and a general will to face up to them. (p.65)
>
> ... the role the Government can itself play in encouraging sensible attitudes to drinking is, as previously explained, still open to debate. (p.67)
>
> Responsible citizens must consider ... what they themselves can do to limit the harm to their own health and the health of others and whether they think the Government should do more to minimise alcohol abuse and to counter its effects. The scope for Government action to influence social habits is limited and the effects of such action on personal behaviour must always be uncertain ... (p.8)

The development of out-patient and social work care

The problem is not simply one of Governmental reluctance to face up to their responsibilities. There are a number of other developments to be taken into consideration. Firstly, there is the changing nature of the debate. During the 1970's it became clear that the emphasis on specialised in-patient care was increasingly out of step with developments in psychiatric practice which tended to stress the importance of out-patient treatment and community involvement. Beginning in 1973 with the DHSS circular on *Community Services for Alcoholics*, enthusiasm for intensive, group therapy based in-patient treatment programmes began to wane. Increasingly, the discussion of service structures and therapeutic strategies tended to play down the role of the specialist and to stress instead the need to involve more front-line professionals such as general practitioners and social workers, in cooperation with a wide range of non-professional groups and organisations, in providing help for problem drinkers.[5] The range of residential and day care services presently available to problem drinkers in Scotland's largest Region Strathclyde provides a good example of the practical consequences of this shift in orientation (Tables 7.1 and 7.2). The development of services and facilities in Strathclyde has succeeded in involving a wider range of agencies. The specialist in-patient treatment of alcohol problems is certainly still in evidence, but the growing involvement of social work and voluntary agencies in the provision of counselling, information, and day care facilities is also clearly illustrated. Progress is undoubtedly slow and the distribution of services throughout the Region remains patchy, but there are, nevertheless, some grounds for thinking that a start is now being made towards the provision of comprehensive services for problem drinkers.[6] A second development of the 1970's was the perceived need to evaluate existing programmes and to keep options open for future developments. In one sense this pressure for evaluation and the concomitant emphasis on community services was not unique to the provision of alcohol treatment. Given the general economic climate of the late 1970's the development of low-cost

community initiatives would inevitably look more attractive than the expansion of expensive ATU provision, particularly if the effectiveness of in-patient treatment was seen to be in doubt. The inability of 'alcohologists' to answer questions about the nature of the addiction, far less to provide a coherent response, served to highlight the gaps in our knowledge about the problem and called into question the role of the specialist units. Policy makers' faith in ATU's began to pail somewhat during the 1970's, a fact that can be judged by the tenor of some official publications:

> There are gaps in our knowledge of the existing services and their effectiveness: more evaluation is needed of different methods and settings of treatment ... New patterns of provision may emerge and we should not yet draw up a definitive policy for future services.
>
> (DHSS, 1975:7)

A considerable amount of evaluative research has now been undertaken, but this has yet to demonstrate the superiority of any one therapy over another. Moreover, the results give scant grounds for believing that any of the treatment regimes can be successful. Miller and Hester, for example, draw the following conclusion from their review of recent alcohol treatment literature:

> First of all it is clear that certain treatments are not supported by research to date which has suggested that they are ineffective, uneconomical or unjustifiably hazardous for problem drinkers ... The majority of treatment procedures for problem drinkers warrant a 'Scotch verdict' of not proved at the present time.
>
> (Miller and Hester, 1980:108)

The conclusion seems inescapable. If the superiority of specialist treatment over less intensive (and cheaper) options could not be demonstrated, then the role played by intensive intervention within the network of services and facilities would have to be reconsidered. In various parts of the country this reappraisal has already lead to the adoption of initiatives which seek to involve more front-line professionals such as social workers and general practitioners in the provision of services at the level of the community. The Community Alcohol Team has taken over the space vacated by the Alcohol Treatment Unit (Advisory

Committee on Alcoholism, 1978; Shaw, et al, 1978). The success of these and other community initiatives is a matter for future consideration.

Faith in the efficacy of specialist treatment was in a sense the cornerstone of the disease concept of alcoholism. Now, increasingly that faith was being questioned. The disease concept itself was coming under attack both from within the medical professions and from outside from sociologists and others who had hitherto played little or no part in the alcohol arena.

Jellinek's well known statement of the problem, 'that a disease is what the medical profession recognises as such', and that doctors 'know what belongs in their realm' (Jellinek, 1960:12) was surely never intended as clarification.[7] It does, however, raise an interesting question. How do doctors view working with alcohol problems?

Medical views of problem drinkers

> Doctors don't like dealing with alcohol problems. They find them difficult to handle and it's just not their scene. The same is true of psychiatry. I think it might be fair to say that not more than ten per cent of consultant psychiatrists have a specific interest in alcoholism and that the other 90 per cent are either apathetic or averse to the problem. I think that might be a fair statement for the medical profession as a whole.

The psychiatrist quoted above gives expression to a commonly held belief that doctors as a group are ambivalent (to say the least) in their approach to alcohol problems. Other respondents provided comments that addressed a broadly similar theme; doctors dislike working with problem drinkers and, being disliked, such work is not infrequently avoided. One doctor I interviewed defined the problem in terms of 'dirty work':

> I don't know if your familiar with the term 'dirty work' ... Anyway, it seems to me that's how many doctors see the alcoholic as 'dirty work'. At an intellectual level we may accept the idea that alcoholism is a disease, but we don't really *believe* that it is a medical problem, that it is something we should be expected to deal with.

Table 7.1 Residential services and facilities for problem drinkers in Strathclyde Region, 1984

Social work Division	Hospital In-patients				Rehab/detox units Dry hostels			Group tennancies/ Supported lodgings		Total number of beds available			
	No.	M	F	Tot	No.	M	F	No.	Tot.	M	F	M/F	Tot.
Argyll/Dumbarton	2	28	10	30	3	25	10	1	3	38	20	18	76
Ayr	-	-	-	-	-	-	-	-	-	-	-	-	-
Glasgow	3	13	8	51	8	81	5	2	15	109	13	51	174
Lanark	1	-	-	8	1	4	-	1	3	7	-	8	15
Renfrew	2	10	5	27	3	61	5	-	-	41	10	42	93

Source: Strathclyde Regional Council
[N.B. Totals include beds that are not specifically for alcohol problems and places that available to both men and women]

Table 7.2 Non-residential services for problem drinkers in Strathclyde Region, 1984

Social work Division	Hospital/ Clinics	Local Council on Alcoholism		Day centres		Infromation/ advice centres		Group meetingd		
		LCA's	Counselling Services	SRC	Voluntary Agencies	SRC	Voluntary Agencies	AA	Al-anon	Al-ateen
Argyll/Dumbarton	2	8	9	2	-	1	-	51	13	3
Ayr	-	1	2	1	-	1	-	32	7	1
Glasgow	4	1	5	2	1	4	1	148	23	4
Lanark	1	1	2	3	1	3	3	38	14	2
Renfrew	2	2	3	-	1	-	1	27	11	2

Source: Strathclyde Regional Council

The concept of 'dirty work' to which this doctor referred has actually been borrowed from sociology, from Everett Hughes' work on professionals. Hughes (1958) argued that within professional groups, as in any other group of workers, there develops a notion, a set of ideas, about what their work is or should be:

> In any occupation people perform a variety of tasks, some of them approaching more closely the ideal or symbolic work of the profession than others. Some tasks are considered nuisances and impositions or even dirty work physically, socially or morally beneath the dignity of the profession.
>
> (Hughes, 1958:121-122)

Given that the trend in the provision of services is likely to continue to favour community based initiatives, the reluctance of general practitioners to work with problem drinkers could inhibit the development of an effective network of services. And G.P's. can be important, not only for their ability to identify problems at an early stage, but also as a source of advice and/or counselling. An understanding of how doctors view working with problem drinkers, and why it might be considered 'dirty work' could, therefore, be crucial to the success of any community based initiative which relies on their active cooperation. I should perhaps enter a caveat at this point. The data which informs the present discussion was derived from a small number of interviews (10) with doctors, most of whom had a keen interest in alcohol problems, and from secondary sources. These interviews can hardly be said to be representative and the findings must be seen as tentative. Nevertheless, the views expressed by the interviewees corresponded not only with the findings of other studies, but also with the perception of medical involvement as seen, as it were, from outside by social workers and members of voluntary agencies.

Despite this perceived reluctance, it might be pertinent to consider whether doctors can avoid working with patients who have a drink problem. After all, if the estimates are to be believed, the number of Scots experiencing alcohol problems may be anywhere between two and five percent of the adult population (Clayson, 1973; Saunders and Allsop, 1985).

Certainly high enough, one might think, to support the contention in the latest report of the Royal College of Psychiatrists that the alcohol problem:

> ... is not a minor and peripheral social ill, worthy of attention only when there is a little reforming energy to spare, but an endemic disorder of frightening magnitude.
> (Royal College of Psychiatrists, 1986: 3)

Can it really be that the average G.P. does not *see* these people? Well, perhaps not, perhaps it is the drinker who is avoiding the doctor. Certainly, the reluctance of individuals to seek help was often commented on and, indeed, some researchers have suggested that the majority of people experiencing alcohol problems have little or no contact with any social agency. Existing services are often seen as unacceptable or unapproachable by potential clients and, even were this not so, most agencies would find the logistics of dealing with anything other than a very small minority of the problem population utterly beyond them (Shaw et al, 1978). Nevertheless, it seems unlikely that a doctor, regardless of his/her detailed knowledge of alcohol problems, could fail to recognise that heavy drinking might be implicated in a significant proportion of the routine diagnosis s/he is called upon to make. A conspiracy of silence often seems to exist between doctor and patient -the former is reluctant to probe too deeply and the latter unwilling to acknowledge that s/he has a drink problem.

The limits of medical intervention

In general, the reasons why doctors do not get more involved with alcohol problems are bound up with the nature of the medical profession itself, the doctor's attitudes to and experience of working with problem drinkers and, of course, their perception of the limits of medical intervention. The crucial point to return to Jellinek's definition of disease for a moment is not so much that "physicians know what belongs in their realm", but that s/he is in the position of being able to define, to a considerable extent, what will count as a

medical problem. The training of doctors and the general orientation of medicine, however, does not immediately suggest alcohol problems as an obvious candidate for inclusion in the medical sphere. Michael Balint's (1968) study of doctor-patient relations points out some of the limitations of medical training. The training of doctors, Balint notes, is almost exclusively concerned with physical or organic illness, so that doctors are disposed to see this as their primary role. In failing to provide doctors with adequate experience in dealing with other 'psychological problems', Balint argues, medical training leaves doctors poorly equipped with skills that will be needed in dealing with "a quarter of his patients, if not more." This deficiency will be carried over into everyday practice, where the doctor must strive "to learn this skill at his own cost and peril and at that of his patients" (Balint, 1968:223). The perception of medicine as being primarily concerned with physical complaints, is held not only by doctors, of course, but also by many of their patients (Balint, 1968; Byrne and Long, 1976).

As may be appreciated, the attribution of medical expertise in any given field carries with it at least two important assumptions; firstly that physicians have some particular knowledge of the aetiology, diagnosis and prognosis of the disease and, second, that they have special abilities in providing a cure. For many doctors, the problem drinker seems to confound both these expectations. The failure of medical research to demonstrate clearly the value of treatment as an effective and potent force in the remission process may undermined the confidence of many doctors that they could provide a cure. What was worse, the apparent success of response strategies which operate outwith the arena of professional medicine seemed to challenge any special claim to expertise which doctors might make. One psychiatrist put the point bluntly:

> I don't know that I'd talk about a cure ... so much of the discussion in that area is just sanctimonious bullshit. You might say we will try anything and everything, but most are not promising. The main thing is to stop treating the alcoholic as a purely medical problem ... The simple fact is that as doctors there's not a great deal we can do to help patients of this sort.

This failure to recognise that the 'extra-disease' factors in alcohol problems are often the most important, has been one of the major barriers to treatment erected by the disease model of alcoholism.

Thus far I have argued that the reluctance of doctors to tackle alcohol problems is explicable in terms of the constraints associated with their profession or the way in which it is practised. The doctor often lacking both knowledge of effective treatment strategies and the inter-personal skills with which to apply them, is expected to confront patients many of whom would resist any attempt to define their drinking as problematic. The responses of individual doctors, however, may also be related to their personal view of problem drinkers. Medical training is 'scientific' and no doubt promotes the adoption of the medical ideology, but individual doctors might well feel personally and morally committed to a legal view or a social welfare perspective.

A number of studies have pointed to the seeming incompatibility in many people's view of alcohol problems (Mulford and Miller, 1964; Tolor and Tamerin, 1975; Dight,1976; Rix and Buyers, 1976). Susan Dight's study of *Scottish Drinking Habits*, as mentioned earlier, found that many people held seemingly contradictory views about problem drinkers, seeing them as simultaneously "sad, bad, and mad". Nor is such ambivalence confined to the general public. In the view of at least one doctor, some of his fellow practitioners do little more than pay lip service to the disease concept, while others clearly reject the notion altogether:

> There are physicians (in Scotland) who do not believe that alcoholism is a medical problem. For them it is a moral problem, pure and simple. Even in psychiatry that's true. I know at least one consultant psychiatrist who would support that view.[8]

Some of the terms used by doctors to describe their alcohol abusing patients 'grossly self-indulgent', 'narcissistic', 'disenchanted with the work ethic' would reinforce this view, suggesting that whatever their intellectual view of the problem, it was tinged with moralistic

attitudes. Kendell highlights medical ignorance of current 'facts and ideas' about drunkenness and alcoholism and provides an indication that the misleading stereotypes born of this ignorance reinforce medical dislike of alcohol problems as 'dirty work':

> To many doctors alcoholism is still largely a working-class problem that results in public drunkenness, injuries of varied kinds, and delirium tremens. Indeed, so tenacious is this image of the derelict Irish labourer that I suspect that we are putting our telescope to our blind eye and do not want to acknowledge the true facts.
>
> (Kendell, 1979: 11)

Not everyone, of course, would accept Kendell's premise that this categorisation of the 'down and out alcoholic' is negative and unhelpful. There are those in the alcohol treatment community who see in this an attempt to narrow the focus in order to thresh out the 'wheat' of the problem population the 'real alcoholic'. The drunken 'chaff' are a special problem who, if they cannot be totally ignored, should at least be carefully segregated from more legitimate concerns (Room, 1976). Kurtz and Regier (1975) posit a more instrumental role for Kendell's 'derelict Irish labourer'. They suggest that if the 'down and out' occupied any space within the treatment world, it was as a 'threatening image' to be cynically manipulated in pursuit of financial support for alcoholism programmes. The findings of the present study, however, would seem to deny them even that very limited role. Habitual offenders were by no means considered to be a suitable client group by any of the caring professionals. They were a nuisance, a group that not only offered little by way of successful intervention but also detracted attention and resources from a more deserving, respectable and motivated client group. One psychologist confessed that he found it difficult to work with 'the down and outs' because he did not share their 'restricted code' of communication. Another described his ideal patient (not altogether facetiously) as an AVIS person an attractive, vocal, intelligent and socially stable individual, everything in fact that the stereotypical problem drinker is not.

If problem drinkers are seen in these terms, it is not too difficult to understand that working with such groups might be seen as 'dirty work' which will not enhance one`s professional status. 'A major thrust of the disease concept,' according to Robin Room, 'was to find, save, and preserve the social status of the "respectable" alcoholic' (Room, 1972:1050). In so far as it engendered more sympathetic attitudes towards the problem drinker, the concept was a success. It is ironic, however, that though the stigma attaching to the drinker may have been attenuated, the perceived status of alcohol specialisation within the medical professions remains very low indeed. The doctor who maintained that 'the only thing lower [than specialising in alcohol problems] is specialising in venereal diseases' may have been exaggerating, but it does not suggest that he felt that working with problem drinkers was given any priority.

Strong's article on G.P.'s attitudes to their patients drink problems defines the strategy used by some doctors when faced with alcohol problems in simple terms:

> They either avoided them unless they were thrust upon them, usually by others, or they reached an accommodation with them ... Or, finally, doctors were forced to wait until complications set in, that is until the drinking caused a more conventional form of medical problem; for here they could intervene with relative ease. Here at last was a problem which was relatively easy to define, which lay more obviously within the natural sphere (whatever its ultimate origin) which was immediately problematic, which could readily be assigned a cause and on which the doctor was an undoubted expert even if its ultimate cause was somewhat problematic.
>
> (Strong, 1980:42)

Conclusions: Wee DRAMS for G.P.s

Not all is gloom and despondency. Enthusiasm for the disease model of alcoholism and for high profile medical intervention is on the wane. Research findings have pointed up the advantages of comparatively low profile intervention by front-line, community-based agencies over specialist, institutional-based initiatives. These front-line workers especially general practitioners, social workers and health visitors are deemed to have the sorts of relationships within the community that can facilitate early identification and, thereby,

improve the chances of successful intervention. In order to be successful of course such initiatives would have to overcome the reluctance of doctors and others to become directly involved in the 'treatment' of problem drinkers.

Perhaps one way of breaking down the resistance is to develop programme that can involve the local G.P., for example, in a meaningful sense, not simply as a referral point. One recent project seems to offer some interesting possibilities in this respect. The DRAMS project - the apt mnemonic standing for Drinking Responsibly and Moderately with Self-Control - involves a kit designed for use by general practitioners. The DRAMS kit contains, a self-help manual, a drinking diary, a self-monitoring card for the patient and a record card for use by the G.P. The DRAMS project is designed to give the doctor a short, easy to apply procedure for identifying and responding to a problem which, hitherto, they have been reluctant to become involved with. Again the procedure is fairly straightforward. On the G.P.'s record card are a number of signs and symptoms that are commonly associated with heavy drinking. If the doctor notices any of these signs, or if for some other reason he considers that the problem may be drink related, the patient is asked to keep a record of alcohol consumption over the next fortnight. If, on the basis of the drinking diary and, perhaps, tests to determine the degree of liver damage (if any), there seems to be a problem, the patient is given the self-help manual.

The DRAMS programme is being piloted in the Highlands and Islands region of Scotland and, if successful, similar kits might well be developed for use by other front line workers (Glen, 1983).

The DRAMS initiative and others like it point to the possibility of a fundamental change in the delivery of help and advice to problems drinkers. It reinforces the movement away from the medical model of alcoholism and suggests a way forward based on education and counselling rather than treatment; a way forward that draws on community-based resources in the form of the primary care professionals.

Some doctors of course are already involved in responding to their patients' drinking problems, and are not content 'to wait until complications set in'. Certainly, most will confine their treatment activities to the physical sequelae of heavy drinking. Other doctors who may feel unable or perhaps unwilling to tackle the problem directly will encourage patients to seek help from other (perhaps more appropriate) groups such as A.A., or they might refer them either to a specialist ATU or to the local authority social work department. Since it is envisaged that some of these agencies, in particular the voluntary and statutory social services, should play a key role in the provision of community based initiatives, it is important to look at how they respond to alcohol problems. It is to this question that we will now turn.

Notes

1. By the turn of the century it seems that the idea of 'curing' the inebriate had been abandoned as unrealistic by all save the most ambitious professionals. The Society for the Study and Cure of Inebriety, for example, dropped the phrase from its title in 1887, just three years after the formation of the Society.

2. The Eugenics Society had given considerable support to the Reformatory experiment as means of further in the "interests of eugenics and social reform" (Radzinowicz and Hood, 1986:312). Their view that drink as a crucial factor in the putative increase in infant mortality and racial degeneration held considerable sway. The publication of a report in which one of the leading exponents of the eugenics thesis presented evidence to show that there was no difference between the children of alcoholic parents and the children of non-alcoholic parents in terms of their physique, intelligence, or vulnerability to disease, posed a severe threat to the rational of the Reformatory as a therapeutic/preventative strategy (Elderton and Pearson, 1910).

3. Only four Regions provided specialist treatment facilities as part of their N.H.S. facilities. Strathclyde, by far the biggest Region, provides approximately seventy in-patient beds in five ATU's. The other Regions Dumfries and Galloway, Lothian, and Tayside have one specialised unit with between 10 to 18 beds in each.

4. The Clayson Committee estimated that about 2 per cent of the adult population of Scotland (approximate 75,000 people) regularly drink to excess. The Scottish Council on Alcoholism, however, put the figure for the problem population substantially higher 150,000 would, they say, be nearer the mark! These sorts of estimated values, of course, are impossible to substantiate and might easily be out by a factor of two or three. Whatever the precise figures, however, the point remains unchanged at their

present level, specialist treatment facilities cannot be expect to deal with anything more than a small proportion of the problem population.

5. There is not the opportunity within a thesis of this nature to discuss either the development of services or therapeutic strategies in any detail. The DHSS advisory committee report on 'The Pattern of Services for Problem Drinkers' (Advisory Committee on Alcoholism, 1978), however, provides a good starting point for any consideration of service development in this area and a variety of books and articles have taken up the issues involved in responding to alcohol problems (cf. Wilkins, 1974; Cartwright et al, 1975; Scottish Council on Alcoholism, 1975; Hunt, 1982; SHHD, nd).

6. This guardedly optimistic view of the development of services in Strathclyde was not reflected in all the interviews. One consultant psychiatrist, working in an ATU in Strathclyde, took a very different line:

"The reality of the situation here [in Strathclyde] makes a mockery of all the policy statements which claim to recognise the need for services such as ours. And as for that Strathclyde Social Work Department cant Addiction: Collusion or Cover-up? I've never read such rubbish!"

7. The problem with Jellinek's definition, of course, is that it fails to recognise that doctors are just as prone to errors as the rest of us. Therefore, they may be just as likely to come up with a governing image of alcohol problems which is both inappropriate and misleading. Indeed, when one looks at the historical record, Jellinek's confidence in the medical professions ability to recognise issues that are 'unquestionably medical problems', looks decidedly misplaced. Benjamin Rush (1745-1813), for example, believed that 'negritude' was a medical problem, that it was symptomatic of a special form of leprosy. The 'Father of American Psychiatry' also categorised not only inebriety, but also lying, murder, and minority group dissent, as types of mental illness (Szasz, 1970). In more recent times, homosexuality, drug addictions, crime, suicide, obesity, homosexuality, political dissent, child abuse, and hyperkinesis are just some of the deviant behaviours that have been labelled as disease, as belonging in the medical realm.

8. The findings of a recent survey of the attitude of medical students to the disease concept of alcoholism provide some support to this doctor's view. On the basis of open-ended interviews, the study revealed that the majority of would-be doctors did not hold clearly medical notions about the nature of alcohol problems, but tended to espouse ambiguous and ambivalent attitudes (Haig, 1984).

8 The Social Welfare Response to Alcohol Problems.

The current fashion in responding to a wide range of problematic behaviours is being defined in terms of the socio-medical professions rather than in terms of the more traditional agencies of the criminal justice system.[1] The development of this so-called 'therapeutic state'(Kittrie, 1971) has been welcomed both as a more humanitarian and a more effective response to social problems. The current emphasis on primary care agents, such as social workers and general practitioners, as potentially major providers of services for people with alcohol problems is a good example of this transition.

The involvement of social work agencies in the management of alcohol problems, however, has not led to the wholesale "divestment of the criminal justice system" that some had predicted (Kittrie, 1971), or, according to some commentators, has it been successful in overcoming the reticence which many social worker have about working with problem drinkers. The history of social work responses to alcohol related problems has been characterised as one of neglect and avoidance. As evidence of this neglect, Hebblethwaite directs our attention to the training and the work practices of the profession:

> A perusal of social work literature in this country, an awareness of the content in professional social work training and a knowledge of practice in social services departments would reveal the lack of effective involvement with the subject of alcohol use and misuse.
>
> (Hebblewaite, 1979: 8-9)

This chapter considers professional practices and attitudes towards alcohol problems in social work caseloads and attempts to explore the validity of Hebblewiate's indictment. After more than a decade of fairly intensive promotion, are social workers now more willing to take on alcohol problems? Has awareness, as reflected in the content of social work courses and/or practitioners knowledge of the area, improved? Or is the situation still pretty much as it was described a decade ago?

Issues in social work policy & practice

The general view is that social work with problem drinkers, whether in collaboration with other agencies or not, is both disliked an often avoided (Hebblethwaite, 1979). Social workers, like doctors and no less than the rest of the community, betray a degree of attitudinal ambiguity in confronting alcohol problems. Unlike the rest of the community, however, social workers are required to make decisions and (perhaps) to intervene in areas related to alcohol problems. Local authority social work departments have a duty under the terms of the Social Work (Scotland) Act 1968 "to promote social welfare by making available advice, guidance and assistance". Given only limited resources with which to meet this responsibility, social work departments must allocate resources to those problems that are considered most important and/or to those client groups that are perceived to be most in need. Decisions have to be made at all levels and the nature of these decisions - reflecting as they do not only definitions of the nature of the problem but also priorities for intervention - must have an impact on the range and quality of services available to the problem drinker. They will impact too on the environment in which these services are offered and on the treatment, or non-treatment, of alcohol problems.

