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A survey of psychiatric social treatment of alcoholics in Massachusetts

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A SURVEY OF
PSYCHIATRIC SOCIAL TREATMENT OF ALCOHOLICS
IN MASSACHUSETTS

A Thesis

Submitted by

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(LL.B., Northeastern University, 1929)
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In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service

1947

BOSTON UNIVERSITY
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1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes that this is essential for ensuring transparency and accountability in the organization's operations.

2. The second part of the document outlines the various methods and techniques used to collect and analyze data. It highlights the need for a systematic approach to data collection and the importance of using reliable sources of information.

3. The third part of the document describes the process of interpreting the data and drawing conclusions from it. It stresses the need for a clear understanding of the data and the ability to identify trends and patterns that are significant to the organization's performance.

4. The fourth part of the document discusses the role of the management in using the data to make informed decisions. It emphasizes that management should use the data to identify areas of strength and weakness and to develop strategies to improve the organization's performance.

5. The fifth part of the document concludes by summarizing the key points of the document and emphasizing the importance of ongoing monitoring and evaluation of the organization's performance. It states that this is essential for ensuring that the organization remains competitive and successful in the long term.

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CHAPTER I

INTRODUCTION

Purpose

This study of the social treatment, both legal and medical, of alcoholics was undertaken for the purpose of comparing present day knowledge of the causation of alcoholism with the public methods used in Massachusetts for meeting the increasing problem, for appraising the public methods of control and attempting to answer the following questions:

1. Is alcoholism now considered a disease or a crime.
2. Is Massachusetts using the most effective methods on controlling the problem.
3. Is Massachusetts making a full use of case work in meeting the problem.

We do know . . . that a veritable army of human beings charged with intoxication passes through our police stations, courts and jails every year; that many of them are alcoholics whom nothing but the most scientific and prolonged treatment can cure; that they (and the common drunks) benefit little from the penal and correctional treatment that they receive and are likely to be harmed by it; that most of those sent to institutions are sent to county jails for very short sentences, often as low as five days and sometimes only two, that they return time and time again; that our jails are notoriously bad, with medical services generally inadequate to care for the physical ailments and psychotherapy of any sort practically unheard of; and that a few of the state farms and larger city institutions have made an attempt to treat alcoholism in a scientific way but are defeated by lack of psychiatric personnel and the shortness of the sentence.¹

It has been estimated that there are over 600,000 people in the

¹ Austin MacCormick, "Penal and Correctional Aspects of the Alcohol Problem," Quarterly Journal of Studies on Alcohol, Volume II, September, 1941, pp. 243-259.



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United States who are chronic alcoholics and the number in the state of Massachusetts has been estimated to be in excess of 20,000 on an estimate that is considered to be extremely conservative. It is believed that 1,400,000 persons in Massachusetts are users of alcoholic beverages.²

Approximately 25 per cent of first admissions to mental hospitals in Massachusetts are intemperate; a slightly higher proportion of the readmissions were classified as intemperate. During the years 1932 to 1941, 8.7 per cent of the first admissions to mental hospitals had an alcoholic psychosis while 7.8 per cent of the readmissions had an alcoholic psychosis.³

The number of mental cases entering mental hospital due to an alcoholic psychosis or a psychosis to which alcoholism was a contributing factor does not tell the complete story.

By comparison with the sum total of misery caused by chronic alcoholism, the number of mental cases is comparatively small. Much minor and major crime and sexual irregularities - alcohol being somewhat of a aphrodisiac - may be traced to acute or chronic drinking.⁴