There is little doubt that social work managers have, in recent years, become aware of the role played by alcohol problems in social work caseloads (Strathclyde Regional Council, 1979; Social Work Services Group, 1981). Some have also become aware of the ineffectiveness of limited and ad hoc initiatives which rely on the development of voluntary services and, therefore, of the need to develop a comprehensive response strategy. As a result, more resources have been made available in certain areas and new initiatives have been launched. In Strathclyde Region, for example, expenditure on alcohol related services rose by over 400 per cent between 1979 and 1981 (from about £100,00 to around £450,00). In part this increase was reflected in the development of specifically Local Authority social work initiatives urban aid projects, walk-in advice centres, Drink Related Offenses

Programmes (DROP) and so on. Social work departments, however, continue to lean heavily on the voluntary sector, particularly for services and facilities aimed at the 'stereotypical drunken offender' the 'down and out, homeless alcoholic'. The plight of these individuals is actually becoming more acute in many parts of the country as the priorities for resource allocation have increasingly tended to operate against them. To quote the example of Strathclyde again, here the level of funding was increased between 1979 and 1981, but there was also a marked shift in the balance of funding in favour of a more stable client group of 'supported problem drinkers'. As a result, support for projects targeted on the 'homeless problem drinker' remained fairly static in real terms. The overall allocation of resources has increased, but services for the unsupported (ie., homeless) drinker have come to represent a much smaller proportion of the overall budget.

This pattern of response might be an important factor in explaining the general social work orientation to problem drinkers, particularly as many initiatives involve social workers and alcohol counsellors who have a special interest in the problem and who may not, therefore, be representative of social work practitioners as a group. In this chapter, therefore, the focus is on social work practitioners in general and not simply on those (possibly unrepresentative) individuals who have a particular interest in responding to alcohol problems.[2]

Alcoholics Too Anonymous?

> Alcoholics, people with alcohol problems if you like, are just too anonymous as far as most social workers are concerned. As far as I can see, most social workers are blissfully ignorant of the role drink plays in the lives of their clients. We're supposed to be able to help people, to relate to their problems and their needs, but where drink's concerned I think most social workers would just rather not know ... It's some one else's problem.

This social worker's view of his fellow professionals is well supported in the literature where social workers have been portrayed as being 'blissfully ignorant' of, or indifferent to,

the needs of clients with alcohol problems. They have been shown to be ill-informed about both the nature of the problem and the possibilities of applying social work skills to the management of alcohol problems (Cartwright *et al*, 1980; Shaw *et al* 1978; Flint, 1979). No doubt much of the criticism is well founded, but can responsibility for perceived reluctance of social workers to deal with alcohol problems be convincingly laid entirely at the door of the practitioner? There are a number of other factors that might be considered.

Firstly, there is the historical dimension. Social work, it is worth remembering, was developing in the same moment as the medical and psychiatric professions were establishing themselves as professions and it is, therefore, not surprising that social work should have chosen to follow the same 'scientific' route in establishing its techniques and modes of treatment. Social workers were struggling to carve out a career niche for themselves within the medical-psychiatric world. They needed to define an appropriate constituency, they needed customers, 'patients' to 'treat'. But the problem drinker looked to be a poor bet. Social workers tended to look askance at inebriety as an inappropriate, perhaps intractable, problem and to reject the drinker as an inappropriate client.

Social work, as a (nascent) profession, was not (is not) in any sense challenging the medical profession over responsibility for responding to alcohol problems. To some extent at least, they have had 'responsibility' for alcohol problems thrust upon them by others. Bacon makes the point in relation to health professions in general. He recalls that:

> Just as "outsiders" pressed the disease-treatment concept upon the medical institution, so did "outsiders" in fact, mostly the same people press the "public health" concept upon the world of public health. In each instance the "outsiders" would seem to have had a rather idealistic and "dated" perception of those other institutions. And just as "public health" was exhibiting great difficulty in establishing its identity as something rather different from the treatment of disease, so did these "outsiders" from the alcohol problems world confuse (or perhaps entirely ignore) this central difference.
>
> (Bacon, 1976:104)

But, of course, the issue was not only promoted from outside. There were groups within, or at least on the edges of the social work world that were involved in promoting alcohol

problems. Many of these groups were identified with religious organisations such as the Salvation Army and some continue to operate within what I have called the non-statutory social work sector. Again the example of the Salvation Army springs most readily to mind. The influence of these 'insiders' was rather limited. The fact of the matter is that neither side - medical or social work - was particular keen to take on what were seen as other people's 'dirty work'. The success of the disease model of alcoholism, however, gave social work a temporary 'out'. If alcoholism was a disease, then responsibility for treatment lay within the purview of the medical rather that the social work practitioner. Social work, therefore, felt no great need to give the lead in fostering new initiatives, in developing precise and workable theories, or, until recently, in providing services and facilities.

Second, there is a problem with the limited nature of the literature, a problem related to the failure of social work researchers to articulate an alternative model of problem drinking that could inform social work practice. The literature that is available tends to eschew discussion of relevant theoretical frameworks and focuses instead on the problematic of working with the problem drinker and his/her family. This emphasis only reinforces the acknowledged reluctance of social workers to intervene and gives rise to questions about what is the most appropriate mode of social work intervention with problem drinkers. And this brings us back yet again to the problem of conceptual confusion. Faced with the diversity of definitions, of terminology, and (not least) with a plethora of possible response strategies, can it come as any surprise to find 'avoidances of recognition or sense of responsibility' for the problem among some members of the social work profession?

Finally, there are the problems of prioritization and resource allocation that were touched on earlier. There may be considerable benefits to be had from involving generic social workers in the response to alcohol problems. Given the lack of any consensus concerning the most effective mode of intervention, generic social work may seem to be a an appropriate way in which to pursue a more eclectic approach to the problem. But how

does this view accord with political reality? Costello (1975) argues that the careful selection of clients, the application of intense and active therapy and the use of effective follow-up procedures, are important elements of successful intervention. Given the current emphasis in social work practice on so-called 'statutory work', it seems unlikely that generic social workers will be afforded either the time or the resources required to make intervention on any significant scale a realistic option. One assistant director of social work I interviewed was equally sceptical about the value of having social workers trained in so 'narrow' a specialism:

> I would not like to see alcoholism, or alcohol related problems, singled out for particular attention. I would see it as falling within a more general mental health category ... We need social workers with a general background supplemented by specialist knowledge of certain areas, but, at the moment, I think the specialism should not be too narrow.

Alcohol problems in social work caseloads

No doubt the reluctance of social workers to address the issues raised by problem drinkers can be explained in a number of ways. Nevertheless, it is difficult to believe that many social work practitioners can be genuinely, much less blissfully, ignorant of the problem. All the available indicators would suggest that a significant proportion of social work clients are experiencing alcohol related difficulties. Moreover, the issue has been widely discussed not only in the media but also (and perhaps more significantly) in all of the major social work publications.[3] Interviews with social work practitioners also suggested that most social workers *did* recognise the existence of a serious alcohol problem. Although the management of public drunkenness *per se* was not regarded as an appropriate task for social workers - most (59%) felt that, when necessary, the police were the appropriate managers of *that* problem - over half (60%) of those interviewed had had some experience of dealing with drunken clients during the month prior to the interview.

When discussing alcohol problems more generally, social workers proved to be almost unanimous in defining it as a serious problem. Moreover, for most of those interviewed (72%) the reasons offered in support of this definition tended to focus on their experiences with social work clients. Practitioners varied in their estimates of the prevalence of alcohol problems in their caseload (see, Figure 6.1, p.165), but, as is clear from the following illustrative quotes, most were convinced that it was significant:

> It is difficult to put an exact figure on it, but social work with clients, 50 per cent of them have a moderate to serious drink problem.

> Eighty per cent of the people I deal with have some sort of problem with drink. Not necessarily alcoholics, but with some sort of alcohol related problem.

A study of alcohol problems in the Western Isles, produced findings which reinforce the social work view that a significant proportion of their caseload is related to alcohol abuse (Blaxter *et al*, 1982).[4] However, the qualification, 'not necessarily alcoholics', is an important one since many social workers were inclined to view drink problems in the context of a whole range of difficulties being experienced by the client. In most cases, it was claimed, initial referral and continued social work involvement with clients was not something that was primarily or exclusively related to problems with alcohol. Social Work statistics tend to support this view, suggesting that difficulties with alcohol is the presenting problem in a relatively small number of cases - around 3-4 per cent. This need not lead us to question the relevance of problem drinking to social work caseloads, however, since all the indications are that alcohol problems play a significant role in many of the other 'reasons for contact'. Family difficulties, financial problems and referrals from the criminal justice system make up a large part of any social work caseload and alcohol has been implicated as a factor in all of these areas (Royal College of Psychiatrists, 1979).

Social workers, then, were clearly aware of the problem. But how well does this awareness translate into practice? In an attempt to address this question and to get some

idea of the orientation of social workers towards alcohol problems, respondents were asked about how they perceived alcohol problems, about their attitudes to drinking and drunkenness, about their experience of dealing with alcohol problems and about their knowledge of facilities and services available in their area.

Perceptions of alcohol problems

In order to gain some understanding of the working definition of alcohol problems used by social workers, they were asked for their views about why some people drink to excess. What they were being asked to do was not so much to define terms such as 'alcoholism' or 'alcohol dependency' - definitions even amongst the 'expert population' being as plentiful "as pebbles on a beach" - but to approach the definitional issue by discussing the background to the drink-related problems they encounter. The question was open-ended and respondents invariable gave more than one answer. From the range of explanations offered it was clear that social workers' perceptions of the problem varied considerably. The tendency, however, was to identify problem drinking with personal troubles. Problem drinking was seen as a complex pattern of behaviour involving a number of related problems and most respondents considered more than one explanation/definition appropriate. Examples of the type of explanation offered included:

- 'an escape mechanism '
- 'the result of social and cultural attitudes'
- 'part of the macho image'
- 'the lack of alternative leisure facilities'
- 'isolation, an inability to socialise'
- 'relationship problems'
- 'inadequate personality'
- 'social deprivation'
- 'depression and frustration'
- 'a way of coping with stress'
- 'loneliness'
- 'boredom'
- 'stress of unemployment'
- 'psychological problems'
- 'financial difficulties'
- 'to lessen inhibitions'
- 'poor socialisation'

Many social workers seemed to feel the need to stress the individuality of their clients - every client was different and each one had his/her own set of personal problems requiring

some form of intervention. It was their job, as one social worker put it, 'to assist the client to make a responsible decision about his drinking'. Given this professional orientation, social workers are perhaps not disposed to think of problem drinkers in terms of stereotypes and are, therefore, more likely to favour definitions that stress the complex network of symptoms involved. The broad definition employed in the new report by the Royal College of Psychiatrists would seem to be consistent with that used by many social workers:

> [A] person has a drinking problem if his or her drinking is, or soon will be, causing him or her any sort of harm or causing harm to any other person.
> (Royal College of Psychiatrists, 1986:38)

This is not to say that there are not those in other agencies with similar views. In fact, when the same question was put to those in the criminal justice sample, they responded with a similarly wide range of characterisations. For some problem drinking was equated with the need for some sort of 'escape mechanism', for others it had to be seen in terms of mental health or as behaviourial problem, and about one in four offered explanations that were not inconsistent with the social work view that problem drinking was part of complex network of symptoms. Table 8.1 was compiled from an analysis of qualitative data and of course the emphasis/importance attached to particular 'explanations' varied considerably. Nevertheless, it gives an *indication* of how members of the various agencies perceive alcohol problems.

The majority of those working in the criminal justice arena, the police in particular, seemed to operate with certain stereotypes of the problem drinker, characterisations which could influence their perception of the problem and, therefore, their response to a particular situation. The nature of these stereotypes will be discussed in the next chapter. It would be a mistake, however, to think that social workers do not have their own stereotypes of the problem drinker. Their focus on the individual makes the precise nature of the stereotype somewhat less accessible. However, in many cases it was clear that social workers were

operating with some sort of (negative) characterisation of the 'alcoholic client.' A significant minority of those interviewed, for example, were prepared to acknowledge as valid the common stereotype of the problem drinkers as 'down and outs' with anti-social habits. Moreover, in discussing with social workers the reasons why some people 'take to drink', it was clear that many of them identified certain client groups as being particularly at risk. These 'high risk' categories included not only young people (a group also singled-out for attention by the criminal justice agents), but also women and the unemployed and, at least in some cases, the justification for their concern reflected fairly stereotypical perceptions of the group(s) involved.

Table 8.1 Perceptions of problem drinking

(Distribution of Respondents Supporting Explanation)

	Police %	Criminal Justice %	Social Workers %
Escape mechanism	57	66	41
Psychological problem	33	57	15
Symptom complex	26	22	62
Behaviourial problem	37	27	26
Other	17	12	13

* Most respondents offered more than one explanation and, therefore, the percentage totals are greater than 100.

Table 8.2 **Social work responses to positive and negative statements about drinking and drunkenness**

	Local Authority Social Workers (N=59)			*Non-statutory Social Workers (N=36)*		
Positive Statements	Agree %	Disagree %	Neither Dis/agree %	Agree %	Disagree %	Neither Dis/agree %
Drink makes people more sociable	78(85)	12(10)	10 (5)	61	28	11
Drink is one of life's pleasures	87(68)	7(22)	7(10)	64	11	25
Drunks can be very amusing	55(65)	41(28)	4 (7)	56	22	22
Getting drunk occasionally does no harm	31(46)	56(45)	14(9)	11	72	7
People are more honest drunk	42(60)	48(23)	10(17)	33	47	19
Drunks should be treated as sick	66	29	5	68	31	-
Negative Statements						
Drink is a main cause of immorality	31(26)	51(54)	19(20)	44	44	11
Drink often brings out the worst in people	78(48)	15(35)	7(17)	78	14	8
Excessive drinking often leads to trouble	80(58)	3(31)	17(11)	78	22	-
Drunks should be punished	3(37)	88(45)	9(18)	11	61	28
Public drunks have no self-respect	51(63)	38(28)	12 (9)	44	22	33
A drunken women is a far worse sight than a drunk man	59(92)	34 (5)	7 (3)	69	31	-

Social workers attitudes to drinking and drunkenness

Stereotypes inform and are informed by individual social workers' attitudes and beliefs about drinking and about drunkenness. The way in which the drink question is perceived - "the sorts of drunken comportment" (to borrow a phrase from MacAndrew and Edgerton, 1969) that will be tolerated in a particular context - may play an important part in determining how (and indeed if) they will respond to the issue. In order, therefore, to understand something of social workers' attitudes towards drinking and drunkenness, they were asked to respond to a ten item attitude instrument.

My hypothesis was that social workers and police would be clearly differentiated in terms of their attitudes to such issues as drunkenness (Punch and Naylor, 1973; Kilby and Constable, 1975; Holdaway 1983; Pratt, 1985). Put simply, my contention was that police officers would be identified with a moralistic perspective, social workers with a more therapeutic model of alcohol problems. The public, lacking any strong commitment to either model, would be somewhere in the middle. The results, as can be seen from a comparison of Tables 8.2 and 9.5 (p.228), conspired to expose this rather naive characterisation. Not only was the difference between the two groups, social workers and police, much less than expected, but it was also less marked than that shown to exist between them and the general public. Table 8.2 presents these findings in relation to local authority social workers and those involved in the voluntary sector. The findings of an OPCS survey of *Scottish Drinking Habits* (Dight, 1976) are given in brackets as appropriate.

Looking at the two groups of social workers, it seemed that those working with non-statutory agencies tended to take a somewhat more negative view of drinking and drunkenness. This is not too surprising. Most of these respondents were working with problem drinkers on a day-to-day basis in, for example, alcohol recovery units. What was surprising, however, was the level of dissatisfaction which they expressed about the possibilities and, in some cases, the appropriateness of treatment. Almost one third (31%) of

these respondents rejected the idea that problems drinkers were sick. Some, albeit a much smaller proportion, favoured a decidedly more punitive option, at least for the 'hopeless cases':

> There isn't a man or a woman living rough in this area that hasn't been through the system. This is the group that would be most likely be taken to these (designated) places. But I really don't see the point in not locking them up ... they just don't want anything else but drinking. That's their lifestyle and they don't want to change it ... You know when you get down to the nitty gritty, they're just hopeless cases. Well at least in prison they can get off it (drink) for a while.

On some items, non-statutory social workers could be differentiated from their local authority counterparts in that they were more reluctant to take a clear position. Non-statutory social workers chose the neutral response more often than their local authority counterparts.

In many cases, however, this response reflected not so much indecision on the part of the respondent, as an unwillingness to be drawn into generalisations. In fairness, it has to said that, although the pattern was more marked among non-statutory workers, both groups adopted an individualistic approach to the problem which made it difficult for them to express an opinion one way or the other without being seen to take account of the individual and situational factors involved. Each case was different or, as a worker in a night shelter put it:

> There's one hundred and fifty men up there during any night. You've got a hundred and fifty individuals, individuals with different problems and different answers to your questions. There is no such thing as the typical drunk.

Social workers' orientation to alcohol problems

A differentiation can also be made between the views of social workers as a group and those of society in general, on at least some of the issues. Social workers were more likely to agree with negative statements about drinking, perhaps reflecting the links made by many social workers between drinking and a broad range of problems encountered in the average

social work caseload. For some social workers, this negative attitude towards drinking was also an expression of a degree of wariness they felt about dealing with clients who had been drinking. The possibility of drunken clients, particularly men, becoming violent was mentioned by about one in seven social workers. One social worker, in discussing what he saw as an appropriate scenario for police intervention, gave expression to this anxiety:

> A lot of the time we really need the police for strength, because these people (drunken clients) can be right out of their minds with drink. They can be violent and really bizarre.

On those attitudinal statements that referred specifically to drunkenness, the trend was for social workers to be more tolerant than the general public. Social workers, and to a lesser degree the criminal justice sample, tended to relate these attitude statements to the problem drinker and to respond in terms of 'what should we do about it'? The 'answer', more often than not came down in favour of some sort of 'treatment'. Almost half (46%) of the local authority social workers interviewed could be said to have expressed views consistent with a therapeutic approach to alcohol problems. Non-statutory workers were not so positive, but overall, only a minority (10%) of social workers adopted a moralistic stance (Table 8.3). For all that, however, there was no consensus about what 'treatment' was appropriate there was no consensual 'social work approach' and, beyond a rather diffuse emphasis on the 'person' rather than the 'act', no obvious model for social work intervention. The categories used in Table 8.3 were based on an analysis responses to two items on an attitude scale (see, Note 5).

Table 8.3 **Distribution of social workers in four ideological categories, by their response to moralistic and therapeutic items.[5]**

Ideological Categories	L.A. Social Work %	Non-statutory Social Work %
Moral-sickness	17	17
Moralistic	3	20
Therapeutic	46	15
Behaviourist	14	17
Neutral	20	30
Total	100 (N=59)	100 (N=46)

The absence of an explicit social work model of intervention leads many social worker to 'borrow' its problem-solving philosophy from another arena. The fact that many social workers' claimed to have rejected the disease model of alcohol, notwithstanding, most of the 'borrowing' is done from the medical-psychiatric arena. The clinical orthodoxy occupies so much of the alcoholic horizon that they could hardly do otherwise. But 'borrowing' from the medical arena has its problems. Fundamentally, social work has no control over the nature or direction of the discourse. Under such circumstances it is difficult to challenge the effectiveness of clinical intervention, to assert the significance of social context or the material bases of problem drinking. Moreover, the range of treatments available 'on prescription' from the clinical professionals contradict many of the central tenets of social work practice. Medical expectations of patient passivity, for example, sit uneasily alongside the social work emphasis on the value of mutual support and exchange and the belief in a self-directed and empowered clientele. For the client with an alcohol problem it looks like a

'no-win' situation. Social workers can decide not to intervene because they feel that their social work skills are inappropriate or unequal to the task. On the other hand, they can decide not to intervene because the perceived nature of the treatment runs counter to what they believe social work to be about. Either way, the client loses out.

Support for designated places & diversion

Preferred response strategies of course are not simply a function of ideological categories, they are also related to physical and structural conditions. The perceived availability of resources, casework priorities and similarities in the professional training of social workers are just some of the factors that clearly influenced day to day practice. Where public drunkenness was concerned, for example, social workers clearly favoured a policy that was aimed at diverting individuals from criminal justice processing.

In most cases, however, the appropriate diversionary route did not take the problem drinker along the local authority social work highway. The 'designated place' a centre approved (designated) by the Secretary of State for Scotland and run as a voluntary association -was the most popular alternative. Virtually every social worker interviewed (90%) felt that the establishment of 'designated places' would be 'helpful' in addressing this particular problem. Almost half (50%) supported the introduction of such centres because they were seen to provide an opportunity for making treatment/support available to individuals with alcohol problems. The response of one local authority social worker provides a fairly typical example:

> I quite often think that (a designated place) would be useful. I can think of occasions where that's just what's been needed. For example, there was one woman was brought in here drunk ... we can't keep her here drunk ... I phoned the police and said what are my options here? 'Right, we'll come round right away and charge her with breach of the peace.' ... what we needed was somewhere to put her till she was sober and we could work with her - a designated place.

The promises and the problems of these 'new initiatives' that are being introduced into the repertoire of strategies for managing alcohol related problems will be discussed in Chapter 10. For the moment, however, it is worth pointing out that only one designated place has so far been set-up in Scotland, Albyn House in Aberdeen, and that no provision exists for direct referrals from any agency outwith the criminal justice system.

Managing the problem drinker

While it would not be possible to make any generalizable comment about preferred therapeutic practices, it would seem that for most social workers working with clients with alcohol problems was seen as a task best left to the specialist, either within the department or with some other appropriate agency. Over half (58%) of the local authority social workers felt that they did not have enough specialist knowledge to work effectively with problem drinkers. And even if they had the knowledge, they didn't have the time! Most social workers were involved in crisis management rather than longer term casework with problem drinkers. They tended to address themselves to the client's more immediate problems -problems associated with housing, child welfare, social security, finance or the court system. Tackling alcohol problems *per se*, in most cases, seemed to be of secondary importance. It was not that social workers were ignorant of the problem, nor did it seem to be the case that they felt the issue was ineluctably outwith the realms of social work responsibility and/or professional competence. Nine out of ten social workers interviewed agreed that there ought to be more social work involvement and that the issue should be given 'fairly high priority' in allocating social work resources. Nevertheless, working with clients with alcohol problems was seen as time-consuming, frustrating work that offered little by way of reward. 'It's a bit like trying to nail jelly to the ceiling,' was how one area officer described social work with the problem drinker.

In reaching a decision about whether or not to respond to a client's alcohol problem, social workers seemed to take account of three factors:

(i) the need to provide assistance/support to the family of the drinker particularly where children were 'at risk'/

(ii) the strength of the client's motivation, the willingness of the problem drinker to seek help in overcoming his/her problem/

(iii) the possibilities for identifying and involving other, more specialist agencies in the response/treatment process.

It is perhaps not too surprising that social workers tended to give priority to the first of these factors. Tackling the alcohol problem *per se* takes second place and often seems to be limited to onward referral to an outside agency or specialist social workers. Eighty per cent of social workers in the sample had recommended that a client seek help for his/her alcohol problem. In many cases more than one such recommendation had been made and a number of different agencies had been involved. Table 8.4 lists the various referral agencies in order of preference. Direct referral of alcohol related cases by local authority social workers was a good deal less common. Only about one third (31%) of the social workers interviewed had referred clients to other agencies, that is, referred as opposed to giving advice and information about appropriate agencies. In a high proportion of cases such referrals were made in the course of complying with a statutory obligation such as the presentation of social enquiry reports to the courts.

The clear preference for self-help groups reflects the fact that these groups, specifically Alcoholics Anonymous and the Local Councils on Alcoholism, are well-known to most social workers. It may also be a reflection of the emphasis which social work places on individual motivation and the need for specialist intervention. The stress on specialisation is also evidenced in the preference for psychiatric over general medical intervention. It would be a mistake, however, to believe that social workers universally endorse the philosophy of these groups.

Table 8.4 Preferred referral agencies for social work clients with alcohol problems

Referral agency	% Selecting Agency	Preferred Rank	% Selecting Rank
Alcoholics Anonymous	72	1	17
Local Council on Alcoholism	58	2	13
ATU/Psychiatric Hospital	43	1	7
Specialised Social Work Resource	32	1+3	6
Other Self-Help Group	30	3	5
Church Groups	15	3	6
General Practitioner	6	3	2
Other	11	3	4

Total N=47

* Respondents were asked to rank *three* choices in order of preference and, therefore, the percentage totals do not equal 100 per cent.

Alcoholics Anonymous in particular, espouses a commitment to the 'disease model of alcoholism' which did not find favour with all social workers. The choice of referral agency is of course limited by a number of factors, not the least of which is the social worker's knowledge of local services and facilities. Obviously, it is only possible to refer a client to an agency if you are both aware of the existence of that agency and know something of the work of the organisation.

Conclusions: A new direction for social work?

In recent years it has become almost routine to stress the need to provide a range of services for problem drinkers, to develop what Glaser *et al* refer to as a 'polychromatic system', rather than a 'monochromatic' response (Glaser *et al*, 1978:219). Social work, in common with the other primary care agencies, has been urged to take a more active role in providing services and facilities for dealing with alcohol problems (Advisory Committee on Alcoholism, 1978; Royal College of Psychiatrists, 1979)? In this chapter I have looked at how social workers view alcohol problems and at their perception of the role of social work as a resource for helping problem drinkers. I have shown that alcohol, or rather the problems caused by the misuse of alcohol, feature significantly in the work of the social work agencies. However, is there any indication that social workers as group are responding to the suggestion of the Royal College of Psychiatrists that *all* of the caring agencies should "systematically examine" their role in the prevention and treatment of alcohol problems (Royal College of Psychiatrists, 1986:185).

The Convention of Scottish Local Authorities (COSLA) appear to have recognised the need for Councils to 'ensure the establishment of Information/Advice and Day Centres in appropriate locations to provide a comprehensive coverage for their areas' (COSLA, 1982:14). At least one of the regional councils in my study, Strathclyde, has taken the initiative by directly providing 'walk in' advice and information centres in various parts of the Region. In essence these 'addiction advice centres' are intended to provide a readily accessible ('walk in'), centrally located, drink-free environment in which a range of services can be made available to those with an alcohol problem.[6] The facilities, which were typically on hand included education on alcohol and alcohol problems, individual and group counselling, "diversionary leisure and community oriented activities". The idea seemed to be that these centres would become accepted as the appropriate location of professional (social work) and voluntary help within the community. Although other local authorities have

funded similar projects, albeit on not so wide a scale, for the most part the emphasis was clearly on voluntary provision. They supported the development of services and, to some extent at least, attempted to structure service provision, not by direct intervention, but by the provision of grant aid to non-statutory agencies. In other words, most local authorities saw their role as one of facilitating and coordinating the development of services. Coordination is necessary because the voluntary agencies are in a real sense competing for clients and for funds. This competition leads to a duplication of effort that is perceived by the local authorities as being an inefficient use of resources. A report by Grampian Social Work Department summed up a situation in which voluntary organisations:

> ... often see the relationship between each other as one of rivalry ... they were all well aware of each others existence but rarely showed much understanding of their aims and philosophies.
>
> (quoted in Lloyd and Taylor, 1986:133)

The irony, of course, is that local authority policies on grant aid contribute to this sense of 'rivalry'. It would be mistaken to attempt to explain the problem as simply a question of conflicting 'aims and philosophies'. There is also a more mundane, more practical consideration - competition for funding. And, the importance of local and central government as a source of funding is obvious enough to require no more than the mention.

The success of these initiatives, then, should not be exaggerated. These centres provide an additional locus of onward referral. They do not involve local authority social workers any more directly with the problem nor do they conspicuously motivate social work interest in working with alcohol problems. Most of the local authority social workers I interviewed had only limited involvement with alcohol problems and they continued to entertain the expectation that voluntary groups and organisations would/should make the major contribution to the management of alcohol problems. There was a general feeling that something had to be done about alcohol problems and that this 'something' would have to make use of resources both from within and from outside the statutory sector. The view of

one manager that there was a "crying need to do something ... (that) *anything is better than what we have*", found an echo not only within the social work ranks, but also with those involved in the criminal justice approach to alcohol problems.

Community based services for problem drinkers

The way ahead has so far been perceived in terms of cooperation across the range of caring professionals. The obstacle has been identified as the reluctance on the part of many primary care workers to become directly involved in the 'treatment' of problem drinkers. Theories have been put forward to explain this reluctance. Shaw *et al* (1979) suggest that it can be linked to a number of factors which relate to the workers' sense of professional competence; concern about the legitimacy of their role, about their (in)ability to cope with problem drinkers, and about the lack of adequate support to help with difficulties should they arise. Solutions have been proposed Shaw *et al* suggest that these difficulties could be overcome by the setting-up of a network of Community Alcohol Teams (CAT's) which would provide alcohol education and support to front-line workers.

There are of course problems. For one thing, the development of CAT's, as with so many other initiatives in the alcohol field, has proceeded in a rather *ad hoc* fashion. At present there are only twenty or so CAT's in operation throughout Britain, most of which seem to work directly with problem drinkers referred from community agencies, in addition to their advice and support role (Clement, 1984). In doing this, in taking direct referrals, these CAT's can only reinforce the primary care worker's faith in the need for specialist intervention precisely what Shaw *et al* were seeking to avoid:

> For low recognition rates and hasty referrals precluded agents ever gaining vital experience in working with drinkers and this inclined them to recognize only the most damaged clients as having problems from drinking. These clients in turn were the most difficult to treat and the most unlikely to improve, and therefore the most threatening to the agent's professional self-esteem.
>
> (Shaw *et al*, 1978:243)

The CAT's that do not do this and, therefore, fail to transfer responsibility for the problem to the front line workers, are, in effect, little different from specialist institutional services such as ATU's, for while they may be *in* the community they are not *of* the community. The theme of getting back into the community is something we will address in a later chapter. There are, however, two aspects of the CAT philosophy that are of more immediate interest. Firstly and most obviously, there is the recognition that front line workers ought to be involved in responding to alcohol problems. Second there is the emphasis on education and support. Faith in the ability of alcohol education to motivate individuals to work with alcohol problems was fairly common among the specialist workers interviewed, although it seemed to be based on some implicit rather than explicit criteria:

> We've got to highlight the resources that are available and raise (social workers') awareness of what can be done ... for various reasons they don't feel comfortable working with alcohol problems and we've had to increase their knowledge base about what resources are available. I think the problem is that it's a slow and incremental thing, getting that message across. It means introducing more teaching on alcoholism into professional courses ... and it also needs more in-service training to educate those already in post.

The provision of alcohol education opportunities, however, is only one element in the equation. An analysis of the attitudes of those respondents who had had some level of training in alcohol problems did not suggest that specialist training, in itself, had any significant impact beyond increasing knowledge and/or making the individual familiar with the problem arena. Moreover, research on the attitudes of 'caring professionals' to working with alcohol problems has suggested that familiarity with the nature of the problem does not necessarily mean that an individual will be any more willing to work with alcohol problems (Shaw *et al*, 1978; Cartwright, 1980). Cartwright (1980) suggests that the effectiveness of training would be improved by offering support and by enabling practitioners to gain experience of working with alcohol problems.

However, if we are looking to 'new directions' in responding to problem drinking, it seems to me that we should not limit the discussion to the role of the caring professions and that the developing interface between social work and criminal justice concerns should command much more attention. It would be interesting and no doubt controversial to speculate about the implications for social work care and for the administration of justice that might result from the adoption of new methods of dealing with drink related offenders. In the final analysis, however, social workers are not being asked to become experts in alcohol problems, but to apply a recognisable mode of social work intervention in a situation which just happens to involve drinking. If they can meet this challenge then it is at least conceivable that they will then be prepared to accept that working with alcohol problems is a legitimate task for social workers.

Notes:

1. This transition from criminal justice to socio-medical responsibility has been studied for a number of problems such as alcoholism, drug abuse, child abuse, and hyperactive behaviour. See, for example, Parton (1979); Conrad (1975); Nelkin (1973); Schneider (1978).

2. Unless otherwise stated, the term social worker is in a generic sense to refer individuals some professionally qualified, some not who are involved in giving advice and counselling. Whatever their official designation with the agency whether they were 'care assistants', 'social workers', 'managers', or whatever the respondents were all working with 'clients' in a way that way broadly consistent with a social welfare ideology.

3. The popular social work journals, *Community Care* and *Social Work Today*, have both published a number of articles in recent years on the subject of working with clients with alcohol problems [cf. Flint, 1979; Brewer,, 1980; Murray, 1985; Hart and Allan, 1986). Articles have also appeared in other social service publications such as the *British Journal of Social Work* at fairly regular intervals.

4. As part of the study, Blaxter asked social workers to keep a daily diary of their activities over one week. On the basis of these diaries, she estimated that 40 per cent of workers' caseloads was devoted to dealing with a range of alcohol related difficulties (Blaxter et, 1982:40).

   A study of family cases in Lothian produced similar results 40 per cent of the cases involved alcohol problems and,of these, three quarters (76%) were long term, having

been open for 12 months or longer (Osborn *et al*, 1980). Osborn *et al* also point out that in one third (35%) of these cases social work intervention was in response to some statutory obligation, thus reinforcing the point that alcohol is not necessarily the presenting problem.

5. The classification was constructed from analysis of responses to two items, one 'Habitual drunks should be viewed and treated as sick' taken to be indicative of a therapeutic orientation, the other 'Drunkenness is a main cause of immorality' identified with a moralistic perspective. Respondents who did not express any clear support for any of the ideological positions were classified as 'neutral'.

6. Although the majority of centres focused on alcohol problems almost to the exclusion of all else, one or two adopted an alternative philosophy that was quite consciously directed towards locating alcohol within the general context of addiction. Having taken that decision, these centres were committed to providing advice and information on a host of problems ranging from alcohol and drug abuse, through gambling to general counselling on hope to cope with stress. This rather diffuse focus was seen, by staff at least, as providing an environment in which it was easier for people to seek (and to receive) appropriate help and advice.

9 Society's Dustmen: the police and public drunkenness

> As things stand, we do nothing for them (drunks). We can do nothing, other than lift them off the streets. We're society's dustmen, if you like, tidying the rubbish out of sight. You see, a drunk man lying in the street offends people and they send for us to take him away. Just like that! Most people are not really interested that the man will then spend the night in a cell, or that he might end up in prison. They just don't know.

The comments of police officers such as the one above direct our attention to a situation in which problem drinking is highly visible. Drunkenness, unlike some other forms of 'private trouble', is a behaviour that is often acted out in public. The management of this drunkenness problem is also visible, in the sense that it too is often acted out in public. The influence of the therapeutic model notwithstanding, traditional responses to the problem of public drunkenness persist. The public drunk as distinct from the alcoholic who is seen as the appropriate object of intervention by socio-medical agencies continues to be processed by the machinery of the criminal justice system. And processed in large numbers. The police, the courts and the prisons continue to operate broadly within the parameters that were established in the closing decades of the nineteenth and the early years of the twentieth centuries.

That is not to say that the tradition is altogether static, that the criminal justice system responds to modern circumstances in exactly the same way as it did (say) a century ago. Some changes have been made and some promised. The ineffectual and ineffective nature of the criminal justice response has been widely recognised - the 'revolving door' of drunkenness arrests has come under increasing attack and demands for a more humane and effective response have come from many quarters (Home Office, 1971; Hamilton, *et al*, 1978; Strathclyde Regional Council, 1979). Recent innovations such as the implementation of Section 5 of the Criminal Justice (Scotland) Act 1980, and the move towards alternatives

to prosecution signalled by the Report of the Stewart Committee (Cmnd. 8947) have to some extent mediated the traditional response of the criminal justice system. Nevertheless, the public inebriate can still anticipate considerable contact with the police in their role as frontline managers of public drunkenness. Problem drinking has been conceptualised as two worlds, one populated by clients known to the treatment agencies, and the other containing a much larger number of problem drinkers who "appear neither to seek nor receive help from specialist services" (Shaw *et al*, 1978:115).[1] For many people in this general population, the police may be, in fact, the *only* agency with which they come into contact.

In the next two chapters I will examine the contemporary criminal justice response to alcohol problems. I will begin by looking at the attitudes, perceptions and experiences of police officers dealing with drunkenness. The police are the front line mobilisation agency for the criminal justice system and, with the advent of diversion programmes, they are increasingly called on to be the 'gatekeepers' of a broader network of judicial and therapeutic control. Chapter 10 carries the story forward from mobilisation (arrest) to consider the processes of prosecution and disposal of drunkenness offences. Let us begin, however, by constructing a profile of that amorphous creature, the drunken offender.

The drunken offender

Who are these 'habitual drunks', these people whose drinking behaviour brings them into conflict with the law? It is tempting to portray public drunkenness as an activity which takes place at the margins of society and to seek in the inadequacies of 'the lost' comfort and reassurance about the 'normality' of our own drinking behaviour. Throughout the literature, in fact, public drunkenness is described in just these sorts of terms. Police encounters with drunks are portrayed as contact between the police and an unemployed, working class male who has a long history of previous arrests for drunkenness and who suffers from an illness known as alcoholism (Nimmer, 1971; Hamilton *et al*, 1978). These

encounters commonly take place in the streets of the more depressed areas of the inner city and are typically proactive in nature. Given that such descriptions focus on drunkenness which is likely to be highly visible, this scenario has something of the air of a self-fulfilling prophecy. It might be expected that the drunkenness of a group of people who are well known to the police, who are characterised by their social instability, and whose drunkenness is acted out on the streets in areas of high police activity, will be disproportionately represented in official arrests statistics. The police reports that were studied yielded information about the characteristics of the offender and of the arrest situation that was broadly consistent with this traditional profile (Table 9.1).

Arrest reports, however, are typically condensed to such a degree that they merely provide a *pro forma*. Name, address, locus and time of arrest, such details are capable of producing only the most partial view of the situation. They cannot inform us about police-public drunk encounters that do not result in arrest, nor can they hope to reflect the diversity of forms of public drunkenness. In order to form an image of the sorts of individuals that are identified with drunkenness offences and the way(s) in which they are dealt with, the police sample were asked for details about their most recent encounters with drunken persons. The importance of the police officer's perception of the situation was underlined by the fact that these discussions strongly supported the view that police involvement with public drunkenness tends to be proactive (Black, 1971; Pastor, 1978). The sample reported a consistently high level of police-initiated contact in both arrest and non-arrest situations. Sixty-four per cent of all encounters with drunken persons were reported to be proactive, a fact which affords the police considerable discretion in responding to incidents. It seems, for example, that the police are much more likely to adopt informal strategies for dealing with drunkenness when no complainant(s) is involved. In over half (62%) of the cases instigated by the police themselves no arrest was made. Tables 9.2-9.4 detail some of the main findings:

Table 9.1 Analysis of Central Scotland Police reports on drunkennes related offenders, 1981

	Charge: Drunk & Incapable %	Breach of the Peace %	Total
Locus of arrest:			
Public highway	46	54	205
Other public space	19	81	31
Hotel/lodging house	-	100	9
Public house/bar	-	100	13
Police Office	8	92	12
Public building	-	100	14
Age of offender:			
16 - 20	9	91	100
21 - 30	13	87	79
31 - 40	28	72	50
41 - 50	53	47	34
Over 50	74	26	43
Sex of offender:			
Male	27	73	274
Female	24	76	29
Number of co-accussed:			
One	-	100	40
Two or more	-	22	22
None	34	66	241
Nature of additional charges:			
Carrying an offensive weapon	-	100	15
Vandalism	-	100	15
Resisting arrest/ escaping from custody	-	100	25
Petty assault	-	100	54
Serious assault	-	100	5
Other	4	96	23
Day of arrest:			
Sunday	25	75	32
Monday	22	88	23
Tuesday	42	58	19
Wednesday	31	69	29
Thursday	31	69	48
Friday	23	77	52
Saturday	50	50	48
Time of arrest:			
0.01 - 400 hrs	16	84	82
4.01 - 800 hrs	100	-	2
8.01 - 1200 hrs	33	67	6
12.01 - 1600 hrs	55	45	20
16.01 - 2000 hrs	40	60	63
20.01 - 2400 hrs	22	78	130
Number of previous arrests:			
One	20	80	25
Two	75	25	8
Three or more	100	-	1
None	26	74	269
Number of additional charges:			
One	-	100	101
Two or more	3	97	31
None	43	57	232
Accomodation:			
No Fixed Abode/ Hostel Accomodation	27	73	33

Table 9.2 **Source of complaints in police encounters with public drunkenness**

(Percentage distribution by outcome of encounter)

Encounter initiated by:	*Charged:* Drunk and Incapable %	Breach of the Peace %	*Not charged:* Taken to hospital %	Informal action[2] %	Total
Police	18	20	13	49	N=386
Licensee/ Bar staff	5	66	7	22	N= 41
Member of public	30	35	23	12	N= 90
Spouse/relative	-	59	10	31	N= 29
Other	30	31	30	9	N= 54

Table 9.3 **Age of drink related offenders**

(Percentage distribution by outcome of encounter)

Age:	Charged: Drunk and Incapable %	Breach of the Peace %	Not charged: Taken to hospital %	Informal action[3] %	Total
16 - 20	5	33	4	58	N=187
21 - 30	7	33	9	51	N=183
31 - 40	44	26	17	13	N= 98
41 - 50	32	20	38	10	N= 69
Over 50	46	10	35	10	N= 63

* Percentages have been rounded to the nearest whole number and, therefore, the percentage total does not always add to 100.

Age of offender

The age distribution of drunken offenders varies quite markedly by the nature of the offence and the outcome of the encounter. The older age groups would seem to be over-represented in drunk and incapable charges and amongst those taken to hospital. Young people, on the other hand, figure more prominently in breach of the peace charges or as the objects of informal action. The police sample, indeed the criminal justice sample generally, seemed to regard young people as significantly different from mainstream drunken offenders. Expressions of concern about the growing problems of alcohol, drug, and solvent abuse among young people were commonplace. The urgency of the need to educate the young about the dangers of these practices and of providing facilities for helping young people in trouble was also a regular feature of research interviews.

The findings of the present study in relation to the use of informal action would tend to support those of recent American studies which suggest that informal processing is directly related to the age of the offender and that the police exercise considerably more discretion with young people than with older offenders (Pastor, 1978; Smith and Visher, 1981). Young people do seem to be disproportionately represented in drunkenness-related encounters 31 per cent of reported encounters involved people under 21 years of age. However, in the majority of cases (58%), these encounters are resolved informally. In those cases where arrests were made the subject's demeanour towards the police was an important factor, an indicator of conformity to informal norms of interaction which seemed to influence the arrest decision. Young drinkers who were, or who were perceived to be, belligerent and uncooperative were, therefore, more likely to be formally processed than older drunks. And, when they are charged, young people are more likely to be charged with breach of the peace which can be a more serious charge than simply being drunk and incapable (Table 9.8).[3]

Table 9.4 Sex of drink related offenders

(Percentage distribution by outcome of encounter)

Sex:	Charged: Drunk and Incapable %	Charged: Breach of the Peace %	Not charged: Taken to hospital %	Not charged: Informal action[3] %	Total
Male	18	29	14	39	N=551
Female	29	16	26	29	N= 49

Sex of offender

The vast majority of those arrested for drunkenness-related offences were men (Table 9.4). Observations of, and interviews with the police suggest that women are less likely to be encountered in situations that might lead to their being charged with some drunkenness offence. When a women's drunkenness does bring her to the attention of the police she is only marginally more likely to be dealt with informally or charged with simple drunkenness 55 per cent of women were not charged as against 53 per cent of men. A recent study of legal and medical approaches to the control of public drunkenness suggested that women are more likely to be systematically diverted from formal processing than men (Pastor, 1978) and that might also be true in the context of the present study were it not for the general lack of resources. In many of the areas studied, facilities for the reception of drunken women were virtually non-existent and, therefore, opportunities for 'diversion' were in effect limited to the so-called 'home option' - taking or sending the drunk home. Although the practice was fairly common in most police forces, it was by no means uniformly approved of by the police organisation. At least one of the Chief Constables I spoke to was opposed to a practice which he considered to be indicative of "lazy police work", as well as being

an irresponsible and potentially dangerous disregard of the welfare of the drunken person. Given this and other operational considerations which tend to limit the use of the 'home option', the low arrest rate for women seemed to suggest that the police are less aware of any problem with women drinkers or, if they are aware of the problem they avoid having to deal with it whenever possible. Drunken women were certainly seen as less threatening by most police officers and perhaps, therefore, their drunkenness is considered to be less problematic than that of their male counterparts.

Carlen (1983) in a recent study of women's imprisonment in Scotland takes a rather different line on police responses to drunken women. Some 43 per cent of the officers interviewed by Carlen felt that a drunk woman generally caused more trouble than a drunk man. Drunken women, or at least those who are imprisoned, are seemingly more vulnerable to arrest because they are perceived to be: (i) more likely to be verbally abusive; (i) less easy to 'talk round'; (3) more likely to be inclined towards sexual exhibitionism; (4) dirtier than drunken men; (5) more likely to make accusations against the police; and (vi) more likely to become 'breaches of the peace' (Carlen, 1983:171). Interestingly in the context of the present study, the police used very similar expressions to explain their decision not to arrest in a particular situation.

This apparent contradiction might be related to the context of the two studies. Carlen was looking at a small group of women, a group that were atypical both as women and as drinkers, in that they were "down, out and in prison" (Pat Carlen's tag). My research, on the other hand, was concerned to illustrate something of the diversity of the problem, to show that it is not confined to a discrete category of "homeless, alcoholic recidivists".[4] Moreover, the women interviewed by Carlen tended to come from Glasgow or Edinburgh , from cities where the problems of drunkenness and homelessness are most severe.[5] Responses to drunkenness in these city areas (and in relation to this particular group of offenders) might well not be representative of the general police response. What does seem

to be clear from both studies is that the police do not respond well to groups with whom they find it difficult to identify. In a police force which continues to be dominated by the precepts of a conventional male ideology, such groups will include not only women and young people, but minorities of various kinds.

The problem population

What all this, the information from police interviews and from arrest reports, adds up to is a picture of the problem population that is much too varied to be readily subsumed under the rubric of 'Skid Row'. The vast majority of those arrested were able to provide a permanent address and only a relatively small proportion, about 10 per cent, of those arrested could be characterised as living in 'non-stable accommodation', having either 'no fixed abode' or living in a hostel (Table 9.1).

As for the patterns of arrest, here again it was only the few 'weel kent' individual that had been arrested on numerous occasions. The results of my analysis of police reports which puts the proportion of recidivists at 11 per cent, would seem to be at odds with the findings of other studies which estimate that, over a twelve month period, about half of those convicted of drunken offences will have had one or more previous conviction (Rix *et al*, 1976; Hamilton *et al*, 1978). It is worth noting, however, that the figures are based on the reports of Central Scotland Police and take no account of arrests outwith that area. This is an important limitation given that the Region has only very limited facilities for the accommodation and/or care of the 'homeless drinker'. There was considerable agreement among both the police and the social services that this 'hard core' client group, the 'homeless alcoholic', had a tendency to gravitate towards those areas which do have facilities, as one social worker made clear:

> I suppose there's a small group, a hard core 'down and out' group, that just moves around the country to wherever the best place is at that time. If you provide food and shelter, give them somewhere to live or just somewhere to go during the day, they get to know about it and so they come live here.

It might well be the case that a proportion of those who appear in the reports as 'one off offenders' may in fact have been charged in some other area during the relevant period.

Whatever may be happening with this 'hard core' group, the important point to emerge from the interviews and discussions with the police and other criminal justice personnel was that problem drinkers were not seen as a discreet, homogeneous entity. Although most respondents identified the stereotypical drunk - the "down and out, habitually drunken offender" - as both a highly visible and particularly intractable problem. Less than one-third of the criminal justice sample felt that they were in any sense typical of the problem. An extended quotation from one police officer expresses quite clearly the perceived diversity of the problem population:

> The way I look at the drunks is you can only classify them by four. You've got what we call the, you know, your down and outs, tramps, sleeping rough sometimes ... (Y)ou see him lying about all over the place, shits himself, the usual carry on. That's one, that's the popular, that's the stereotype drunk, isn't it? Then you've got the Saturday night drunk who doesn't bother anyone all week. You know, likes of the fisher boys. They're away all week, maybe for a fortnight. They come back and they're steaming out of their minds. They're a popular drunk in [this town]. When I say popular, they're a common sight ... and their wives haul them out of the pubs and everything.
>
> (T)hen you start moving up the scale and you've got the semi-professional classes, the commercial traveller type, that kind of drunk. Then you've got the big time drunks. I am thinking of one guy in particular ... a brilliant businessman and an absolute drunk. That's the top of your scale and then you've got the down and out drunk at the bottom.[6]

Characterisations of this sort are important in as much as they help shape police perceptions and subsequent definitions of particular events. Precisely how they relate to action in any given situation is less clear. Some researchers have suggested that categories which relate to physical or situational characteristics (stereotypes) are rationally employed by the police so as to enable them to focus their attention in a selective and appropriate manner. Police officers, so this explanation goes, develop, as part of their policing skills, sets of categories or stereotypes which they use to help them assess situations and/or individuals quickly and, thereby, anticipate 'trouble' (Sknolnick, 1966; Bittner, 1967; Muir, 1977). While it was clear

that the police did indeed stereotype individuals, the findings of the present study would not support the contention that in applying these stereotypes the police were particularly rational, consistent or competent.