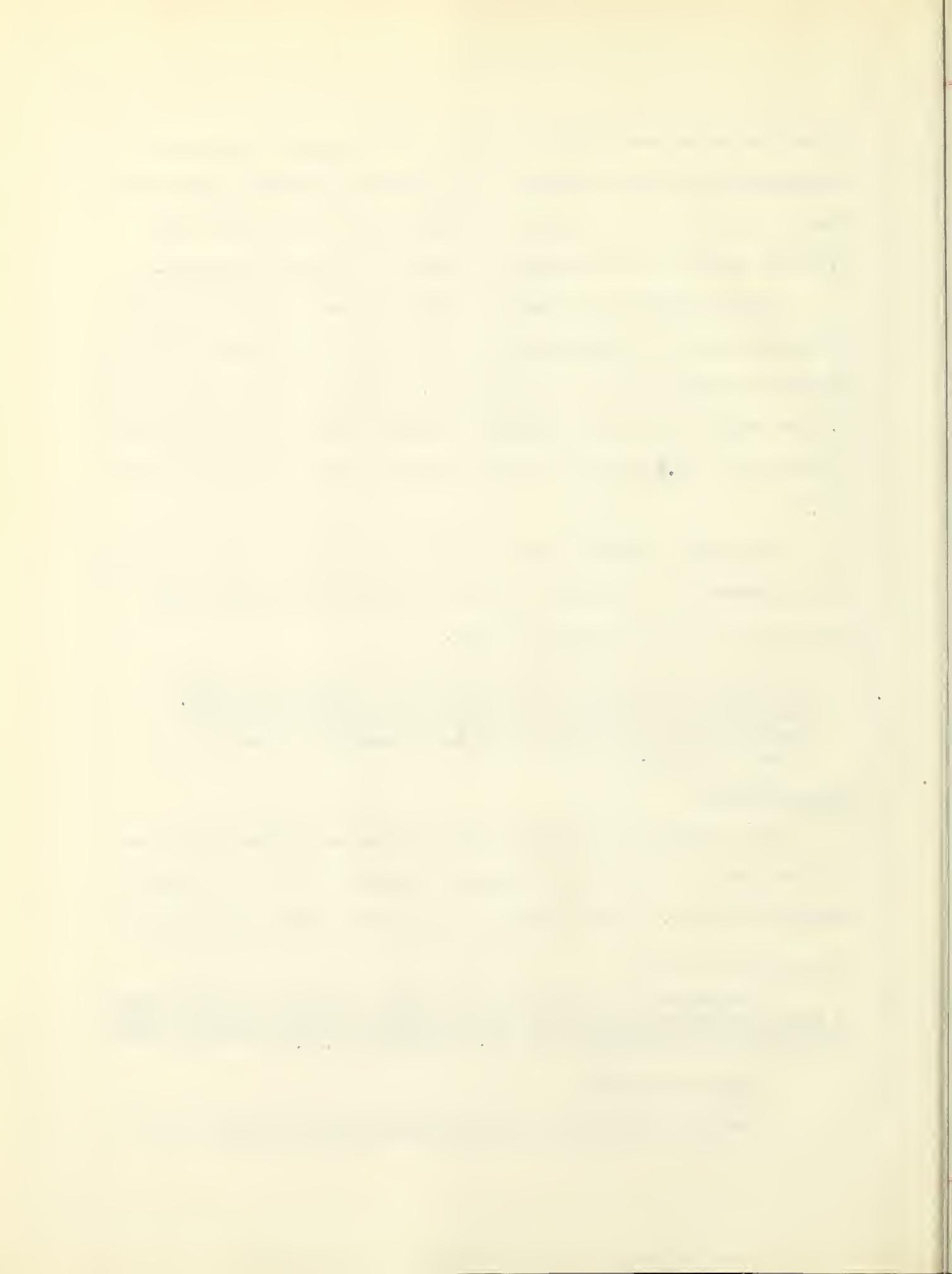
Method of Study

The literature in the field of alcoholism was reviewed to determine the present day penal and psychiatric attitudes toward the cause of excessive drinking. A review was also made of the public methods which

² Commonwealth of Massachusetts, Special Report of the Department of Mental Health on the Advisability and Expense of Establishing a Bureau for the Care of Inebriates, House No. 1276, 1943, p. 9.

³ Ibid., pp. 13-15.