The dangers of stereotyping individuals or groups are well recognised and, although they may help in defining the context, the prevalent characterisations of drunken persons did not determine the nature of the police response in any systematic way or mean that they were any more likely to bring any rigid (or rational) logic to bear when exercising their discretion in relation to individual situations. Police action was also influenced by other factors such as the availability of alternative resources, police officers' knowledge of extant and/or appropriate alternatives to arrest, the attitudes which they held vis-a-vis drinking and drunkenness and their perception of what the community expects (needs). And, of course, not all of these influences related to the job, as one police constable explained:

> You should think carefully before depriving a man of his liberty. It is after all a serious thing. Unfortunately, however, the decision to arrest is too often made because you're harassed, you've had a bad day, or something else colours your view.

Criminal justice attitudes to drinking and drunkenness

> The moral, then, is this, since societies, like individuals, get the sorts of drunken comportment that they allow, they deserve what they get.
>
> (MacAndrew and Edgerton, 1969:173)

The judgement might seem a bit harsh, particularly as communities and individuals have had, for the most part, only limited access to the sorts of information that would allow them to make a proper assessment of the sorts of drunken comportment they allow. Nevertheless, it was felt that, particularly where the agents of the criminal justice system were concerned, attitudes and beliefs about drunkenness, about what sorts of 'drunken comportment' are to be allowed in particular situations, might play an important part in determining responses to drunkenness.

In order to understand something of respondents' attitudes to drinking and drunkenness, police officers were asked to say whether they agreed, disagreed, or were neutral in their response to a number of attitude statements, just as had been done with the social workers earlier. The findings are presented in Table 9.5 below and, as before, the findings of an OPCS survey of *Scottish Drinking Habits* (Dight, 1976) are given in brackets as appropriate to allow for some comparison with public opinion.

As indicated above, the results did not provide any strong support for the hypothesis that police officers and social workers would be clearly differentiated in terms of their attitudes to drunkenness. There was in fact considerable common ground between the various agencies as evidenced, for example, in the tendency exhibited by both criminal justice and social work personnel to agree not only with positive statements, but also with those statements which indicated a negative disposition on the question of drunkenness. Although these findings are consistent with those of other studies in highlighting the ambiguity and inconsistency of attitudes towards alcohol use and abuse, the ambiguity displayed by those working with the criminal justice system and those in the caring professions was much less marked than that shown to exist in the population at large (Dight, 1976; Rix and Buyers, 1976). The police, then, were not as rigid in their attitudes to drunkenness as some of the literature in the area might lead one to expect.

A number of factors might combine to explain this 'flexibility'. First, it can be related to police experience of dealing with drunkenness on a fairly routine basis. Despite the stereotyping, 'the drunk' is not an abstract concept, s/he is a day-to-day reality. So much so in the case of some particularly 'well-kent' habitual offenders, that police officers often seemed to have a paternalistic (sometimes patronising) concern for their well-being. For many of those interviewed, and this is the second point, knowledge and/or experience of alcohol problems was not simply a function of the job, there was in many cases a distinctly personal dimension. Over half (54%) of the officers reported knowing at least one person (a

relative, a close friend or colleague) who had experienced, or was experiencing, a drink problem. Finally, the attitudes displayed by the criminal justice sample have to be seen in the context of changing social attitudes to alcohol problems. The data on public attitudes to drunkenness which was used in comparing the attitudes of the two sample groups was gathered nearly two decades ago (Dight, 1976). Many changes have taken place in the interim and as the public have been made more aware of the issue so the attitudes and perceptions of society in general have changed.

Figure 9.1 Cartoon from cover of Police Review, February 1984

'Look Sarge, isn't it Jim Pavingstone, the well-known stand-up comedian. . .?'

© Police Review 1984

Table 9.5 **Police responses to positive and negative statements about drinking and drunkenness**

Positive Statements	Agree %	Disagree %	Neither Dis/agree %
Drink makes people more sociable	75(85)	17(10)	8 (5)
Drink is one of life's pleasures	83(68)	14(22)	3(10)
Drunks can be very amusing	65(65)	24(28)	11 (7)
Getting drunk occasionally does no harm	33(46)	60(45)	7 (9)
People are more honest drunk than sober	47(60)	40(23)	12(17)
Drunks should be treated as sick	63 (-)	24 (-)	13 (-)
Negative Statements			
Drink is a main cause of immorality	42(26)	42(54)	16(20)
Drink often brings out the worst in people	74(48)	14(35)	12(17)
Excessive drinking often leads to trouble	69(58)	21(31)	10(11)
Drunks should be punished	21(37)	72(45)	7(18)
Public drunks have no self-respect	55(63)	25(28)	20 (9)
A drunken women is a far worse sight than a drunk man	64(92)	28(5)	8 (3)
No. of respondents = 150			

What emerged from the interviews and discussions was that the police, the fiscals and the courts those who regularly encounter the consequences of drunkenness and who are expected to respond in such situations, have sometimes very divergent beliefs concerning the nature of the problem and the individuals involved. There was no consensus, no dominant criminal justice approach to the problem. In common with social workers, indeed in common with the population at large, criminal justice attitudes to drinking and drunkenness were characterised by a considerable degree of inconsistency and ambivalence. A cartoon which appeared in *Police Review* (Figure 9.1) reflects something of this ambivalence. The drunk is seen as an object of humour and yet, at the same time, he is depicted as a 'helpless victim' and, therefore, as warranting sympathy and concern. He is simultaneously sinned against and sinning.

The police view of the sick role

Although there is no clear criminal justice approach to the problem, there does appear to be a general view, an orientation, identifying alcohol problems with illness - the notion that habitual drunken offenders were sick *in some respects* was a recurring theme of the criminal justice interviews. The caveat is an important one, given that most respondents exhibited mixed attitudes towards the problem drinker.

Taking the sick role as a cluster of four dimensions defining behaviourial expectations, Parsons (1951) argued that to be recognised as sick meant that; a) the individual was excused from normal social responsibility; b) the person in the sick role was not blamed for being sick s/he was not at fault; c) individuals, however, were expected to define their condition as undesirable, and d) they would also be expected to seek help in overcoming the condition. What was very clear, looking at the research interviews, was that the outlook of the criminal justice agents favoured some form of therapeutic intervention, but they, nevertheless, retained a firm belief in individual responsibility. Although only a

relatively small proportion of those interviewed expressed a strongly moralistic point of view, the others - the 74 per cent who could be classified in terms of either the 'therapeutic' or the 'moral-sickness' category (Table 9.6) - were not averse to embroidering their responses with the language of 'moral weakness'. The categories used in Table 9.6 were based on an analysis responses to two items on an attitude scale (see, Note 8).

The sense of the offender's 'inadequacy' or 'irresponsibility' came to the fore particularly strongly when the police were talking about those who had 'hit the gutter', one desk sergeant expressed the ambiguities of the situation:

> You take a 'wino' like Willie there. Alright, he's had a hard life and everything is against him ... and he's an 'alki', he's sick. But he doesn't try to do something about it. He doesn't want the responsibility and he ends up doing something bloody stupid like that. Now, you can't just ignore it. You can't just say, it's not his fault.[7]

Clearly, then, habitual drunkenness offenders were not accepted in every aspect of the sick role. On the question of fault, in particular, while there was a fairly strong consensus view that problem drinkers should not be seen as having brought the condition entirely upon themselves, this lack of fault was not considered sufficient reason to grant exemption from social responsibilities. But perhaps we should not be too surprised by this. After all, the disease model of alcoholism, as it was developed from the nineteenth century, was (is) an essentially moral orrery. It is a construction the exact provenance of which is unclear, but which operates by assigning the problem drinker a label, 'sick'. The sick role not only alters his/her self-concept but also affects the social image of the person, the way in which s/he is seen and responded to by 'significant others'. For 'sick' read 'deviant'.

Roman and Trice see a certain inevitability in the process. By labelling the deviant drinker and assigning him/her to the sick role in a situation in which the individual was initially in control, the operation of the disease model might "serve to aggravate and perpetuate a condition" and so reinforce the appropriateness of the labelling in the first place (Roman and Trice, 1968:249). What we are seeing with the police and with the other

agents of the criminal justice system is the end product of a transformation that began in the nineteenth century and led from drunkenness, to 'alcoholism', defined as a medical problem, while the machinery for the social control of drunkenness remained firmly in the hands of the criminal justice system.

Table 9.6 Distribution of police officers in four ideological categories, by their response to moralistic and therapeutic items.[8]

Ideological Categories	% Police Officers
Moral-sickness	37
Moralistic	11
Therapeutic	22
Behaviourist	8
Neutral	20
Total	100 (N=119)

From the outset, of course, there was considerable overlap between the two arenas, as was seen, for example, with the Inebriate Reformatories. It is important to recognise this interpenetration for what it is, a vital part of an expanded network of social control. Part of the success of the disease concept lay in the ability of the medical profession to negotiate the terms of the cooperation - to direct the legislative gaze as it were - by appealing to every level of the system from policy making to the routine exercise of discretion 'on the streets'. The influence of course is neither direct nor dominant. As the medical/therapeutic ideology was titrated against the solution of legislative tradition, *both* were modified.

Sad, bad, or mad?

At the end of the day, then, are drunken offenders to be considered to be sick, immoral, or criminal - are they "sad, bad or mad?" This is not a trivial question because the ways in which it is answered - and it is unlikely that many people will be categorical for one definition against the others - can have very real implications for the ways in which the problem is responded to, or, indeed, whether or not it is responded to at all. If offenders are sick, some sort of medical or social work intervention might be appropriate. If, on the other hand, they are not seen as being sick, or are only accepted as such to a limited extent, then the 'appropriate response' might be to invoke penal sanctions or some other form of institutional control.

Of course, the relationship between attitudinal indicators of the kind presented above and what actually happens 'on the street' is neither simple nor direct. It is worth considering, however, because the police and, indeed, the other agents of the criminal justice system are better placed than most other groups when it comes to translating their attitudes into action, giving them tangible form on the streets. They have very considerable discretion. It is far from absolute and may be qualified either by operational limitations or by situational factors, but, nevertheless, it does exist and we should consider the sorts of factors which can 'colour' the police view of an incident and influence decisions about whether or not to arrest an offender.

To arrest or not to arrest?

From the police interviews, it would seem that perceptions of appropriate response activities owe more to knowledge of the individual and to general notions of 'peace-keeping' in the area, than to any narrow concept of 'law enforcement' "the law is the law" was offered as an explanation of response activities on no more than one or two occasions. Where an individual had been found drunk and incapable, the arrest decision was almost invariably

explained by reference to the well-being of that person. When discussing such arrests police officers usually began by explaining that drunken individuals are picked up by the police in order to protect them from the dangers of criminal attack, accident, or illness, which might otherwise be the consequence of their drunkenness. The following explanation was so typical as to be almost routine:

> (He was arrested) because he had no money on him. He refused to tell us where he was living ... and we thought for his own good, due to the fact that it was freezing cold and if we had let him wander off there's a good possibility he would have been overcome by the elements so, for his own safety, we locked him up.

Arrest of course also served to protect the police from the adverse criticism that would result from the drunken person succumbing to exposure in a public place as most police officers were only too keenly aware. The possibility was highlighted during the fieldwork by the unwelcome publicity Lothian and Borders Police were receiving after two of their officers had left a man on the outskirts of Edinburgh 'to sober up', the man subsequently died of exposure. Most police officers, however, were also aware that arresting a drunken person or taking him/her into 'protective custody' could be equally problematic since it removes the concern about the 'death in the street' only to replace it with the spectre of 'death in police custody', one policeman expressed the dilemma:

> The problem with taking drunks into custody is not simply the nuisance value of having to go out and pick up these people. But its the continuing problem of making sure they don't become ill or die in the cells as has happened in some forces. There's the continual problem of supervision which we're not really equipped for. You've seen our cells and there's no way they can be described as a medical facility.

The degree of intoxication

Where they were confronted with incidents involving simple drunkenness, the degree of intoxication appeared to be a major determinant of the decision to arrest. In cases where the person was judged to be 'highly intoxicated' s/he was more likely to be charged with drunk

and incapable or taken to a hospital casualty unit. Informal action was invoked more readily when the offender was considered to be moderately or only slightly intoxicated (Table 9.7).

If there was disorderly conduct, however, the situation was likely to be reinterpretated, leading to a more formal 'law enforcement' perspective. Whether or not this reinterpretation resulted in an arrest was in itself subject to the influence of a number of factors, the most important of which was the demeanour of the person involved.

Table 9.7 Perceived degree of intoxication of subject[9]

(Percentage distribution by outcome of encounter)

Degree of intoxication:	Charged: Drunk and Incapable %	Charged: Breach of the Peace %	Not charged: Taken to hospital %	Not charged: Informal action[3]	Total
High	49	14	34	3	N=218
Moderate	3	41	4	52	N=278
Slight	-	22	4	74	N=104

Demeanour of offender

Most police officers were very clear about the importance of the suspect's response to police intervention. It was implicit in discussing stereotyping earlier in this chapter that the police enter into a potential arrest situation with certain expectations about the behaviour of the individuals involved. These expectation are related to such factors as age, sex, social class and ethnic origin. Any violation of these expectations whether by aggressive behaviour, by failure to show proper respect for, or willingness to cooperate with the police, will leave the individual more vulnerable to arrest.

Table 9.8 provides information about the reaction of drunken persons to police intervention and how their demeanour is related to outcome. Subjects were classified, on the basis of policer's assessments, according to whether they were:

(i) polite, deferential and willing to cooperate [Cooperative]

(ii) indifferent, not fully aware of, or reluctantly compliant with the demands of the police [Passive-resigned]

(iii) verbally abusive or challenging [Aggressive], or

(iv) physically violent [Violent].

Surprisingly, perhaps, the threat of violence did not feature very strongly as a factor in explaining arrest decisions. Although there was always the possibility of violence, of the situation escalating to the point where the 'simple drunk' found him/herself charged with something more serious, most people observed during the course of the study were passive or at least manageable by verbal means. That said, it was clear that as behaviour tended toward the 'aggressive-violent' end of the continuum, the likelihood was not only that the individual would be arrested, but that s/he would be charged with something more drunkenness.

Table 9.8 Police perceptions of the demeanour of offenders

(Percentage distribution by outcome of encounter)

Demeanour of subject:	Charged: Drunk and Incapable %	Breach of the Peace %	Not charged: Taken to hospital %	Informal action[3] %	Total
Cooperative	28	14	17	41	N=152
Passive-Resigned	19	7	22	52	N=253
Aggressive	16	59	4	21	N=135
Violent	3	83	5	8	N= 60

The drunkenness charge, typically drunk and incapable, was in a sense an intermediate step on a continuum of responses. In dealing with minor incidents, the police often sought to resolve the situation by informal means. As a stronger response was considered appropriate, however, so they would opt for a more serious charge or for a number of charges. When asked about their most recent breach of the peace arrest, more than half (55%) of the police officers interviewed claimed that the person(s) had been arrested because s/he had not been receptive to police handling of the situation. Arrest under these circumstance was deemed to be an appropriate response to trouble-makers; those who were not amenable to informal processing, who would not 'heed the warning' or who had in some other way 'earned' arrest.

This pattern was also evident in the analysis of police reports over half (53%) of those charged with breach of the peace while intoxicated, had had at least one other charge preferred against them and 12 per cent had been charged with three or more offences. The most common secondary charges involved petty assaults, resisting arrest, and carrying concealed weapons (Table 9.1) Being amenable to informal processing, however, does not of itself guarantee freedom from arrest. A variety of organisational and situational constraints can militate against informal action. The presence of an audience and/or a complainant may be one such determinant of outcome (Bittner, 1967; Westley, 1953). In these situations the perceived need to respond quickly in order to control the situation, to re-establish authority, can override other considerations and lead to an arrest being made.

Social police or society's dustmen?

Two interesting findings about the perceived role of the police, although not related exclusively to their attitudes toward the management of drunkenness, appeared to be quite important in the overall pattern of response. The first was that the police were more aware of the 'social welfare' aspects of their work than some studies would suggest (Punch, 1979).

When asked to evaluate their work, police officers laid only slightly more emphasis on the traditional 'law enforcement' role, over their 'social welfare' function. On a six item opinion scale, the mean score on the 'law enforcement' items and the 'social welfare' items were 8.4 and 7.6 respectively. This finding was well supported in subsequent conversations with the officers:

> The duty of the police does not begin and end with the protection of life and property. We provide a much more diverse range of services and I think we should provide this range of services. I wouldn't like to be in a Force which was simply concerned with catching thieves or other law breakers.

Many officers acknowledged that, by the very nature of things, a "majority of police manpower, time, and resources, is and must be, allocated to activities that have either nothing or only very little, to do with law enforcement in the strict sense of the term". (Bittner, 1975:22).

The modern police force serves a variety of functions and the uniformed branch in particular is expected to respond to a wide diversity of situations. Uniformed officers make-up approximately 70 per cent of police establishment and, of these, slightly more than half will be employed in patrolling duties of one kind or another (Hough, 1985:7). These beat duties have never been exclusively, nor even primarily, concerned with criminal matters. From their inception it was envisaged that the police (the Watch) would not be limited to controlling the streets. They were to have the all-embracing tasks of "enlightening and cleansing of the streets" as well. We no longer expect that our local police force to organise the collection and disposal of 'common middens', but we do expect that they will be 'on call' should we require their assistance on a wide range of non-criminal matters. And, the police share this expectation to a considerable degree.

The police function as a 'social police' (Donajgrodzki, 1977) has been institutionalised (internalised) to the point where they are seen as the appropriate reference point for a wide

range of problems relating to social order and the social life of the city. There may be some dispute about scale; Punch (1979) estimates that social welfare incidents make-up about 70 per cent of police work, Hough (1985) opts for a much lower proportion (31-35 per cent), but it is clear that the social service function is an important element of police work. However, because it is largely unrecorded and in comparison to 'law enforcement' functions relatively under-researched, the social welfare role of the police is particularly difficult to understand or interpret. This study could not hope to go into the issues in any depth, but it did seem from discussions with police officers that recognition of the welfare aspects of their work did not necessarily mean that they were well adjusted to this role. In fact the police sample appeared to be subject to a fair degree of role conflict and confusion. Despite their positive attitudes toward some aspects of this work, there was a tendency to see much of it as a waste of time or an inappropriate use of police resources. Public drunkenness was a good example of the kind of task that was considered to be beyond the limits of normal and/or appropriate police work, it was 'dirty work' (Hughes, 1958). That such work was disliked and often avoided was a commonplace of police interviews:

> Most policemen will try and avoid picking up drunks. The average cop will walk past them when it comes to pulling in drunks because there's nothing he can do with them. I think too you're afraid they're going to throw up either in the police car or over your uniform and you're responsible for cleaning your own uniform. You know for these kinds of reasons most cops very rarely take them in.

Society's dustmen

Of course there may be other reasons for not arresting drunks. Public drunkenness is, after all, only one - and one of the least serious - of a range of crimes and offences for which the police have responsibility. Formally processing all or even most of the public drunks they encounter would place an intolerable burden not only on the police themselves, but on the whole Criminal Justice System. As the same police officer put it, "if you went around pulling in everybody who's the worse for drink, the police cells would have to take up half

the town". For whatever reason, many police officers clearly resented being used as 'society's dustman'. The front line role played by the police in the management of public drunkenness was seen by them as an abrogation of medical and/or social service responsibility for the problem just one more example of 'ineffectual' social service agencies using the police as a repository for their more distasteful tasks. For all that, the police were less than optimistic about the social services ability to cope with these problems, especially where there was a likelihood of incidents involving violent or seriously disruptive individuals.

Perhaps part of the problem relates also to the police perception of themselves as independent professionals engaged in important work. The habitual drunken offender in particular presented the police with a problem which few of them really understood. Training was (is) virtually none existent. Of the 160 police officers interviewed, only 31 per cent had had any sort of training in alcohol problems. Moreover, the training that was available tended to look at the issue in terms of police duties and procedures (Grampian Police, 1978). As with many other aspects of police work, there seems to be a widespread assumption that the job requires no special skills but simply the exercise of 'commonsense' - 'commonsense', of course, being that which is best learned from colleagues and supervisors as part and parcel of some kind of 'occupational culture'. Manning in his study of the organisation of police work summarises the implications of this occupational culture for those who have to interact with the police for whatever reason:

> (P)eople are expected to fill categorical niches and fall into line with the commonsense policy theory about human nature. The observed facts are assembled under the umbrellas of a commonsense theory. The facts are not taken as a means to disconfirm the police theory of human nature.
>
> (Manning, 1977:237)

Police discretion

The existence of some sort of rank-and-file occupational culture is particularly significant because the police exercise considerable discretion in their routine enforcement of the law. Platitudes such as "the chief constable makes the decision, then the locker room makes the decision" (Banton, 1964), are perhaps too much of a generalization, but certainly when dealing with drunken persons the police have the ability to 'ease' the regulations considerably should they so wish. In the interviews with police officers, for example, there were frequent references to informal modes of dealing with the problem and occasional glimpses of operational priorities:

> I don't care if acceptable or not ... if I've got the time, I'll take the guy home ... just stick him in the back (of the police van) and take him round to his mother who is a law-abiding soul.
>
> (Y)ou can make an issue of it (drunkenness). It's your priorities that's different you see and it is this conveyor belt, once it goes too fast you can't do too many, so, therefore, when you're out there (on the streets) you're using your discretion. If it's a Friday or Saturday night ... I'm not going to deal with it. I think it's not good to be into something rubbish when you should be doing something else.

Although the exercise of discretion is an integral and essential part of the criminal justice system it is an area that has received scant attention and, indeed, some senior police officers are reluctant to recognise this or admit its existence. There are no established principles to guide the police in exercising discretion, particularly in 'low visibility' situations such as are often associated with drunkenness. Lord Scarman recognised that discretion, "the art of suiting action to particular circumstances", was vitally important to effective policing (Scarman, 1981:para 4.58). However, not a great deal has been said about how this 'art' is acquired or what factors inform the individual's decision to exercise discretion or not? It seem at least likely that an individual's perception of the problem of drunken offenders and of their behaviour will be an important determinant of the arrest decision. Certainly, research that has looked at the use of police discretion in a variety of situations points to

the importance of characteristics and/or the behaviour of the offender in arrest decisions (Goldstein, 1960; Banton, 1964; Cressey and Ward, 1969).

Conclusions

The picture that emerges from the research, and the image I have tried to portray, is of a police force that is fairly phlegmatic in its approach to the problem. Although they appeared to be more tolerant in the attitudes than the general public, police officers displayed the same sort of ambivalence about alcohol misuse that has been widely commented on in studies of public attitudes to the problem. It is, therefore, difficult to identify a unique police orientation other than the obvious interest in law enforcement. The police, however, did share some common ground with social workers, particularly in terms of their acceptance of the need for some kind of therapeutic initiative that would place the drunken offenders in a more caring environment than that which they currently find within the criminal justice system.

If the proposed alternatives to criminal justice processing of drunkenness are to have any chance of success this commonality of interest may well be very important. There will have to be a significant degree of inter-agency cooperation from police and social workers in particular. This, in turn, will necessitate a reappraisal of the 'commonsense' approach which *both* groups hold with respect to alcohol problems and, I suspect, to many other issues.

For the moment, however, the promises of alternatives to criminal justice processing of drunkenness remain in essence just that - promises. The expressed reluctance of the police to 'lift drunks' notwithstanding, the formal processing of drunken persons continues to be a commonplace of the Scottish criminal justice system. Those who have failed to avoid arrest must now move on through the machinery of criminal justice to confront the courts and, for a sizeable minority, the prison system.

Notes

1. Robin Room is generally credited with having coined the term 'the two worlds of alcoholism' in discussing the difficulties of estimating the patterns and problems of alcohol use in the general population (Room, 1977). The concept has been seized on (and in some instances distorted) in an attempt to enlarge the problem arena well beyond the clinic and into the heart of the society itself. After all, if one talks about people in treatment, we might estimate (guess) in tens of thousands; if we expand the boundaries to those who have had some problem with their drinking, the estimates might be five or even ten times higher.

2. Informal action includes some individuals taken by the police to the 'designated place' at Albyn House, Aberdeen. The police sample were asked for details about their most recent experiences of dealing with drunkenness and in some cases particularly where informal action was taken, more than one individual (offender) was involved. This explains the difference in the total number of cases included under each heading.

3. Breach of the peace is a crime at common law in Scotland, that is it is not referable to any legislative enactment but to 'our ancient and immemorial customs', as Lord Stair put it. While in theory this means that the sentencing powers of the courts are unlimited, in the case of breach of the peace the normal practice is to invoke summary procedure either in the District Court or, if the offence is of a more serious nature, in the Sheriff Court. See, Figure 10.1 (p.247) for an explanation of the Scottish court system.

4. Carlen herself quotes a Scottish Health Education pamphlet, Understanding Alcohol and Alcoholism in Scotland, which makes this very point:

> "(T)he stereotype of the skid-row alcoholic or meths-drinking vagrant represents only a tiny fraction of the total alcoholic population of Scotland, possibly as little as 2 per cent."
>
> (quoted in Carlen, 1983:193)

5. It seems reasonable to infer that the majority of the women were resident in the Clydeside conurbation, in Glasgow or its environs. Of the 20 women interviewed by Carlen, 13 were deemed to have some kind of alcohol problem. Ten of these 'drinking women' would seem to have come from the Glasgow area because that number had made an appearance before the same Glasgow stipendiary magistrate at one time or another (Carlen, 1983:171).

6. In discussing the problem drinker, most of the police officers interviewed offered a similar differentiation. The problem drinker, it seems, could be identified in terms of four broad categories:

Down and Outs

Although numerically a very small group, these individuals were generally perceived to be the most serious, most immediate problem for the police. As individuals they were most often cast in the role of the habitual drunk, in that they were seen to

exhibit that degree of social instability and/or inadequacy that was felt to be characteristic of the 'Skid Row Drunk'.

Weekend Drunks

These are individual who are repeatedly drunk in public, but who lead an otherwise fairly 'normal' existence. They have stable accommodation arrangements, a reasonably steady employment record, and an ongoing relationship with the opposite sex (ie, married or co-habiting). From the police point of view they were quite simply a nuisance a group of annoying and potentially troublesome individuals:

"(T)hen there's the pure bloody nuisance. The guy who maybe doesn't drink all week even, but, come Thursday when he gets his pay or his Social Security Giro, he's off! He gets drunk and he ends up D.& I.(Drunk and Incapable)."

It is difficult to estimate the number of 'weekend drunks' because, except where they were particularly belligerent or uncooperative, the police seem to favour informal processing. Nevertheless, there is a marked increase in arrests for drunkenness-related offenses at weekends (see, Appendix III) and many officers attribute this, in part at least, to the activities of individuals in this category.

Occasional Drunks

The vast majority of the public drunks encountered by the police did not fit easily into either of the above categories. They were 'occasional drunks'. Occasional either in the sense that their drunken episodes were infrequent and, therefore, unlikely to attract the attention of the police, or because the drunken episode(s) followed an identifiable 'occasion' in their life. For some at least, drunkenness was the unintended consequence of a special social event such as a wedding, or a traumatic event such as a bereavement or redundancy. As might be expected from the diverse nature of the interaction, police responses to this group varied not so much in relation to the person's drunkenness, as in relation to other situational and individual characteristics.

Young Drinkers

Although drunkenness among young people could be subsumed under one of the headings above, the police do seem to regard this group as being significantly different from the main stream problem drinker. Many police officers expressed concern about what they saw as the growing problems of polydrug (ab)use by young people.

7. The comments were made in relation to a particularly well known offender. This man had, during his lifetime he was 50 years old at the time of the interview amassed a total of over 150 convictions for 'drunkenness' and associated minor offenses. His offence, the 'bloody stupid thing' he had done, on this occasion was petty theft from the kitchen of a local hotel. Being 'well drunk' at the time, the attempt was incompetent and doomed to failure and, in fact, had more the air of comedy than of crime. Nevertheless, the sergeant's choice of objurgatory epithets such as 'wino' and 'alki' gives a clear indication of the social 'value' he placed on this man.

8. As with the caring professions, the classification was constructed on the basis of responses to two items, one 'Habitual drunks should be viewed and treated as sick' taken to be indicative of a therapeutic orientation, the other 'Drunkenness is a main cause of immorality' was identified with a moralistic perspective. Respondents who did not express any clear support for any of the ideological positions were classified as 'neutral'.

9. Unfortunately, it is not possible to discuss the level of intoxication with any accuracy, (a) because the police simply record drunkenness as a dichotomy 'drunk'/'had been drinking', and, (b) because the definition of drunkenness is a highly subjective one and there is no evidence that the police are any more accurate in their perception of intoxication than the general public (Pagano and Taylor, 1979). In most cases, however, the general criteria seemed to be associated with impaired coordination, slurring of speech and so on.

10 Prosecuting Drunkenness

It would take a confirmed optimist or someone gifted with self-deception to argue that all is well in the way society responds to alcohol misuse. There is a distinct air of despondency about the field, a sense of something going wrong or by default. The *general* level of awareness of alcohol problems is fairly high, compared, say, with twenty years ago. The policies, and the enthusiasm for tackling these problems, however, appears to be much more diffuse. Nowhere is this *malaise* better reflected than in the continued use of criminal justice precessing of drunkenness offenders. The weaknesses of the legal response have been well documented. The heavy burden it places on the criminal justice system, the bankruptcy of a response that locks drunken offenders into a cycle of arrest-court-prison-release-rearrest, and the recognition of drunkenness as a 'victimless crime', all argue strongly for a change in orientation from criminalisation to a response based on the ideals of therapeutic intervention.

The need for change in a sense forms the basis of this chapter. Beginning from an analysis of extant responses - in terms of the operation of the prosecution system and the views of those who operate within it - I will explore the possibilities and the limitations of recent changes in this pattern of response. I will begin, however, by outlining the present system, the route that drunkenness offenders typically travel after their arrest by the police.

The drunk in court

Scotland has a three-tier system of criminal courts (Figure 10.1) The High court, at the pinnacle of the judicial system, is both a trial court and a court of appeal and has sole jurisdiction over certain serious crimes such as murder, rape, and treason. The Sheriff court is the principal court of local jurisdiction and can try cases under either solemn procedure (judge and jury of 15 lay persons) or summary procedure with a judge (or judges) sitting

alone without a jury. Most minor offences, including the vast majority of drunkenness offences, are dealt with not in either of these criminal courts, but in lay summary courts called District courts.[1]

The District courts came into existence with the reorganisation of local government in 1975 to replace the Burgh and Police courts, in towns and cities, and Justice of the Peace courts in rural areas. With the exception of Glasgow, these courts are presided over by lay magistrates who need have no formal legal, medical or social work training. District courts have lesser powers than the Sheriff court. Sitting summarily the maximum fine for a common law offence such as breach of the peace is £500 and the maximum period of imprisonment is generally 60 days.[2]

Under the Scottish system, however, it is by no means certain that, having been arrested and charged, an offender will end-up in court. The police may exercise considerable discretion in relation to the arrest situation but, unlike their colleagues in England and Wales, they *NEVER* prosecute. The responsibility for the prosecution of all offences falls to the procurators fiscal and their deputes.[3] The specifics will vary from case to case and/or from District to District but in general the sequence of events following a drunkenness arrest would be as follows.

The Police Station

After being arrested offenders will be taken to the local police office where they will be cautioned, charged and, where minor offences are concerned, released. The drunk and incapable offenders, however, are usually detained for a time, often overnight, until they have sobered up. Assuming they are being detained, offenders will be searched, their personal possessions will be documented, and they will then be 'treated' to a night in the police cells.

Figure 10.1 The Structure of the Criminal Courts in Scotland

Jurisdiction	Court	Sentencing Powers
All common law crime All indictable statutory offences Exclusive jurisdiction in cases of murder, rape, incest, and treason	High Court of Judiciary Solemn procedure: Judge & 15 jurors	Unlimited As specified in the relevant statutes Unlimited
All common law crimes except rape, murder, incest , and treason All indictable statutory offences	Sheriff Court Solemn procedure: Sheriff and 15 jurors	Unlimited fine, up to 3 years imprisonment As specified in the relevant statutes
All common law crimes except rape, murder, incest , and treason All summary statutory offences	Sheriff Court Summary procedure: Sheriff sitting alone	Up to £1000 fine, Up to3 months (sometimes 6 months) prison As specified in the relevant statutes
All common law crimes except rape, murder, incest , treason, theft and reset over £500, serious assault, and housebreaking Statutory offences where the maximum sentence does not exceed sentencing powers	District Court Summary procedure: Lay justices; Stipendary magistrates (Glasgow only)	Up to £500 Up to 60 days prison

Marking the drunkenness offence[4]

Next morning (excluding weekends and holidays) offenders are brought before the court. However, it is at this point that the fiscal intervenes to examine the police report of the offence, in the case of simple drunkenness this usually amounts to a very brief *pro forma*, and decides whether or not to proceed. Until recently it would have seemed that one was being excessively punctilious in pointing out that this was the accused's last opportunity of avoiding prosecution. It was clear from interviews with fiscals that more often than not drunkenness charges were simply rubber stamped.

Marking preferences, however, seem to have changed over the last few years and some fiscals most notably in Ayr, Hamilton and Glasgow have adopted a policy of diverting selected drunken offenders to social work or medical agencies. In other areas of the country, fiscals now seem to be much more willing to avoid prosecution by deciding to 'no pro' the charge - that is simply to decide not to proceed with the case in any way. In 1972, as I have already shown (Figure 6.3, p.166), approximately 90 per cent of drunkenness charges were proceeded with, whereas ten years later this proportion had fallen to about 60 per cent. While it would be impossible to state that this was entirely due to changes in marking procedure, this influence cannot be wholly ignored. Moody and Tombs (1982) suggest that one of the major reasons for a 'no pro' decision is based on the principle *de minimis non curat lex*. One of the fiscals I interviewed described the distinction thus:

> ... you have to draw a line between criminals with a capital C, a sixteen year old who vandalises property and breaks into people's houses, and criminals with a small c, the persistent drunk and incapable offender who contravenes the Licensing (Scotland) Act.

The fiscal's identification of the "criminal with a capital C" with the young offenders was rather interesting and perhaps a little idiosyncratic. Nevertheless, the point is that fiscals have considerable discretion over whether or not 'the law is concerned with trivialities' and increasingly this discretion is being used. Again it was a fiscal who articulates the point:

> Its still very much left up to fiscals in their own location ... (but) I think it's true to say that over the last five or six years this discretion, which has always been a part of a Fiscal's armoury, has been much more widely used ... I mean it's the up and coming thing now.

Figure 10.2 outlines the prosecution process and indicates some of the possible avenues for diversion from prosecution, some of which will be discussed later. The various possibilities for avoiding prosecution notwithstanding, around 27,000 persons still managed to find themselves before a Scottish court during 1982, charged with drunkenness related offences.

The court appearance

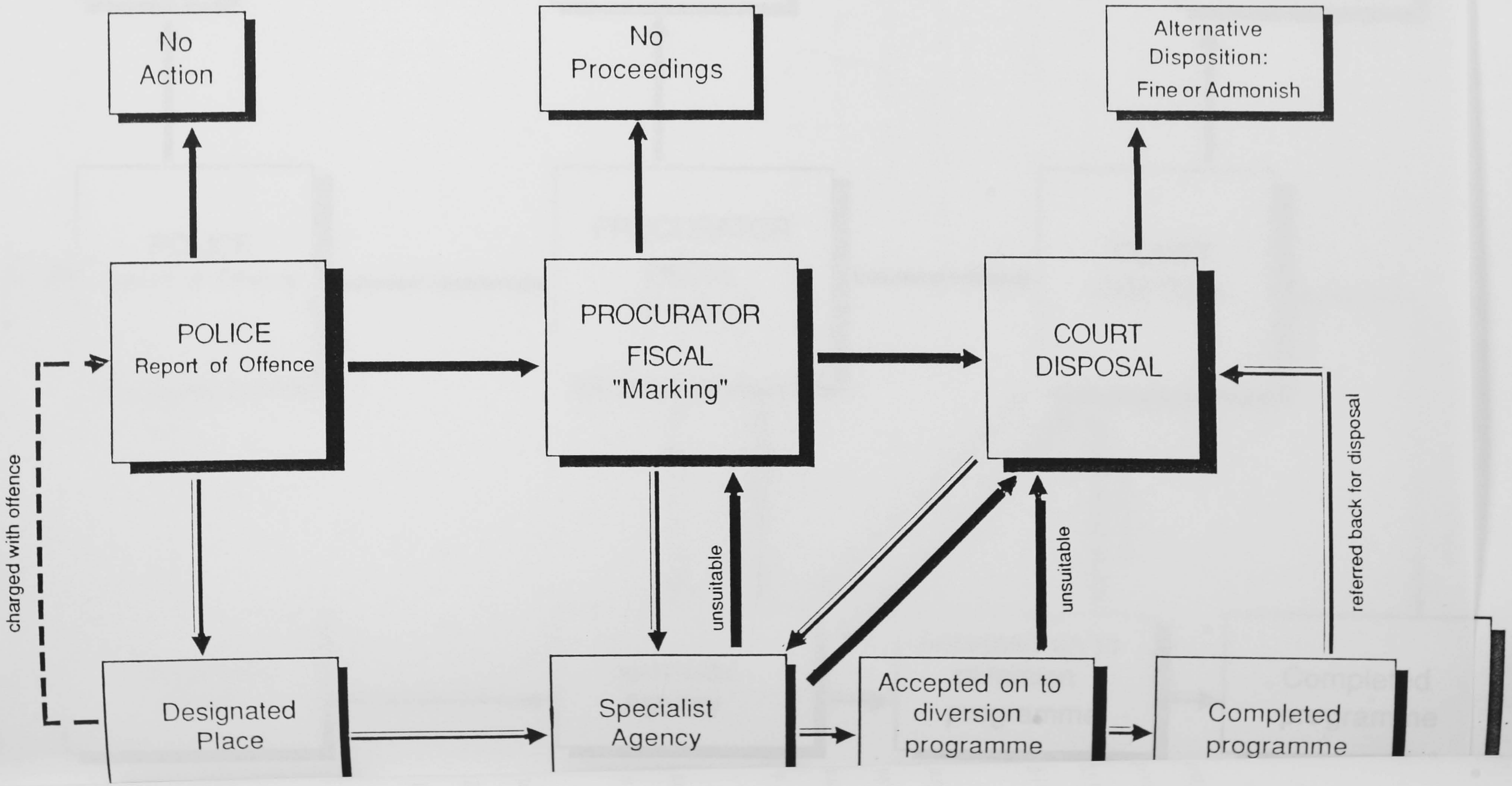
The offenders now appear in court. They will not be there long. It takes no more than a few minutes to process the average drunken offender.

You stand in the dock, answer your name, and are read the charge libelled against you (or asked if you have seen a copy) "at 11:30pm on Friday, 27 February 1986, in King Street, Stirling you were found drunk and incapable. How do you plead?"

In over 90 per cent of cases the accused answers 'guilty'. The clerk of the court then asks if you accept the previous offences libelled against you (if any). The accused usually answers 'yes'. Your personal circumstances are briefly outlined - unemployed, no fixed abode, £7.20p on you when arrested. The magistrate asks if you have anything to say for yourself 'no' and then passes sentence. And that's that!

You will have been fined (£14 on average) or admonished. Almost three-quarters (74%) of the 9,730 drunk and incapable offenders prosecuted in 1982 were fined and most (23%) of the others were admonished with a caution. For a minority of those prosecuted, however, the drama is not yet over. They move on to the next and final stage in the criminal justice process prison.

Figure 10.2 Flowchart of the prosecution and diversion process in Scotland



Prison for the overdue

> The felonies that took them there send shudders down the spine,
> There are some who purloined property, and some drank too much wine,
> And others lost to decency who failed to pay a fine.
>
> (Woodis, *The Ballad of Holloway*)

In 1977, over one quarter (27%) of all male receptions into penal custody on sentence from the courts were for drunkenness or breach of the peace (Moody, 1979:para 10). Fine defaulters - those "lost to decency" - accounted for 17 per cent of the total. The remainder had been sentenced directly from the courts. Although, under the provisions of the Criminal Justice (Scotland) Act 1980, the offence of 'drunk and incapable' can no longer be punished by direct imprisonment, the indications are that the pattern of receptions into Scottish custodial establishments has not changed in any dramatic sense. In 1982, 1,060 cases of breach of the peace were directly sentenced to imprisonment. That figure, which would include a substantial number of alcohol related offenders, represented 11 per cent of all direct receptions into prison under sentence. And non-payment of fine of course continues to be a significant cause of imprisonment.

In the period 1980-1985, the number of fines imposed by the courts fell by 28 per cent, while the numbers received into prison in default of fine has risen by 55% . Almost half (49%) of all receptions into prison were in default of fine and half of these involved drunkenness and/or breach of the peace (SHHD, 1986). But, who are likely to end up in prison and why are they there?

The image of the fine defaulter that can be gleaned from the available information - from official statistics and research findings - is depressingly familiar. Working class men are most vulnerable to arrest. But it is the most powerless group within (below) the working class - those categorized as 'homeless and rootless habitual drunkards', those who are

isolated and have no-one to 'buy them out'[5] - that are most likely to have experience of imprisonment, the 'non plus ultra' of the criminal justice process.

> (A) large proportion of defaulters are unemployed, living on low incomes (many at subsistence levels) and are clearly having difficulty meeting bills for essentials such as housing, fuel and food. Many of those who have problems making fine payments were found to have experienced a deterioration in their financial circumstances due to loss of job or illness.
>
> (Millar, 1984:42)

For many, imprisonment is no 'one off' experience. Ratcliff's study of men imprisoned for drunkenness in Scotland, for example, found that 27 per cent had been in prison on between 1 and 5 previous occasions, 25 per cent six to ten times, and 31 per cent had experienced prison on more than ten occasions (Ratcliff, 1965). More controversially, Ratcliff argues that these men had 'elected' to return to gaol rather than pay a fine. Prison was a useful port in which the habitual drunk might 'weather the storm'. McCulloch (1975) takes a similar line. He suggests that for many habitually drunken offenders imprisonment was seen as a welcome "opportunity to get 'dryed out' (sic) and get fit enough to enjoy a good bevvy on release" (McCulloch, 1975:12).

But how can we reasonably claim that habitual drunken offenders *choose* prison? As often as not they have no choice. Many magistrates or sheriffs, faced with habitual offenders with no fixed abode, are inclined to feel - not unrealistically perhaps - that they are unlikely to be willing or able to pay a fine. In many instances, therefore, though they imposed a fine, offenders are given 'no time to pay'. If, as was often the case, the offender could not pay the fine on the spot, then they went to prison. Spradley succinctly (if a little dramatically) summed-up the predicament of many those who found themselves in this situation when he wrote of their "doing life on the instalment plan":

> The urban nomad has little money, cannot beat the drink charge in court, and so must pay for his style of life by doing time. He is punished for the crime of poverty .... his punishment may reach grotesque proportions as he does a life sentence on the instalment plan.
>
> (Spradley, 1970:252)

In taking this line of action, however, the courts were not (simply) looking to punish the individual. Like the police who 'lift the drunks', the magistrates and sheriffs who send them to prison often felt that it is for their own good. One sheriff expressed himself clearly in favour of the prison option as being particularly useful for short-term prisoners, giving them an opportunity to 'dry out' and think about their situation:

> I think, a lot of people will be motivated [in prison] because they're, by definition, off drink and if for the first time ever they were to think about what the future holds for themselves. Some prisons do offer quite good counselling sessions ... but I really feel that something of that sort should be fairly intensive in every prison because your short-term prisoners, I think, ninety-five per cent probably have drink-related problems.

However, in looking to prison for an opportunity to get the offender some kind of help, most magistrates and sheriff's recognised that it was a far from ideal solution, but, in the words of one senior magistrate, "something has to be done":

> Of course prison doesn't really help. It's all just one vicious circle. But what do you do? You saw C this morning (referring to a man who had been sentenced on a number of drink-related charges earlier in the day). You can't just leave him to it. Something has to be done and at the moment prison really is the only option. We're trying to get a scheme going with the local council (on alcoholism), but I doubt if they'd have him.

This magistrate was, of course, saying nothing that had not been said before, and said often. Such statements have been commonplace in prison reform debates since the first half of the nineteenth century. Mary Carpenter, commenting on the repeated imprisonment of women for petty offences such as drunkenness wrote, in 1853, that it was "a mockery of justice" for magistrates "to be constantly inflicting a punishment which is thus publicly stated to produce no impression" (Carpenter, 1970:110).

The failure of imprisonment

Why doesn't prison work? For one thing, prison staff - like police, magistrates, and social workers - are not particularly knowledgeable about the issues involved or about the

resources available to them. That particular problem could of course be addressed by improved training and, indeed, some prisons have already established addiction units dealing with the problems of drink and drugs. But is it realistic to expect that the prison service could provide facilities that would address the needs of prisoners, bearing in mind the short-term nature of most drink related sentences? Most sentences in default of fine, for example, are of 14 days or less. In 1985, for example, the average sentence was only 19 days (ADSW, 1987). In that space of time no agency could hope to do more than a 'drying out' exercise. Useful as that may be for the short term health of the prisoner, prison cannot be defined as 'treatment' in any real sense of the word. Detoxification is not the problem. It is relatively easy to achieve sobriety and it certainly does not require (nor does it benefit from) a prison environment. The real challenge is in staying sober or staying in control of one's drinking, either goal, by definition, requires some longer term input.

The question is not really about whether or not imprisonment *is* helpful, rather whether or not it *can* be helpful? The principal objection to imprisonment for drunkenness is not that it does little or nothing to tackle the problem, but that it is actually counter-productive. Imprisonment increases the likelihood that offenders will re-offend, that they will become trapped in the 'revolving door' of arrest, followed by court appearance, followed by prison in default of fine. Release from prison and resumed drunkenness leads back to custody and to prison often within days. And so the 'revolving door' continues to turn (Pittman and Gordon, 1958). Each time a person goes round the circuit of drunkenness, arrest and imprisonment - each time s/he "does the loop" to use the argot of Skid Row, USA (Wiseman, 1970) - his/her chances of breaking free are reduced still further.

Those trapped in the 'revolving door' can become dependent upon the system. They become progressively institutionalised. For those who find life on the 'outside' intolerable, the relative security of the prison offers a brief respite and a sense of belonging, or at least of familiarity. In prison at least they 'know the score' and prison officers come to regard

some of their 'regulars' with the same paternalistic concern as was noted earlier in relation to police interactions with this 'down and out' population. However, their is a high price to be paid for 'weathering the storm' in this particular port. Prison is an alienating and degrading experience. The more often the process is repeated, the more the ties which bind the individual to the larger society are weakened until, in the end, the alienation becomes routinized and the individual's self-perception is transformed. S/he is "alienated from himself and the rest of society as he is stripped of his former identity and labelled a bum" (Spradley, 1970:255).

The processing of drunken offenders through the institutions of the criminal justice system has been likened to a 'rite de passage' which, while removing the offender from society and transforming their self-perception, fails to address many of the problems which prisoners must face upon release. Only rarely does the system allow for the 'delabeling' of individuals and their readmission to the world 'outside':

> Prison made us children again and, when our term was ended, let us loose into an adult world.
>
> (Turner, 1964:8)

What should be done?

How can the institution of the "adult world" - the medical, legal and social welfare institutions that have been discussed in this thesis - meet the needs of these "children"? Questions about what should be done about alcohol problems produced a range of suggestions. The most common answers are shown in Table 10.1.

The responses reflected a strong level of support for health education initiatives and for a greater degree of resources to be allocated to tackling the alcohol problem. On the other hand, they also reveal a marked difference between social workers and all the other agents on the issue of licensing restrictions. Only 12 per cent of social workers suggested such increased restrictions, as against 35 per cent of criminal justice staff and almost half of

the police and the health care agents who were interviewed. There was generally a much lower level of support for some of the other measures aimed at curbing consumption that have been proposed by groups such as the Royal College of Psychiatrists (1986). The idea that we, as a society, should place a ban on alcohol advertising or that we should increase the price of alcoholic drink, either directly or through increased taxation, received only limited support and most of that from the medical and health care professionals.