⁴ Lawson G. Lowrey, M.D., Psychiatry for Social Workers, p. 63.



have been used in Massachusetts since early colonial times in an attempt to better control the ever-present problem of alcoholism.

This review included a study of the present laws which provide for the current penal and medical treatment of the alcoholic. This study traced penal procedure on drunkenness from arrest through release on parole from the State Farm, including such intermediate steps as release by probation officer or other official without trial, the use of fines, short and long sentences, appeals and the use of nol-pros and filing of charges.

In like manner, the law covering the admission or commitment of the alcoholic as an insane person under temporary or emergency admissions, observation, regular and criminal court commitments, was studied. Also reviewed were the laws covering release of the alcoholic from mental hospitals on trial visit and discharge.

The special but little used procedure for addicts, including alcoholics, which procedure incorporates some of the features of both the penal statutes and the commitment of the insane, was examined.

Reports of Massachusetts legislative committees and commissions which have made studies concerning the cause and treatment of alcoholism were also carefully examined.

In addition the writer utilized his experience as a social worker in a public welfare agency in a large urban community and his experience as an attorney to furnish material and to assist in forming opinions and recommendations about the value of the present day penal and medical treatment of alcoholics. The writer's experience in a psychiatric social work field placement in a large state mental hospital located in a metro-

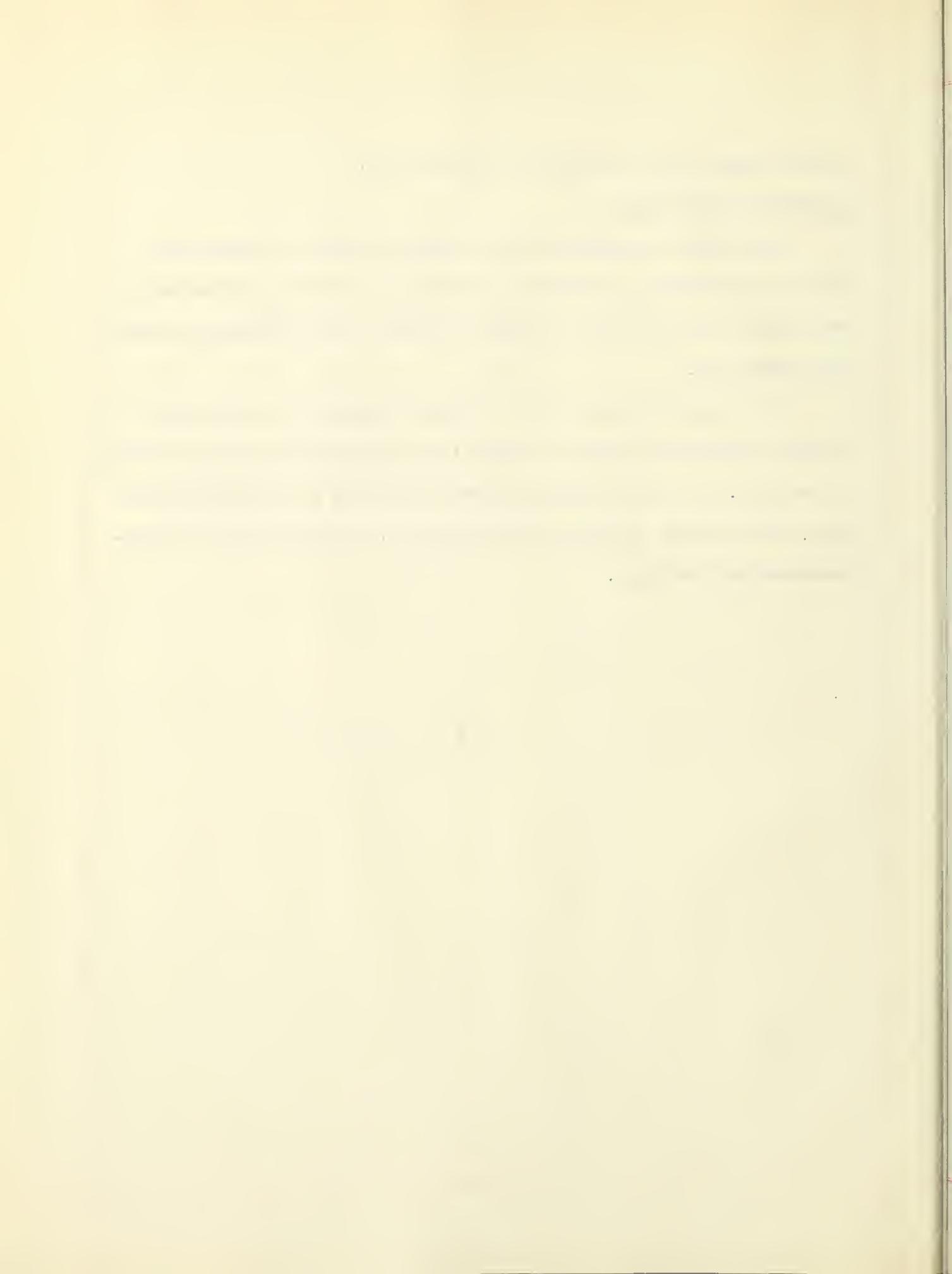
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politan center also contributed to the material.