Table 10.1 Suggested strategies for dealing with alcohol problems

(Percentage support for each strategy, by agency)*

	Police %	Criminal Justice %	Social Workers %	Medical/ Health Care %
Health education to help change attitudes	29	40	42	60
More resources to tackle the problem	19	25	36	66
Restrictions on licenses/availability	49	35	12	47
Increase in price and/or taxation	5	10	3	40
Ban on advertising	12	5	3	27
More responsible attitude by the drink trade	7	15	14	20
Total	N=132	N=20	N=104	N=15

* Most respondents suggested more than one strategy and, therefore, the percentage totals are greater than 100.

Support for designated places

There was a general acceptance between and across all groups interviewed that the extant legalistic response was both inappropriate and ineffective. The criminal justice system does not help individuals whose problems are manifested as drunkenness. It was never designed to help and, despite the now almost routine articulation of a therapeutic (as opposed to punitive) ideology (Dobash *et al*, 1986), there does not seem to be much scope for reforming the system except by diverting people from formal processing at as early a stage as is possible.

But diversion to what? For those within the criminal justice system the answer seemed obvious enough. The problem is a medical and/or social one and, therefore, the appropriate agencies to deal with it are the so-called caring professions - G.P.'s and other medical experts, social workers, and self-help groups such as Alcoholics Anonymous. The comments of one police sergeant reflect an uncertainty with the legitimacy of the police role coupled with a belief in the appropriateness of therapeutic intervention that was characteristic of criminal justice personnel:

> What these people, these habitual drunks or whatever, what they need is some sort of treatment. But we're not involved in treatment. We're not equipped for it. You've seen our cells and there's no way they can be described as a medical facility. It would be better if some other body was to be responsible for transporting and caring for these people ... if we could go up to some agency and say 'he's all yours', then we'd save on paper work, on police time, courts and all the rest. And the man would get the kind of help he needs.

This preference for therapeutic intervention was also evident in the response of criminal justice personnel to questions about advice and onward referral. Three-quarters of those interviewed claimed to have advised a drunken offender to seek help at one time or another. The vast majority had recommended that the person see their G.P. in the first instance. Alcoholics Anonymous was also considered appropriate, but there was little support for alternative ports of call such as the social work department (see, Table 8.2. p.201), a fact

which perhaps reflects the general ignorance of the range of options available in a given area. Interestingly, although G.P.'s were seen as the most appropriate source of help, there was no real feeling that they would (or could) prove helpful. Doctors themselves, it must be said, are often equally pessimistic about their ability to tackle alcohol problems (Strong, 1980). The vast majority of those interviewed felt that diversion from criminal justice processing was both a useful and desirable goal. A variety of diversion schemes are already operating, on a more or less ad hoc basis and with varying degrees of success, throughout the country. For most of those interviewed, however, diversion was most readily identified with the 'designated places' provision in the Criminal Justice (Scotland) Act 1980.[6]

Support for such 'designated places' was high in all groups with 90 per cent of social workers and 74 per cent of the criminal justice sample expressing themselves positively on the issue.[7] Although there was this general level of support for the idea of 'designated places',there was some difference of emphasis between groups on the question of why such places would be helpful. The criminal justice respondents tended to stress the benefits of the 'designated place' as an alternative to the existing system of control which was perceived to be wasteful of criminal justice resources, in that it diverted the attention of the police and the courts from more serious crime. Support for Section 5, however, was not simply a matter of self-interest. In fact, 1 in 4 of those interviewed stressed the importance of the 'designated place' as a potential locus of treatment/social work intervention, a view not surprisingly shared by most social workers.

What was surprising was the level of agreement within and across agencies about the nature of the client group(s) that might usefully be referred to this network of support. The stereotypical offender - the homeless, down and out drunk - was *not* considered a suitable case for treatment. It was perhaps a reflection of their desire to see the 'designated places' alternative succeed that the most intractable elements of the problem population those perceived to have a poor prognosis, were defined as unsuitable for diversion. The following

responses, from a magistrate and a police officer, are typical of the pessimism that was expressed in relation to this particular group:

> The [District] court has tried to get something going with the local council [on alcoholism], but they're not really wanting to take on this type of man. The habitual drunken offender is just not a very promising case.
>
> I wonder about the effectiveness of taking 'winos' up there [to Albyn House]. You take someone up there and (say) he was in this afternoon or something like that, that gets up your nose a bit ... I mean when you're speaking of 'winos' ... they live in a pattern which is not going to change.

Keeping drunkenness offenders out of court

In 1977 a committee was set up under the chairmanship of a court of session judge and former Solicitor General, Lord Stewart:

> To consider the effect on the criminal courts and the prosecution system of the volume of minor offences dealt with by summary prosecution and whether some other process might be devised to deal with such offences, while maintaining essential safeguards for accused persons.

Least there should be any misunderstanding about the motives underlying this inquiry the second and final Report of the Committee, submitted to Parliament in July 1984, makes things very clear.[8] The Report outlined concern about the steady growth in offences made known to the police and subsequently processed through the courts. It highlighted the increasingly varied 'social purposes' that are supposedly served by criminal justice processing. Most importantly, the Report argued that in the absence of more resources with which to meet these 'social purposes', less expensive responses to minor criminality should be pursued.

The move away from formal prosecution, therefore, is informed (directed) by the perceived need to alleviate increasing pressure on the system. Where alcohol related offences are concerned, both informal and formal mechanisms exist which allow for alternative means of dealing with the offender outside the court system. A number of

different schemes are currently being discussed or are in operation that could be defined as being essentially diversionary in that they favour "halting or suspending proceedings against a person who has violated (the criminal law) in favour of processing through a non-criminal disposition" (National Commission for Criminal Justice Standards and Goals, 1973:50). The various schemes differ in the precise details of their operation, but in broad terms they fall into one of three categories of diversion - primary, secondary, or tertiary diversion.

Primary diversion

Primary diversion involves the operation of measures to halt criminal justice processing before a decision to prosecute is taken and, in some cases, even before the matter is referred to the procurator fiscal. The use of designated places, for example, in most cases serves to halt prosecution before any charges are preferred.

The first and to date the only 'designated place'[9] in Scotland was opened, at Albyn House in Aberdeen, on 12 September 1983. The criteria for diversion were set out in guidelines issued by the Scottish Office (see, Appendix II) and the interpretation of the guidelines in General Orders issued to officers of Grampian Police laid down the ground rules for the operation of the Aberdeen project. What this means in practice is that, except in 'exceptional circumstances', the designated place is considered to be the appropriate destination for drunken offenders in the city of Aberdeen and, after 1985, in some of its outlying areas. In the first two and a half years of its operation, Albyn House has accepted almost 1400 referrals and court appearances for drunk and incapable have fallen to less than 10 per year (Lloyd and Taylor, 1986).

Assuming the drunken offender fits all the requirements and is admitted to the designated place, what sort of institution have they been admitted to? The idea of the designated place, as it is viewed by its proponents, is to offer drink related offenders an

integrated and comprehensive range of services. In line with this thinking, Albyn House itself offers sobering-up facilities in a four bed reception area (the designated place proper).

The upper floor of the house is a support hostel, offering detoxification, support and accommodation for up to 13 residents. On their leaving the support hostel, residents are also offered continuing support on 'aftercare'. Within this 'supportive environment' the staff of Albyn House pursue the aims of the association which are:

(i) to decriminalise the drunkenness offender

(ii) to dry them out in a more humane environment

(iii) to rehabilitate the drunken offender

On the basis of existing research one might be forgiven for wondering whether or not such goals are realistic. There are some fairly obvious difficulties. What are the criteria by which rehabilitation is to be judged, for example, or how can the effects of other variables such as improved accommodation or aftercare be controlled for? Existing research in the area, though illuminating in many ways, is often ambiguous, even contradictory when it comes to answering such questions. Studies in North America and in Britain have provided findings which perhaps suggest that, at best, the rehabilitative aspects of the designated place should not be stressed to strongly (Nimmer, 1974; Hamilton, 1979; Annis and Liban, 1980). Lloyd and Alan draw much the same conclusion from their evaluation of Albyn House:

> Our conclusion regarding rehabilitation must be that the designated place on its own does not or cannot have any demonstrable rehabilitative effects. As an alternative to police arrest and detention it offers a greatly enhanced experience of recovery from drunkenness. For the hostel ... this again provides an enhancement of quality of life and dignity of treatment. As a rehabilitation centre it is unproven.
>
> (Lloyd and Taylor, 1986:105)

On decriminalisation Lloyd and Taylor are more optimistic. They acknowledge the problems of selective enforcement by the police and the courts, the net widening nature of the exercise and so on, that have been identified in other studies of decriminalisation (Nimmer, 1974; Annis and Smart, 1978; Daggett and Rolde 1980; Shaw *et al*, 1982). Nevertheless,

they believe that, thanks to the positive cooperation of the police, Albyn House has succeeded in meeting the first of its stated aims. Decriminalisation, however, if it is to mean anything must have some basis in law. It cannot be left to the vagaries of 'local arrangements'.

What the Aberdeen project has developed is a scheme for diverting offenders from the criminal justice system. In doing so, it has capitalised on a climate of opinion within the criminal justice system and the socio-medical professions (and, perhaps, in society generally) that is broadly sympathetic to the idea that simple drunkenness should not be regarded as a crime. But operating for the moment *as if* being drunk and incapable were no longer an offence does not take that offence off the statute books. The essence of decriminalisation is that it places the behaviour in question entirely outwith the ambit of the criminal justice system and to do that requires positive action by government. The reluctance of governments to face up to this fact would seem to question the strength of the official commitment to tackling alcohol problems.

The concept of the designated place has been widely welcomed and to a very great extent the stated aims of the politicians and the policy makers have been taken at face value. The Act was seen by many people as a positive expression of the Government's commitment to the notion of therapeutic intervention and as an 'initial step' towards the eventual decriminalisation of drunkenness offences (SWSG, 1982). The seriousness of that intention can be assessed by the level of official support for building a network of such places, since logically the police cannot invoke the provisions of Section 5 unless and until a designated place is available in their area. There are plans in hand for two further designated places - one in Dundee, the other in Inverness - but no places have so far been designated in the Clydeside conurbation, where the population - and many would argue the need - is greatest.[10]

At the end of the day, however, it seems unlikely that the provision of designated places will ever develop to the point where they become the normal mode of primary diversion. Reservations about the cost effectiveness of 'detoxification centres' over other forms of primary diversion and the need to locate such centres within easy reach of a sizeable problem population might well serve to limit the spread of the provision to the major cities Glasgow, Edinburgh, Dundee, Inverness and, of course, Aberdeen. In such circumstances *de jure* decriminalisation could not be regarded as a satisfactory response and other forms of diversion would continue within the framework of the criminal justice system.

Initiatives such as that developed in Ayr, which involve cooperation between fiscals and social work or health care agencies provide another means of primary diversion. The aim of such schemes is to provide help rather than prosecute those accused of minor offences, especially where the offence seemed to be related to personal and/or family difficulties. Although they might appear to be obvious candidates for such a scheme, drunken offenders did not prove particularly amenable to diversion at least not in the early stages of the project. As the fiscal responsible for the setting up the Ayr scheme frankly acknowledged:

> In the sort of pilot scheme they (drunks) got a warning and that was it finished. We would send out letters to people warning them and telling them they could get help from the council (on alcoholism) and there was a leaflet. I forget the exact phrasing, but we used some innocuous phrase. Not one turned up! ... [W]e then realised that we were aiming more at the 'skid row' types, so we raised our sights a bit and tried to be more selective and, hopefully, more successful.

The letters and the selection process have become more formalised and the range of referral agencies has been widened to include not only social work departments but also local councils on alcoholism and specialist medical facilities. The operation of these schemes, however, continues on the same general lines as the Ayr 'pilot'. The success of such schemes has yet to be fully evaluated.[11]

Secondary diversion

Secondary diversion takes the offender into court, but they are then assessed for some form of diversion programme *prior to sentencing*. A number of courts in Scotland call upon the services of a range of statutory and voluntary agencies to help them decide on the appropriate disposition over a range of alcohol related offences.

The operation of secondary diversion is reasonably straightforward. The accused appears in court - the District court if a simple drunkenness offence is alleged, or in the Sheriff court if the charge is more serious. If it is felt that some form of 'treatment' might be appropriate, the court will call for a report(s) on the offender's suitability. Where the offender agrees to this, sentence is deferred for a short time (2 to 4 weeks appeared to be the norm) for an assessment to be carried out and a report prepared for the court. If the report suggests that help with a drink problem would be appropriate and that the offender is willing to accept this help, sentence would again be deferred this time for a period of between 3 to 12 months and at the end of that time a further report would be submitted to the court. A favourable report would then lead to the offender being admonished. At present this form of diversion is being initiated on an ad hoc basis in individual jurisdictions and it is, therefore, difficult to say very much about how widespread the practice is, or how effective.

Most of the sheriffs and magistrates I interviewed had made some, albeit limited, use of secondary diversion. Interviews with other interested parties, however, did tend to suggest that this experience was far from the norm. Success is again difficult to assess, particularly since the range of agencies involved may have very different ideas as to what constitutes a successful outcome. The experience of individual courts can be very different. David Tate's report of a diversion programme being operated by Dumbarton District court and the Local Council on Alcoholism claimed that:

> [A] total of 50% of all persons assessed (during 1982-83), maintained satisfactory progress during a period of 12 months without re-offending and were subsequently admonished. Excluding those subjects who were either not offered or would not accept further support, the report indicates that 83% of all those who agreed to accept an offer of on-going support maintained satisfactory progress as defined above.
> (Tate, 1985:39)

Not everyone is so optimistic. The senior magistrate I qouted earlier (p.259) to was fairly typical in that he supported diversion in principle, but felt that there were overwhelming practical difficulties. From his comments, and from those of others I interviewed, it seemed that the problem lay in the perceived disparity that existed between the habitual offender he dealt with in court and the sort of client that the local agencies seemed prepared to accept:

Tertiary Diversion

The final diversionary option available within the criminal justice system is strictly speaking not diversion at all, since it neither halts nor suspends criminal proceedings. Tertiary diversion requires that the offenders pass through all the stages of the process from arrest to conviction. Only then are alternative measures introduced. At present formalised post-sentence schemes are operating in just two Scottish Regions one scheme in Tayside, in the Angus Sheriff court area, and two others in the Cumbernauld and Monklands Districts of Strathclyde Region.

The limits of diversion

It is clear from the research that there was considerable enthusiasm for diversion. The police would welcome any scheme which could offer an alternative means of dealing with "your average D+I (drunk and incapable)" - "most of them are harmless individuals, but you can waste so much bloody time on them". This is reflected in the views expressed by other criminal justice personnel and by those in social service agencies, most of whom would agree that:

> ... the time has now come for a radical look at the way in which society deals with a host of minor offences so that the criminal courts would be retained to deal only with matters which the man in the street regards as criminal.
>
> (Justices' Clerks' Society, 1981:766)

The attractiveness of diversion, however, should not blind us to the difficulties inherent in all of these proposals. And it is not simply a matter of practicality. Certainly, there are practical difficulties to be overcome. There is the question of resources that has already been touched on in relation to the designated places provision. There are also considerable difficulties to be overcome in creating closer cooperation across (and often within) a variety of agencies which have very different functions some of which cannot be easily reconciled. Formal diversion schemes which would involve social work intervention in the context of prosecution decision making, for example, might be perceived as a threat to the autonomy of the fiscal and/or the courts. At a more mundane level there is straightforward professional rivalry and ignorance to overcome:

> You know the old joke about the policeman, "there's never one there when you want one?" That's social workers. They're unable to assist when required ... in the wee small hours. But if it suits them they come out at a minute's notice.

Given the level of support for diversion, we might reasonably suppose that these problems can be overcome, or at least sufficiently ameliorated as to make the system workable. There are, however, more fundamental issues to be raised; issues which challenge the legitimacy and the desirability of the diversion option.

A small number of respondents, for the most part members of the criminal justice fraternity, expressed concern about the legitimacy of primary diversion in particular. It was seen somehow as 'justice operating by the back door' and, therefore, as an initiative that had the potential to undermine 'due process'. The important point seems to be that, whereas a decision by the fiscal to 'no pro' a case effectively ends the accused involvement with the criminal justice system, diversion usually involves referral to another agency. This can have

important implications for all parties, not least for the accused person, and therefore the legal status of diversion needs to be clarified. As Zander and Rose point out:

> ... diversion prior to conviction does require an answer to the question whether some formal or informal admission of guilt would be required as a condition of taking part in the diversion programme.
>
> (NACRO, 1975:14)

Certainly, no formal admission of guilt is required as a condition of admission to Albyn House or for consideration for diversion by the fiscal. In both instances, however, it can be argued that there is necessarily an informal acknowledgement of guilt. The counter argument - that the individual has a choice whether or not to accept diversion - touches on an issue which many feel lies at the heart of the debate about alternatives to traditional criminal justice handling of drink related offences, the issue of involuntary treatment. The legislation which permitted the establishment of designated places and detoxification centres makes no mention of compulsory detention, far less treatment. The voluntaristic nature of the provision is highlighted in the SWSG guidelines which recognise that:

> (S)uccess in persuading a person to stay for some time and in motivating them to cooperate in longer term measures for their care and treatment, will depend mainly on staff attitudes, relationships and practices.
>
> (SWSG, 1982:2)

Ironically, this lack of compulsory powers has proved to be one of the main criticisms of detoxification programmes. Take, as an example, the attitude of police officers towards the introduction of 'designated places'. Although the great majority welcomed the idea of a facility which could offer them a quick, easy, and safe end to encounters with drunken offenders, it would be an oversimplification to interpret this as support for voluntary treatment. If the futility of the 'revolving door' was one theme of my interviews with police officers, the need for some degree of coercion in the treatment regime was often another. Without coercion, it was argued, 'designated places' are simply a soft option - "a sure-fire way of not getting up into the cells". The experience of some of their English colleagues

who had been operating a diversion programme for almost a decade could only serve to reinforce their faith in coercion.

> Detox? Its just a waste of time ... I'm just a bloody taxi service, taking them [the drunks] up there [to the detox centre] so they can get their heads down for the afternoon ... The only way round that would be to make it compulsory for them to stay there.
>
> (Police Interview, Leeds, April 1982)

Police officers, of course, are not alone in identifying as problematic the low take-up of detoxification services. As most studies of detoxification confirm, few clients take up offers of continued support on a voluntary basis. At Albyn House, for example, only about one referral in six continued on to the support hostel. Another frequent criticism of detoxification centres is that their clients often end up back on the street much quicker than they would under criminal justice procedures (Room, 1976; Finn, 1985). For some the 'revolving door' becomes a 'spinning door'. Almost ten per cent left Albyn House within the first two hours, the shortest stay was only 15 mins. The majority, however, spent a little more time at the centre, the average length of stay being just over nine hours (Lloyd and Taylor, 1986:49). In suggesting that the legislation could be (or should be) amended to allow for compulsory detention, many people overlook the fact that diversion programmes do not operate entirely within the ambit of the criminal justice system. Diversion, whatever form it takes, is not simply diversion from the criminal justice process, but implies referral to a variety of outside agencies. Diversion contributes to an expanding criminal justice treatment nexus and in doing so involves agencies for whom the notion of coercive treatment runs counter to their stated humanitarian and/or professional ideology.

Coercive therapy versus constructive confrontation

Introducing an element of coercion into treatment programmes, while it might address the concerns of the criminal justice world and make them less likely to subvert the

implementation of the policy, can be seen to be in conflict with the traditional values of a therapeutic model which places a premium on volition and trust. There is presumed to be 'therapeutic alliance' between the carer and his/her client. "To the extent that coercion is introduced to get client and therapist together," as when the client is referred by the court, "that trust, that 'alliance' for a common objective is destroyed" (Dunham and Mauss, 1982:7). Not everyone would agree with Dunham and Mauss that the advocacy of coercive treatment is detrimental to the clients interest or contrary to the attainment of desirable therapeutic goals. Indeed there are many in social work and in the voluntary agencies who would not recognise the parameters of the debate. They have either not taken on board the changing nature of the relationship between criminal justice system and the caring agencies, or they have failed to grasp the possible implications of such changes. Others recognise the drift towards compulsory treatment but argue in support of such arrangements. Coercive treatment, it is argued, can be a useful 'therapeutic tool'. It can accelerate the process of 'breaking through denial' and help problem drinkers come to acknowledge that they have a problem (Robertson and Heather, 1981:35).

What supporters of 'constructive confrontation' fail to point out of course is that there is very little evidence to indicate there is any treatment which offers a good chance of curing the patient. Certainly there is no reason to believe that coercion or 'constructive confrontation' is any more effective in dealing with the problem drinker than voluntary treatment (Fagan and Fagan, 1982). Szasz, perhaps the most strident critic of compulsory intervention, has gone so far as to suggest that involuntary treatment, even though it may be medically correct, should be an offence punishable by law (Szasz, 1963:185). Concern about the growing acceptance of legal coercion and the difficulties it raises vis-a-vis informed consent, has also provoked considerable debate among sociologists (Roman and Trice, 1967; Roman, 1980; Room 1980).

The kind of project that was recently tried in a London Magistrates court is fairly typical of the sorts of schemes that have been proposed. This particular project involved selected offenders in a programme of therapy which involved taking Antabuse under supervision as a condition of a probation order. The (implied) alternative was to be sent to prison. Marco and Marco (1980), describing a similar Antabuse programme in the United States, discuss some of the implications for the freedom of the individual. They conclude that the theoretical presumption of choice is questionable and that, since consent to treatment is given under some duress, the treatment itself is involuntary and violates the constitutional right to privacy and which may constitute cruel and unusual punishment. For Marco and Marco, the choice between a drug programme and prison is in reality no choice at all. The offender being offered 'limited freedom' on condition that s/he participate in an Antabuse programme is presented with a dilemma:

> (T)he defendant either must subject his or her body to a daily dose of a toxic chemical for one year or go to jail. Incarceration means loss of employment and income, loss of contact with family and friends, loss of social status, and, most important, loss of personal liberty and the freedom of movement. Though the defendant may not fully realise, or even have heard of, the risks associated with Antabuse,[12] it is a rare defendant who would not submit to Antabuse to avoid jail.
>
> (Marco and Marco, 1980:318-19)

The Antabuse programmes, it might be argued, are at the extreme end of the coercive treatment continuum - not all diversion schemes conjure up quite so vividly the image of 'moral treatment' that was so much a part of the nineteenth century response to the problem. At the other end of the continuum there is the possibility of informal coercion from others, in most cases family members, in which case it becomes very difficult to draw a distinction between voluntary and involuntary treatment. Indeed, some agencies actively counsel family members to adopt a coercive posture to distance themselves emotionally from the problem drinker and to engage in 'constructive confrontation'; to let the drinker know s/he has a problem rather than adopt more 'negative coping strategies' (Seixas, 1980;

Meyer, 1982). However, to suggest that the coercion exercised within families is on a par with, or can somehow be used to justify, the more formalised exercise of coercion within the social control arena, fails to understand the central point of the debate which has to do with attempts to present what is in reality coercion in the rhetoric of therapy and choice.

In a similar vein, the fact that we are all of us subject to constraint and coercion as a matter of course does not mean that we should not discuss the limits of coercion. The problem is a complex one and the limits of acceptable behaviour cannot be clearly drawn, but the question must be raised nevertheless. The point is clearly made by Wiener in her discussion of *The Politics of Alcoholism*:

> It is a legal axiom that protective privilege ends where the public peril begins, so that programs addressed to convicted drunken drivers cannot be equated with community outreach (early case finding) programs. Although even here the lines are not so clear, for presumably the "early case" is a potential drunken driver. Obviously, the presence of any authority throws a moral-ethical blanket over the "deviant".
>
> (Wiener, 1981:107)

Diverting offenders from the criminal justice system to the caring agencies spreads the "moral-ethical blanket" ever wider. This net-widening process brings into the treatment arena many people who might never have sought 'help' voluntarily and some who might not even have needed it. No doubt it will be argued that the 'costs' which might be incurred by all concerned in the operation of diversion schemes will be more than offset by the benefits to be had from their introduction. And, it has to be said that the general introduction of diversion schemes offers many attractive features. Diversion it seems has something for everyone. The problems of an overloaded court system and overcrowded prisons can be ameliorated, if not entirely resolved.[13] The police can have access to facilities which allow for a quick, easy, and satisfactory end to most police-public drunkenness encounters. For the various caring agencies that are involved in diversion schemes there is a ready-made pool of clients/patients, plus an opportunity to show that a therapeutic model can succeed where the

more traditional models of social control have failed. And what of the offenders? Well, recast as the client/patient, they have an opportunity to seek help or at least to avoid gaol.

A less attractive feature of some diversion schemes is the cost. In financial terms, the benefits of diversion are not as demonstrable as was at first assumed. One recent study concluded that, whereas "the wet centre and the cautioning system are more cost effective", detoxification centres and designated places (Albyn House) must be rejected as economic alternatives to criminal justice processing (Lloyd and Taylor, 1986; Kingsley and Mair, 1983). Despite reservations about the cost effectiveness of some projects, diversion enjoys considerable popularity and it seems likely that the interface between criminal justice and social work agencies will continue on these lines. This being the case, it is important that, in planning and implementing new initiatives, serious consideration should be given to *all* the issues involved.

Notes

1. A recent study of the prosecution system in Scotland found that where there was a choice of summary court, 94 percent of drunkenness offenses and 78 per cent of cases involving disorderly behaviour were referred to the district courts. However, certain categories of offence, for example breaches of the peace at football matches, are not sent to the district court because of an express direction by the Lord Advocate (the principal Law Officer) that they should be dealt with by the Sheriff Court (Moody and Tombs, 1982:154)

2. In Glasgow, where the District Court is presided over by a full-time stipendiary magistrate, the court has the same criminal jurisdiction and powers as a sheriff in summary procedure which can mean a fine of up to £1000 and/or a maximum of three (sometimes six) months imprisonment.

3. The procurator fiscal is the chief prosecutor in each Sheriff Court district and is independent of the police, being appointed by the Crown. He is usually assisted by one more procurators fiscal depute. The generic term 'fiscal' is commonly used to describe both procurators fiscal and their deputes.

4. When a fiscal considers reports of alleged offenses to decide if the accused person will be prosecuted and, if so, on what charge(s) and in which court, s/he is said to be 'marking'.

5. The point about the social isolation of fine defaulters, about their having no-one to 'buy them out' is well illustrated by the fact that less than one-third of those imprisoned for default are released without serving their full sentence, after payment of all or part of their fine.

6. Section 5 of the Act states that:

> Where a constable has power to arrest a person without a warrant for any offence and the constable has reasonable grounds for suspecting that person is drunk, the constable may, if he thinks fit, take him to any place designated by the Secretary of State for the purposes of this section as a place suitable for the care of drunken persons.

Two points are worth noting. First, that this is permissive legislation, the police are *not* obliged to take the drunk to a designated place. Second, that the Act does not exempt the offender from the possibility of prosecution. In fact, however, it seems that charges are seldom if ever preferred.

7. Interestingly the generic social workers interviewed in the present study were much more optimistic about the proposals than the staff of specialising agencies who had been interviewed in the pilot study. In the latter case, less than half the sample (44%) felt that Section 5 was a step in the right direction.

8. The first Report of the Stewart Committee was issued in December 1980. This Report dealt exclusively with the possible extension of existing fixed penalty procedures to endorsable motoring offences, such as speeding and ignoring road signs. The recommendations contained in the Report make no reference to alcohol-related offences and need not detain us further.

9. In Scotland the term 'designated place' is preferred to the more commonly used epithet 'detoxification centre'. The conscious use of the term is intended as an expression of the non-medical philosophy of the designated place as distinct from the medical orientation implicit in the term detoxification centre. Unlike the English experience of detoxification centres during the 1970's (Arroyave *et al*, 1980; Shaw et al, 1982) an experience which informed many aspects of the Scottish legislation the S.W.S.G. guidelines did not advocate the employment of staff with a medical background or put any particular stress on medical or psychological treatment.

10. The stumbling block would seem to be the issue of funding. The capital costs of setting up a designated place have been put at between £100,000 and £200,000 with annual recurring costs of a similar magnitude (COSLA, 1982:18). An analysis of the actual costs of operating Albyn House put the figure at £347.10 per admission which place the running costs in the region of £150,000 to £200,000 per annum (Lloyd and Taylor, 1986:123). It is significant, therefore, that the Act makes no provision for the full implementation of Section 5. Indeed, the Government has made it clear that it sees the provision of services and facilities for problem drinkers as a matter for the local authorities and the health boards. Central government funding is only made available 'to get things off the ground' and not for long-term support. It was clear from the research interviews and discussions that this lack of long-term central government funding was seen as a brake on the development of other designated places schemes.

11. Sue Moody, a researcher with the Criminology Research Branch of the S.H.H.D. has produced a report on the diversion scheme at Ayr (Moody, 1983). This report provides a fuller description of the operation of the Ayr scheme and a limited evaluation of its first year of operation.

12. The generic name for the drug is disulfiram, Antabuse being the registered trademark of its manufacturers, Ayerst Laboratories. Despite claims made for the success of such drugs, questions have been raised about their continued use in alcohol treatment programmes, particularly in the light of reports about the dangers from drug-induced toxicity.

Antabuse's usefulness, and its dangers, is associated with its aversive properties. When the drug is taken prior to drinking alcohol, it provokes a strong aversive reaction. At low levels of alcohol consumption the effects are mildly unpleasant facial flushing, throbbing headache, shortness of breath and mild palpitations associated with an increase in heart rate and blood pressure. If drinking continues, however, the aversive effects become progressively worse until, at higher concentrations:

> Nausea and vomiting, shock, and loss of consciousness can occur ... and there have been reports of death due to myocardial infarction and intracranial haemorrhage.
>
> (Peachey and Naranjo, 1983:405)

13. Although, under the provisions of the Criminal Justice (Scotland) Act being drunk and incapable is not longer directly punishable by imprisonment, a considerable proportion of receptions into Scottish prisons continue to be drink related. In 1985, about half of those admitted to Scottish prisons under sentence were there in default of fine and in many cases the original fine had been imposed for an alcohol related offence (Association of Directors of Social Work, 1987). Clearly an alternative disposition that did not involve an unrealistic financial penalty would be welcomed by the Courts and the prison service.

11 The Future is a Serious Matter

And for the future (but I write this reeling,
Having got drunk exceedingly today,
So that I seem to stand upon the ceiling)
I say the future is a serious matter -
And so for God's sake Hock and soda water!

(Byron, *Don Juan*)

This thesis has emphasised the nature of perceptions, attitudes, and experiences, in relation to responses to alcohol misuse. No exploration such as this which looks at the nature of responses over time would be complete, however, without some discussion of the relationship between the historical tradition and those contemporary issues which seem likely to be influential in directing future developments. If, as has been suggested, Scottish society's use of alcohol is a "manifestation of deep-seated symbolic values which have grown and developed ... over hundreds of years" (Scottish Health Education Unit, 1977:4), it would be equally true to say that responses to the problems associated with the use of alcoholic drink have been informed by an enduring historical legacy.

Part One of the thesis examined the development of this historical legacy. Two factors emerged from this analysis that are important to the future development of policy and practice. Firstly, the definition of drunkenness as deviant is a subjective one. There are no moral absolutes involved here. The claim-making activities that resulted in the promotion of alcohol misuse as a social problem must be located in their historical and social context. That is equally true of the policies that were developed to respond to the problem. The policy options that were implemented in the nineteenth century and in the early part of this century had their ideological foundations in the new institutional forms of control, particulary the police and the legal system. The overall nature of this response was

restrictive and legalistic. It is, therefore, not too surprising that it should be seen to be inappropriate and ineffective in responding to the problems of the late twentieth century.

Secondly, there is the continuing question of the relationship between the therapeutic and the legalistic nexus. The example of the Inebriate Reformatories illustrated the importance of medical imagery (ideology) and practical intersection of the medical world and the legalistic network of control. Understanding this relationship has become more urgent as increasing emphasis is being put on the need to involve primary care agents such as social workers in the development of a comprehensive system for responding to alcohol problems. However, the historical legacy - embodying as it does an ideological tradition of punishment and moral reform - can (and does) inhibit fundamental changes in the way(s) in which the society responds to alcohol problems.

Not that changes have not taken place. Of course there have been changes. In varying degrees, local government departments, statutory and voluntary agencies, and professional associations, have all initiated proposals for a 'more effective' management of alcohol problems. The growth of medical interest in the issue, perhaps most succinctly captured in the notion of 'the disease model of alcoholism', has been of fundamental importance in directing and orchestrating this changing pattern of response. The response of central government has been more ambiguous and their concern about alcohol problem more difficult to assess. On the one hand, government-backed reports and publications such as the recent discussion paper on *Drinking Sensibly* (DHSS,1981), have been produced and legislation has been introduced which attempts to address at least some of the issues. These actions, however, have often been of a very limited nature and successive governments have been accused of prevarication and lack of interest as, for example, over the decision to suppress a 'think tank' report on *Alcohol Polices in the UK* (CPRS, 1979).

Part Two of the thesis examined the attitudes, perceptions and responses of those who effect the day-to-day implementation of contemporary policies relating to alcohol

misuse. The general picture would support the contention that, for all their differences, these groups acknowledge the limitations of traditional responses to the problem and, on the more positive side, that they share a belief in, and some degree of commitment to, the benefits of therapeutic intervention. In the Scottish context, however, it is important to recognise that the 'success' of therapeutic models in transforming the discourse and, therefore, the production of knowledge about alcohol problems has *not* resulted in the wholesale divestment of the criminal justice process. There has been no clear break with the historical legacy of moral and punative control. The transfer of responsibility to the caring professionals - doctors, psychiatrists, psychologists, and social workers - has *not* meant the removal of penal sanctions nor has it loosened the strictures of social control.

For those who like to see the history of definitions of alcohol problems as a progression from moral weakness, to crime and, latterly, to disease or illness - as a journey in search of rationality and/or greater humanitarianism - the question may be about the *process* by which the 'drunk' became positively (re)defined as the 'alcoholic'? This thesis has also been concerned with the changing nature of the discourse, but I would reject the notion that with the discovery of the 'alcoholic', the moral and social control aspects of the discourse have been expunged. The Kirk, the criminal justice authorities, and the socio-medical institutions represent, in different institutional forms, alternative strategies for obtaining the same social goal - the elimination of a social condition that is *perceived by them* to be undesirable.

In this final chapter I do not intend to make *detailed* recommendations concerning the future development of policy and practice. That task is more properly the responsibility of the agencies and the policy makers most directly involved. What I can do, however, is to help inform the discussion of policy and, with this in mind, this chapter will focus on the one aspect of the response - the provision of training and resources - that seemed to me to be increasingly important given the current emphasis on inter-agency cooperation.

Training and knowledge of alcohol related services

Two factors need to be addressed. First, how well informed about alcohol problems are the people who are responsible for dealing with them on a routine basis? Second, what do they know about the services and facilities that are available to deal with the problems in their area?

The most straightforward way to deal with the first of these questions was simply to ask respondents about any training they have had which dealt specifically with alcohol problems. Although, the range of opportunities to learn about alcohol problems has been expanded quite considerably in recent years, this is not reflected too well in the sorts of experiences the various respondents have had of alcohol education both in their professional training and in their subsequent career development. Table 11.1 outlines the various context in which respondents might have been exposed to information about working with alcohol problems. These were basically of four types:

(i) Courses, seminars and summer schools organised by specialist groups such as the Scottish Council on Alcoholism.

(ii) Post qualifying Diploma and certificate courses in alcohol studies offered by the Alcohol Studies Centre at Paisley College.

(iii) In-service training courses organised either by the agencies themselves, or in collaboration with one of the specialist groups.

(iv) Opportunities for learning about alcohol problems as part of a professional training course such as the Certificate of Qualification in Social Work (CQSW).

Almost half of the social workers interviewed (49%) had had some opportunity to learn about alcohol problems, whereas for both police and other criminal justice agents the proportion was nearer one-third.[1] Yet even amongst social workers there was a strong feeling that the training on alcohol related problems was inadequate - almost two thirds (64%) of qualified social workers opined that coverage of alcohol problems on professional

courses was so minimal as to be effectively non-existent. It did not leave them feeling confident in their ability to work effectively with clients who had alcohol problems.

Table 11.1 Experience of alcohol education

Type of Course	Police %	Criminal Justice %	Social Workers %	Medical/ Health Care %
Alcohol 'schools'	6	10	25	40
Professional Training	10	5	46	80
In-service Training	32	38	32	13
Paisley Course	-	-	12	7
None	69	62	39	13
Total*	N=160	N=21	N=111	N=15

* Some respondents had had more than one experience of alcohol education and, therefore, the percentage totals are greater than 100 percent'

A recent survey by the Scottish Council on Alcohol suggests that the situation is being improved and that 'some priority' is now being given to alcohol education on social work courses (Scottish Council on Alcoholism, 1984). Some social work departments are making efforts to utilise existing expertise by developing in-service training, running seminars and encouraging the formation of special interest groups. Whether or not these initiatives were perceived to be addressing information needs was far from clear. Certainly, some social workers, while they were conscious of training needs, were sceptical about their agencies ability to 'deliver the goods' as one local authority social worker made clear:

> Yes, we need in-service training especially about resources. But the information just doesn't filter down. The region sends these people off to Paisley (college), or wherever, and I suppose they're to do the training, run the courses or whatever. But where are they? In headquarters? I don't know. I've certainly never seen them down here.

Does it really matter that so many of those involved in the management of alcohol problems have little or no formal education on the subject? From the discussion of attitudes and experiences it might be assumed that response strategies can be learned, and indeed are learned, 'on the job' from colleagues and supervisors. The important question, however, must be about what is learned and about the implications of this in terms of policy implementation. The effect of occupational culture, defined as a set of attitudes and beliefs and related practice that orient a group's perception of the nature of their work, has been widely discussed in relation to policing. Numerous studies have argued not only that such a culture exists, but that it supports a police personality that is cynical, authoritarian and antagonistic towards the public, while fostering a group 'morality' which involves secrecy and solidarity against superiors and public alike (Colman and Gorman, 1982; Skolnick, 1975; Westley, 1970). The impact of a social work occupational culture on policy in practice has received little or no attention by comparison, though it might well be important.

Conceptualisation of problem drinking - conceptualisations involving attitudes to and experiences of dealing with alcohol problems as well as an understanding of the nature of the problem - are obviously translated into different response practices. We have already seen how virtually every respondent stressed the need for specialist services and facilities to which those with alcohol problems could be referred. But how aware are they of resources already available within the local area? The answer to this question might provide an indicator not only of group's perception of appropriate referral agencies, but also of their willingness to utilise such services now and in the future.

Knowledge of services and facilities

Alcohol, or rather the problems caused by the misuse of alcohol, play a very significant part in the work of the legal and social welfare services. For the uniformed police officer and the basic grade social worker in particular, confronting problems in which alcohol is a major component is a familiar routine. These groups, however, are not the only agencies involved with problems drinkers, nor are they necessarily the most important point of referral. A wide range of voluntary groups and organisations contribute to the management of alcohol problems. As one social work manager observed:

> For a variety of reasons, and not necessarily for good reasons, much of the support and much of the constructive work with these (alcohol abusing) clients has been left to the voluntary agencies.

Social workers of course are not alone in their reliance on the voluntary sector as a source of therapeutic and supportive activities. Initiatives by local sheriffs, magistrates, procurators fiscal, and police have also involved non-statutory agencies at various levels. But how knowledgeable is the average police officer or social worker about the local services and facilities for problem drinkers?

Respondents were asked about local agencies and about whether or not they would recommend a particular agency if they were approached by someone seeking help with a drink problem. Table 11.2 gives an overview of their responses and indicates a quite dramatic divergence of opinion about the appropriateness of some referrals.

Table 11.2 Recommendations appropriate to those seeking help with an alcohol problem

Type of Course	Police %	Criminal Justice %	Social Workers %	Medical/ Health Care %
Alcoholics Anonymous	79	91	93	97
General Practitioner	86	67	44	55
Specialised Alcohol Treatment Unit	37	76	75	56
Social Work Unit	20	67	80	81
Local Council on Alcoholism	20	71	71	81
Psychiatric Hospital	10	10	29	28
Minister of Religion	8	33	9	33

* Most respondents offered more than one appropriate agency and, therefore, the percentage totals are greater than 100.

As might be expected, given our knowledge of actual referral patterns in social work (Table 8.4, p. 208), Alcoholics Anonymous was strongly favoured as a point of onward referral by all groups. Those who were aware of their existence, were also in favour of recommending support groups such as Al-Anon and Al-Ateen to members of the problem drinker's family. Even those respondents who expressed serious scepticism about the usefulness of the 'disease model of alcoholism' - a notion that is central to the philosophy of A.A. - were prepared to take a pragmatic approach in relation to A.A. For social workers in particular, A.A. was often seen as a useful 'starting point':

> In my opinion alcoholism is not a disease and I don't believe that A.A. is for everyone. But specialist support is important. A.A. might not be right for every client, but it's a starting point and I certainly would support a client who thought he might benefit from A.A.

The preference for Alcoholics Anonymous seemed to have as much to do with the 'visibility' of the organisation as its perceived usefulness. A.A. was clearly the best known and most easily accessible of the organisations working with alcohol problems. It was not unusual for at least one member of A.A. in the local community to be known to a respondent. Apart from the police, 18 per cent of whom did not know if there was an A.A. branch in their area, all those interviewed claimed to be aware of the existence of a group, although not all could to be said to be as knowledgeable about where the group met, or indeed what it did. The following comment from a police constable provides a fairly typical example:

> There is a branch of Alcoholics Anonymous locally, which I don't know a great deal about. The man we [the police] know is an ex-alcoholic, John. You only ever seem to know one man. I suppose they want to keep their identity as secret as possible Anyway, we have quite a lot of contact with John we have a telephone number for him and you get a number of people who have been in his care calling for him again.

In contrast, the level of knowledge about other specialising agencies was very much lower. More than half (59%) of the police officers interviewed did not know if there was a Local Council on Alcoholism in the area. Although social workers were better informed, one in five did not know of the LCA's existence. The general level of knowledge of the local availability of alcohol treatment units (ATU's) was equally low, with 37 per cent of the police and 23 per cent of the social work sample unable to say whether or not such a unit was available locally. Generally speaking, detailed knowledge about the resources available locally seemed to be limited to those with a particular interest in the problem. Few respondents had any clear understanding about what the various organisations did, or could do, to help the problem drinker.

This goes some way to explaining the differences between the two major groups - police and social workers - over the appropriateness of referral to a G.P. For many police officers, 'helping alcoholics was not part of the job'. They did not expect to know about

local services and facilities in any detail and, though they did not necessarily see 'drunkenness' as a medical problem, most felt that the family doctor was in the best position to direct the individual to the most appropriate agency. Social workers, on the other hand - perhaps because they were more aware of the limitations of medical treatment, or of the medical professions dislike of working with alcohol problems - were less inclined to see doctors as a helpful source for referral.

Overall, knowledge about alcohol problems and about the services and facilities available for addressing these problems tended to be general rather than specific. The vast majority of both the social work sample (96%) and the criminal justice sample (79%) felt that education on alcohol problems should be an important part of training. Those who had more experience of, or a particular interest in the problem tended also to stress the need for in-service training. There was also a fairly general feeling that in order to be effective, the response to drinking problems would have to become more broadly based, developing and encouraging communication and support between agencies.

The research findings suggest that, at present, contact between the agencies - between police officers and social work practitioners, for example, - is fairly limited. Excepting their formal involvement with the criminal justice system (usually in relation to the courts), most respondents seemed to be poorly informed about how agencies other than their own operated. The climate of relations between the various agencies, while it could hardly be described as cordial, at least gave some ground for believing that a joint initiative on alcohol problems was possible.[2] Goodwill alone of course does not provide any guarantee that cooperation between the various front line agencies can be realised or, if it is achieved, that it can effectively deal with alcohol problems. However, if policy makers are intent on continuing down the path of cooperation and community based response, then it would seem that training for staff at *all* levels and *all* stages in their career is an immediate priority.

Training in alcohol problems

The nature and relevance of training will of course vary with the demands of the job and there may be differences both between and within agencies. There was general agreement, however, about the need for education on alcohol problems and about the appropriateness of incorporating this alcohol education into existing training programmes. However, as might be expected given the current low level of understanding in the area, there was virtually no consensus on what these education programmes should include. Lawrence (1986) argues that certain features should be common to all professional training courses about alcohol problems. Although he was primarily concerned with alcohol education of the health and social welfare professionals, Lawrence's general principles could usefully be adapted to the needs of other agencies such as the police. The main features are the development of:

(i) an understanding of the complexity of alcohol problems, the context in which they occur and their interrelation with other problems.

(ii) the ability to recognise and identify specific problems which may not always be obvious and which may be conflated with a range of other personal problems.

(iii) a realistic acknowledgement of the agents' role and responsibility and the limits of their experience - when it is appropriate to intervene; when to refer, and where to seek support or referral.

(iv) an overview, or global perspective of the network of service provision, which will locate relevant professional skills in the context of what is available and what is possible.

In the light of my research findings, I would add one other ingredient, and that is the importance of recognising the implementation fo policy is often informally negotiated. In assessing an agent's role and responsibility, trainers - and perhaps more importantly policy makers - will have to address the conceptual gulf that often exists between those who make the policy decisions and those who have to put them into effect. If they are to make a realistic appraisal of the agent's role, this disparity, and the agent's potential for

discretionary action, must be taken into account. One way this could be done would be to actively involve 'street level' staff in the decision making process.

The provision of opportunities for training in alcohol problems of course is only part of the answer. For it to be effective, training has to be reinforced by providing on-going support and by enabling agents to gain experience of working positively with alcohol problems (Cartwright, 1980). Many of those interviewed in the present study would add that training, of whatever kind, is of limited value without a concomitant improvement in service provision at local and national level. If we were to introduce community based responses without this general improvement in provision, it is likely that a substantial number of problem drinkers will fall through the net. There is, therefore, a real possibility that moves aimed at providing a more humane response to alcohol problems will end-up delivering either a more limited service, or no service at all.

Conclusions: Back into the community

The management of problem drinking presents us with an unusual, perhaps unique, problem in that the issue not only straddles the divide between 'private issues and public troubles' and 'public issues' (Mills, 1959), but it also stands at the intersection of two apparently competing ideologies. It is a problem for the criminal justice system and, simultaneously, the subject of therapeutic intervention by medical and social work professionals. The recent report of the Royal College of Psychiatrists, *Alcohol: Our Favourite Drug*, recognises the diversity of responsibility in proposing that:

> Each of the caring professions should systematically examine the role which its members can play in the prevention and treatment of drinking problems, and review the present adequacy of training to meet these responsibilities, and in the light of such considerations formulate and institute appropriate training.
>
> (Royal College of Psychiatrists, 1986:185)

While I would agree about the need for a review of training that does more than pay lip service to the concept of training, I would argue that it has to go much further. A good beginning might be made by recognising the possibilities, as well as the problems, presented by the diversity of groups with (or claiming) responsibility fro dealing with alcohol problems. The shift away from the disease model of alcoholism, with its emphasis on medical intervention, towards a community based response involving the front line professionals, provides an opportunity for reappraising responses to alcohol problems. Certainly there is a need for just such a reappraisal. There is a need to improve communication between the various agencies involved. There is a need to improve the level of awareness about what other agencies can do. There is a need to make groups aware of the different conceptions of alcohol problems that exist and which inform the behaviour of different agencies in dealing with problem drinkers. There is a continuing need to explore the possibilities of extending services beyond the limits of the traditional legalistic and therapeutic responses. Training is an important part of responding to all these needs.

If training is to be carried over into practice, however, it must aim to do more than merely provide an understanding of the complexity of responding to alcohol problems. Certainly training should help staff to develop a realistic understanding of their responsibilities and the limits of their expertise. Within these limits, however, staff should be encouraged to address alcohol problems and that means encouraging them to view alcohol problems as an area where they can employ the professional skills they already have, rather than seeing it, as at present, as necessarily demanding of specialist intervention.

The adoption of a community based response - if it is to be anything more than a cosmetic exercise - demands one other thing of the front line professions. It calls for the reintegration of the community into the decision making process. This may prove to be the most difficult task of all. The social acceptability of alcohol is a very real hurdle to be overcome if levels of alcohol consumption and, therefore, of drink related problems are to

be reduced. The importance of alcohol, the positive value placed on drinking by many people in Western society (and in many other societies) has been widely commented on (Spring and Buss, 1977; Porter, 1985; Royal College of Psychiatrists, 1986). Alcohol has been "our favourite drug" for two or three thousand years and it is perhaps not surprising, therefore, that a sizeable proportion of the population seem to be inured to the problems associated with its use. Alcohol related problems are seen as immutable or intractable. Like that 'morning after feeling', it is the price that must be paid for imbibing to excess. Unlike the hangover, however, the more serious sequelae of heavy drinking are identified with a few unfortunate individuals who suffer from a disease called alcoholism.

Although I did not interview members of the public as part of this study, I did take the opportunity to talk to respondents about how they viewed the attitude of the public to alcohol problems. The results were far from encouraging. Most respondents were pessimistic about the possibility of engaging the community in discussions about alcohol use. The public were seen as being apathetic at best. Police officers in particular tended to have a rather jaundiced view of the motives of people in reporting public drunkenness to them. Although they were prepared to concede that some reports were motivated by concern for the welfare and/or safety of the individual involved, the majority of complainants, it was felt, wanted nothing more than to have the offending drunk removed. For the most part, however, the public were seen as being reluctant to become involved. Despite the fact that they are more likely to witness drunken events and are, presumably, in the best position to intervene, in most cases the public did not respond.[3] Or rather they did not respond by calling for police assistance, for, as we saw in chapter 9, police involvement with public drunkenness was usually proactive.

It would be unwise to read too much into this data and to take away the idea that the community is not involved in any way with responding to alcohol problems. The plain fact is that the majority of problem drinkers do not come into direct contact with any of the

agencies we have been discussing. The problem is dealt with within the community or, more usually, within the family. Some researchers have looked at the ways in which family members attempt to cope with the problem drinker in their midst (Orford et al, 1975; Schaffer and Tyler, 1979). Others have taken up the issue of spontaneous remission, the resumption of 'normal drinking' or abstinence without outside intervention (Roizen et al, 1978). By comparison, outwith the world of the self-help groups such as A.A. and Al-anon and the local councils on alcoholism, the role played by the community in responding across a wide range of alcohol related issues has yet to be explored. If we are to succeed in minimising the damage caused by alcohol, we must make the effort to 'disaggregate' alcohol problems, to understand more about how (and indeed if) alcohol is connected to problems such as domestic violence, accidents, drunk driving, and crime. The social meanings attached to drinking and to drunkenness must also be taken into account. Without this sort of background knowledge all the fine phrases about community involvement sound rather hollow:

> Responsible citizens must consider in the light of these facts what they themselves can do to limit the harm to their own health and to the health of others and whether they think the Government should do more to minimise alcohol misuse and to counter its effects ... informed public discussion will help the Government to decide policies to follow in this important and sensitive field.
>
> (DHSS, 1981:8)

In the present circumstances with the range and ambiguity of views about alcohol; with industries and governments actively or passively promoting its use; and a medical model of the problem drinker which conveniently attaches the label 'alcoholic' to someone else, it is difficult to see how this community of 'responsible citizens' can realistically be expected to contribute to even the limited debate about the amelioration of alcohol problems that is envisaged. But, suppose for a moment that the suggestion is a serious one. If policy-makers really are looking to inform and mobilise public opinion in support of some sort of positive, community-based response to alcohol problems, then they must find some way to bring the

community back into the arena. The social problems associated with alcohol use have, to a large degree, been 'enclosed' by the events of the past two centuries. The topic has been removed from the agenda of public debate.

We saw in Part 1 of the thesis how control over the processes of problem definition and response was systematically abstracted from the community. The problem was constructed without reference to the community, first by the church, then by the State and then, most persuasively, by the socio-medical professionals. The limits of the discourse have already been set. The discussion is not to be about whether a 'problem' exists or not, but about how the community might help in tackling the problem. To cling to this agenda is to miss an opportunity to learn from, as well as to educate, public perceptions of alcohol use. Bringing the community back in, if it is to mean anything, will mean 'opening' the debate once more, re-politicising the issue, with all that that would entail.

Notes

1. The health care professionals and the non-statutory social workers, by the nature of their involvement, were much more likely to have had experience of alcohol education 62 per cent of the social workers and 87 per cent of the health care group had attended at least one course on dealing with alcohol problems.

2. When asked to evaluate their agency's relationship with the police, one-third of the social workers said they were 'good'. Just over have (51%) claimed that relations were more 'mixed'. The police, perhaps surprisingly were a little more optimistic - 48 per cent said relations were 'good' and only 28 per cent considered that they were 'bad'.

3. Dight gives some indication of both the general incidence of drunkenness and the level of under-reporting. A high proportion of those interviewed reported having witnessed drunkenness on a fairly regular basis - 66 per cent of men and 52 per cent of women in central Scotland claimed to have witnessed scenes of public drunkenness at least once a week (Dight, 1976:230-234). Yet, most do not intervene. Why not? It's not that drunkenness is not perceived to be a problem. Over 50 per cent of Dight's sample expressed dissatisfaction with the way in which drunks are dealt with, and all but a tiny minority (2%) wanted to see stiffer penalties. Perhaps the answer has something to do with the proximity of the witness to the incident, or to the individual involved. Those who witness such events are often friends and/or neighbours of the drunken person and may, therefore, be disinclined to become involved.

APPENDIX I

Summary of Scottish Office Notes of Guidance Relating to the Provision of Designated Places under Section 5 of the Criminal Justice (Scotland) Act, 1980.

i. Guidelines for the establishment of designated places.

Guidelines for agencies wishing to set up designated places were issues by the Scottish Office in 1982. The areas covered in these guidelines include:

General Aims - Section 5 enables a constable take a drunken offender to a place where s/he can receive immediate care while still intoxicated and where staff can encourage him or her to use local facilities which may exist for the support of single homeless people and/or for those with a drink problem.' The guidelines acknowledge that 'success in persuading a person to stay for some time and in motivating them to cooperate in longer term measures for their care and treatment, will depend mainly on staff attitudes, relationships and practices.

Target Client Group - the intended client group, as the above quote would suggest, is the homeless drunken offender. Other groups could also be included if, for example, their problem behaviour was reflected in offenses related to drunkenness. However, considerable discretion is afforded the police and the designated place in reaching local agreements about the criteria for admission.

The Aims of the Designated Place - the guidelines suggest that a designated place should provide:

entry for care and treatment according to individual needs; a good standard of care;

access to resources for people who wanted to change their lifestyle; an entry point to facilities for long term support and care for drunken offenders, including those who are homeless;

an open door for repeat referrals;

It is also suggested that designated places should operate a strict 'no drink' policy.

The Criteria for Designation - in order to be 'designated' by the Secretary of State a centre has to demonstrate its suitability in terms of the following:

the standard of care offered;

access to facilities and services for the care and treatment of clients;

round the clock (24 hour) access to facilities;

support from local health and social work services;

quality and level of staffing necessary to provide a good standard of care and supervision;

provision of warmth and shelter and acceptance of individual behaviour;

adequate resources for assessing, and meeting, any special problems of an individual may have before admitting him/her to any of the treatment facilities;

resources to monitor progress;

Links with Health and Social Services - the guidelines do not advocate the employment of staff with a specifically medical background, as was the practice in many of the English detoxification centres (Shaw et al, 1982). They stressed instead the importance of establishing links with community-based health services, through general practitioners and the community nursing service, with ready access to hospital were necessary.

Relationships with Other Agencies - the importance of establishing and maintaining good relations with local agencies that provided services and facilities for problem drinkers and/or the homeless was stressed. An assurance about the adequacy of these services was a requirement of designation.

ii. Guidelines for the police.

Guidelines for the police on the use of designated places, issued by the Scottish Office in April 1982, included coverage of the following points:

Local Cooperation - the guidelines stressed the need for discussions, at local level, between police, social work departments, health boards, and other agencies involved in the operation of the designated place.

Target Client Group(s) - subject to the local agreement on admission, the client group should include:

persons who were drunk and who had committed a minor offence (though not necessarily a drunkenness offence) and who were arrested within the agree catchment area of the designated place;

persons who had committed offenses other than drunkenness such as minor breaches of the peace.

Admission Criteria - individuals could only be admitted to a designated place if the following criteria were meet:

their identity was known or could be readily established; a check had been made and there were no warrants outstanding against the individual;

a bed was available in the designated place;

If a person was refused admission to a designated place, or if s/he refused to be admitted, the offence would be dealt with by the normal criminal justice process. Police were also expected to consider the amount of trouble that might be anticipated from an individual when making a decision about whether or not to admit that person to a designated place.

Handover - the transfer of an individual from police custody to the care of the designated place could take place either at the designated place or at a police station.

Illness or Injury - if an individual showed signs of illness or injury, s/he could be taken for examination either to a hospital casualty department or to the police surgeon, before being taken to the designated place.

Preferring Charges - admission to a designated place would not affect the individual's liability to prosecution. Reports would be sent to the Procurator Fiscal if the offence was so serious (drunkenness apart) that it would normally be dealt with by arrest, or if the minor offence committed whilst drunk would have resulted in a report for citation and not arrest.

APPENDIX II

MANAGING PUBLIC DRUNKENNESS

Department of Sociology
University of Stirling
Stirling, Scotland

INTERVIEW SCHEDULE

Introduction

A. *Introduce self*

B. *Discuss the project:*
Types of information sought (attitudes, perceptions and experiences of problems associated with drink and drunkenness).

C. *Uses of information:*
To provide policy makers with a balanced view of the issue; a view that takes account of the day-to-day reality for those who must deal with public drunkenness.

D. *Confidentiality assured and freedom to decline to answer any question(s) stressed.*

E. *Cooperation in the study helpful and greatly appreciated.*

Q.1. Interview number

Q.2. Sex of respondent

Male
Female

Q.3. Designation

Q.4. Date of interview

Day
Month
Year

Q.5. Location of interview

*****

A. BACKGROUND DETAILS

Could I begin by asking you a few questions about yourself?

Q.6. How old are you?

Under 20
21-30
31-40
41-50
51+

Q.7. Have you always lived in this part of the country?

Yes
No

*If 'NO' **PROBE** for knowledge of drinking habits or alcohol problems in other areas of Scotland and/or other countries.*

Q.8. How long have you worked/served with (Name of Agency)?

Q.9. Have you worked/served with any similar agency/police force?

Yes
No

*If 'YES', **PROBE** for further details*

Q.lO. Could you tell me about any jobs you had before joining (Name of Agency)?

A.

Professional
Skilled non-manual
Unskilled non-manual
Skilled manual
Unskilled manual
Armed Forces
Student
No previous employment

B.

Drink-related (manufacture)
Drink-related (retail)
Treatment-related (medical)
Treatment-related (social)
No previous relevant employ

Q.11. In general, would you say your friends were drawn mainly from the ranks of your police/social service colleagues, or from contacts outside the job?

Mainly colleagues
Fairly mixed
Mainly outside contacts

Finally in this section I would like to ask you about your experiences of drinking/drunkenness outwith the work setting.

(Reaffirm confidentiality and freedom to decline to answer)

Q.12. On average, how often would you say you go out for a drink?

Q.12a. On average, how often would you say you drink at home?

If 'NEVER DRINK'

Q.12b. Do you have any strongly held religious, moral, or conscientious objections to alcoholic drink?

Yes
No

B. DRINKING AND DRUNKENNESS

I would now like to go on to ask you a number of questions about drinking and about the issue of public drunkenness in particular.

Q.13. Over the years a good deal has been said, and written, about drunkenness in Scotland. In your opinion, is drunkenness a serious problem in this part of the country?

Very serious
Serious
Not too serious not at all serious
DK

If 'SERIOUS'

Q.13a. Why do you believe that drunkenness is a serious problem?

If 'NOT SERIOUS'

Q.13b. Why do you believe that drunkenness is not a serious problem?

SHOW CARD

Q.14. I am going to show a number of statements about drinking. In each case I would like you to say wether you agree or disagree with the statement.

i. Drink is one of the main causes of people doing things they shouldn't.

Agree
Neither agree nor disagree
Disagree

ii. Having a drink with someone is just a way of being sociable.

Agree
Neither agree nor disagree
Disagree

iii. Drink often brings out the worst in people.

Agree
Neither agree nor disagree
Disagree

Q.14. (continued)

iv. Having a drink is one of life's pleasures.

Agree
Neither agree nor disagree
Disagree

SHOW CARD

Q.15. I am going to show you a number of statements about drunkenness. Again, in each case, could you say 'ether you agree or disagree with each statement?

i. People who are drunk can be very amusing.

Agree
Neither agree nor disagree
Disagree

ii. People who are always drunk should be punished.

Agree
Neither agree nor disagree
Disagree

iii. It does you good to get drunk once in a while.

Agree
Neither agree nor disagree
Disagree

iv. If a man drinks and neglects his wife and family, the society should give them support.

Agree
Neither agree nor disagree
Disagree

v. A person who gets drunk in public has no self-respect.

Agree
Neither agree nor disagree
Disagree

vi. People who are always drunk should be viewed and treated as sick.

Agree
Neither agree nor disagree
Disagree

Q.15. (continued)

vii. A drunken woman is a more disgusting sight than a drunk man.

Agree
Neither agree nor disagree
Disagree

viii. Most people wouldn't like to have a place where people with alcohol problems are treated to be established near their home.

Agree
Neither agree nor disagree
Disagree

ix. People are often more honest drunk than sober.

Agree
Neither agree nor disagree
Disagree

x. Drunkenness is a major cause of immoral behaviour.

Agree
Neither agree nor disagree
Disagree

Q.16. People drink and, presumably get drunk, for a great many reasons, but what would you say were the main reasons behind a person's repeated drunkenness?

I would now like to ask you some questions about your experiences in dealing with public drunkenness.

If SOCIAL SERVICES SKIP TO Q.21

Q.17. When was the last time you had to make a drunk and incapable arrest?

Can you remember, on that occasion:-

i. Who called the police?

Police initiated
Publican
Spouse/relative
Other emergency service
Member of the public
Shopkeeper
Other (specify)
NA

ii. How many persons were involved in the incident?

iii. Where did the incident take place?

Street/road
Public house
Hotel/lodging house
Police Station
Other public building (specify)
Other public place (specify)

iv. Were there other members of the public present?

None
Less than 5 persons
5-10 persons
More than 10

v. Approximately how old was the person(s) involved?

Under 16 years
17-20
21-30
31-40
41-50
Over 51

Q.17. (continued)

vi. How intoxicated would you say the person(s) was?

Highly intoxicated
Moderately intoxicated
Slightly intoxicated
Relatively sober

vii. How would you describe the subject's demeanour, his/her attitude towards the police?

Friendly-Cooperative
Passive-resigned
Aggressive
Violent

viii. Did the person(s) show any signs of illness or injury?

None
Slight injury/illness
Serious injury/illness

ix. Was the subject(s) involved in any other disorderly or criminal behaviour?

Yes
No

x. Why did you decide to arrest the person(s)?

Q.18. When did you last arrest someone in a public place for Breach of the Peace where, in your opinion, drink was a major factor involved in the offence?

Could you give me some brief details about the incident?

i. Who called the police?

Police initiated
Publican
Spouse/relative
Other emergency service
Member of the public
Shopkeeper
Other (specify)
NA

ii. How many persons were involved in the incident?

iii. Where did the incident take place?

Street/road
Public house
Hotel/lodging house
Police Station
Other public building (specify)
Other public place (specify)

iv. Were there other members of the public present?

None
Less than 5 persons
5-10 persons
More than 10

v. Approximately how old was the person(s) involved?

Under 16 years
17-20
21-30
31-40
41-50
Over 51

Q.18. (continued)

vi. How intoxicated would you say the person(s) was?

Highly intoxicated
Moderately intoxicated
Slightly intoxicated
Relatively sober

vii. How would you describe the subject's demeanour, his/her attitude towards the police?

Friendly-Cooperative
Passive-resigned
Aggressive
Violent

viii. Did the person(s) show any signs of illness or injury? None

Slight injury/illness
Serious injury/illness

ix. Was the subject(s) involved in any other disorderly or criminal behaviour?

Yes
No

x. Why did you decide to arrest the person(s)?

Q.19. When did you last have occasion to warn someone (but not arrest them), about their behaviour in public, again where in your opinion drink played an important part of their behaviour?

Could you give me some brief details about the incident:-

i. What was the precise nature of the incident: what was happening?

Q.19. (continued)

ii. Who called the police?

Police initiated
Publican
Spouse/relative
Other emergency service
Member of the public
Shopkeeper
Other (specify)
NA

iii. How many persons were involved in the incident?

iv. Where did the incident take place?

Street/road
Public house
Hotel/lodging house
Police Station
Other public building (specify)
Other public place (specify)

v. Were there other members of the public present?

None
Less than 5 persons
5-10 persons
More than 10

vi. Approximately how old was the person(s) involved?

Under 16 years
17-20
21-30
31-40
41-50
Over 51

vii. How intoxicated would you say the person(s) was?

Highly intoxicated
Moderately intoxicated
Slightly intoxicated
Relatively sober

Q.19. (continued)

viii. How would you describe the subject's demeanour, his/her attitude towards the police?

Friendly-Cooperative
Passive-resigned
Aggressive
Violent

ix. Did the person(s) show any signs of illness or injury?

None
Slight injury/illness
Serious injury/illness

x. Was the subject(s) involved in any other disorderly or criminal behaviour?

Yes
No

xi. Why in this case did you decide not to exercise the power of arrest?

Q.20. When did you last take a drunken person to a hospital casualty department?

Again, could you give me some brief details of the incident:-

i. Who called the police?

Police initiated
Publican
Spouse/relative
Other emergency service
Member of the public
Shopkeeper
Other (specify)
NA

ii. How many persons were involved in the incident?

Q.20. (continued)

iii. Where did the incident take place?

Street/road
Public house
Hotel/lodging house
Police Station
Other public building (specify)
Other public place (specify)

iv. Were there other members of the public present?

None
Less than 5 persons
5-10 persons
More than 10

v. Approximately how old was the person(s) involved?

Under 16 years
17-20
21-30
31-40
41-50
Over 51

vi. How intoxicated would you say the person(s) was?

Highly intoxicated
Moderately intoxicated
Slightly intoxicated
Relatively sober

vii. How would you describe the subject's demeanour, his/her attitude towards the police?

Friendly-Cooperative
Passive-resigned
Aggressive
Violent

viii. Why did you decide, in this case, to take the subject(s) to the hospital?

Q.20. (continued)

ix. Was the subject(s) involved in any disorderly or criminal behaviour other than simple drunkenness?

Yes
No

If 'YES'

x. Was this charge related to his/her drunkenness or to other behaviour?

Drunkenness related
Non-drink related

ASK SOCIAL SERVICES ONLY

Q.21. When was the last time you had to deal with a drunken client?

Could you give brief details of what happened on that occasion?

ASK ALL

Q.22. In the course of your work have you ever recommended that someone seek help for an alcoholic problem?

Yes
No

If 'YES'

Q.22a. To which agency (or agencies) did you refer them?

Q.23. If ever referred, how helpful did you find the agency?

(Record for maximum of 3 agencies)

Very helpful
Helpful
Undecided
Fairly unhelpful
Very unhelpful

SHOW CARD

Q.24. If, in the course of your work, you were asked by someone where they might seek help with an alcohol problem of their own, would you recommend one or more of these groups?

(Select as many agencies as desired)

i. General practitioner

ii. Social worker

iii. Psychiatric hospital

iv. Minister of religion (Priest/minister/rabbi)

v. Local Council on Alcoholism

vi. Is there a LCA in this area?
Yes
No

vii. Self-help group (eg., Alcoholics Anonymous)

viii. Do you know if any such groups exist in this area?
Yes
No

ix. Specialised Alcoholism Treatment Unit

x. Is there an ATU in this area?
Yes
No

xi. Other (Please specify)

.1

Q.25. Apart from your work with (Name of Agency) do you know anyone personally who has, or has had, an alcohol problem?
Yes
No

Q.26. Have you ever attended any course, lecture, or discussion, where the issue of alcohol problems was covered in some detail?

Yes
No

If YES, please give details:

Q.27. Do you think it would be helpful to include some information about alcohol problems as part of the training of the police and/or social service workers?

Yes
No
Undecided

C. ALTERNATIVES IN MANAGING ALCOHOL PROBLEMS

We have been talking about the existing methods of handling the problem of drunkenness. I would now like to ask you a few questions about possible alternatives.

Q.28. As you may know, Section 5 of the criminal Justice (Scotland) Act 1980 gives the police some discretion in their handling of public drunkenness. The Act allows the police to refer the drunken person to some 'designated place' as an alternative to taking him/her into custody.

Do you think that setting up such 'designated places ' will be helpful in tackling the problem of drunkenness?

Very helpful
Fairly helpful
Undecided
Fairly unhelpful
Not at all helpful

If 'UNHELPFUL' SKIP TO Q.31

Q.29. Why do you think 'designated places' will be helpful?

Q.30. Who, which group(s), do you see as benefiting from the introduction of new methods of handling public drunkenness?

SKIP TO Q.32

Q.31. Why do you think 'designated places' will not prove helpful?

Q.32. Can you think of any other ways in which the Government, or any other group(s) in society, might be able to tackle alcohol problems?

Q.33. Tackling the problems related to the abuse of alcohol can be expensive both in terms of financial and human resources. With so many groups in the community competing for these limited resources, what priority do you think should be given to helping those with alcohol problems?

Very high priority
Fairly high priority
Undecided
Fairly low priority
Very low priority

D. THE ROLE OF THE AGENCY

I would now like to ask you some questions about those groups, including the social service agencies, which can be involved in the routine management of public drunkenness.

Please remember that there are no right or wrong answers : what I want is YOUR opinion.

SHOW CARD

Q.34. Here are a number of statements about the police. In each case I would like you to say whether you agree or disagree with the statement by circling the appropriate response.

i. The job of the police is to protect life and property, to catch thieves and so on.

Agree
Neither agree nor disagree
Disagree

ii. The responsibility for improving police-community relations lies mainly with the police.

Agree
Neither agree nor disagree
Disagree

iii. The police could do a better job if they didn't have to deal with situations, such as public drunkenness, that should be the responsibility of other groups.

Agree
Neither agree nor disagree
Disagree

Q.34. (continued)

iv. The police shouldn't ignore the 'social welfare' side of their work, because they cannot do the job without public support.

Agree
Neither agree nor disagree
Disagree

v. The police often abuse the power they have in carrying out their duties.

Agree
Neither agree nor disagree
Disagree

vi. There is no discrimination by the police against any particular group of individuals.

Agree
Neither agree nor disagree
Disagree

vii. Most policemen are unsympathetic to the problems of minority groups, 'down and outs' and so on.

Agree
Neither agree nor disagree
Disagree

viii. People who criticise the police do not understand the difficult, and sometimes dangerous, circumstances in which they have to work.

Agree
Neither agree nor disagree
Disagree

SHOW CARD

Q.35. I will now show you a number of statements about social work and social services in general. Again, in each case, would you say whether you agree or disagree with the statement?

i. How people lead their lives is their business and no concern of interfering busybodies in the social services.

Agree
Neither agree nor disagree
Disagree

ii. Social workers and others like them generally serve society well. Caring for people is a difficult, often rewarding, job.

Agree
Neither agree nor disagree
Disagree

Q.35. (continued)

iii. Social work is often no more than a sop to society's conscience. There is not much that it can do about the problems of the real world.

Agree
Neither agree nor disagree
Disagree

iv. Having trained and experienced people to talk to, to provide advice and material help if need be, is important for many people.

Agree
Neither agree nor disagree
Disagree

v. Most social workers are too busy with court reports, and so on, to be able to really help their clients.

Agree
Neither agree nor disagree
Disagree

vi. Social workers favour the deviant, the criminal, rather than the police or the society in general.

Agree
Neither agree nor disagree
Disagree

Q.36. At the moment the police play a leading role in the initial, day-to-day, management of public drunkenness. Do you think the police are the most appropriate agency to carry out this task?

Yes
No
DK

If 'NO' GO TO Q.38.

Q.37. Why do you think the police are the best people to deal with the problem in the initial stages?

GO TO Q.40.

Q.38. Why do you think the police are inappropriate in this instance?

Q.39. What group(s) would you see as being more appropriate?

Q.40. How well does (Name of Agency) measure up to your ideal of what a caring agency/police force should be?

Very well
Fairly well
Undecided
Not too well
Not at all well

Q.41. Considering your work as a whole, would you say you were satisfied or dissatisfied with your job?

Satisfied
Undecided
Dissatisfied

E. QUESTIONNAIRE EVALUATION

Finally, I would like to ask a few questions about the interview itself.

Q.41. Have you ever taken part in an interview like this before?

Yes
No

Q.42. Is there anything which you feel we should have discussed but which hasn't been covered in the interview?

Yes
No
DK

If 'YES' Specify:

Q.43. What do you think would be the most useful thing that could come out of this research?

Q.44. Have you any other comments to make about the interview, or any questions which you'd like to ask?

THANK YOU

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