Limitation of the Study

The survey is confined to tax supported methods of meeting the problem of alcoholism although the practices of private agencies and institutions concerned with the alcoholic problem were considered in making recommendations.

No attempt has been made to evaluate the need for major changes in the control of the supply of alcohol as in prohibition or the licensing of the user. In a democratic government such laws, no matter how desirable, must meet the approval of the majority of the population to be enforceable and permanent.



CHAPTER II

DESCRIPTION OF ALCOHOLISM

Defined

It is necessary that the term "alcoholism" be defined so that the expression will be clearly understood when used in the various fields. It will be defined, therefore, from the general, medical, and legal or criminal viewpoints.

The general definition is as follows:

"A diseased condition of the system due to the excessive use of alcoholic liquor."¹

The medical definition is more specific, descriptive and differentiating and emphasizes the toxic qualities of alcohol:

Alcohol poisoning; the morbid effect of excess in alcoholic drinks. Acute alcoholism, drunkenness, or the temporary disturbance caused by the excessive use of alcohol. Chronic alcoholism, the state induced by repeated and long continued excess in the use of alcohol.²

The legal definition describes alcoholism or drunkenness as follows:

A person is 'drunk' when he is so far under the influence of liquor that his passions are visibly excited or his judgment impaired, or when his brain is so far affected by potations of liquor that his intelligence, sense-perceptions, judgment, continuity of thought or of ideas, speech and coordination of volition with muscular action (or some of these faculties or processes) are impaired or not under normal control.³

The Massachusetts Supreme Court has described the alcoholic or

1 Webster's New International Dictionary.

2 The American Illustrated Medical Dictionary, 20th Edition, 1945.

3 Black's Law Dictionary, Second Edition, 1910.



drunkard in the following words:

The exact degree of intemperance which constitutes a drunkard, it may not be easy to define. But speaking in general terms, and with the accuracy of which the matter is susceptible, he is a drunkard whose habit it is to get drunk, 'whose inebriety has become habitual'. To convict a man of being a common drunkard it is at least necessary to show that he is a habitual drunkard. Indeed the terms 'drunkard' and 'habitual drunkard' mean the same thing.⁴

Etiology

The debate as to whether chronic alcoholism is a crime or a mental illness has gone on for many years with supporting opinions on both points of view from penologists and psychiatrists. During the last part of the nineteenth century and the early part of the twentieth century the medical or psychiatric point of view was strong in the public favor but the efforts of the medical men were not particularly successful in curing the chronic alcoholic and even the medical men in desperation felt that the problem should be treated as a penological problem.

Today authoritative opinion, penological and medical, tends to the opinion that the problem can be best attacked from the psychiatric approach.

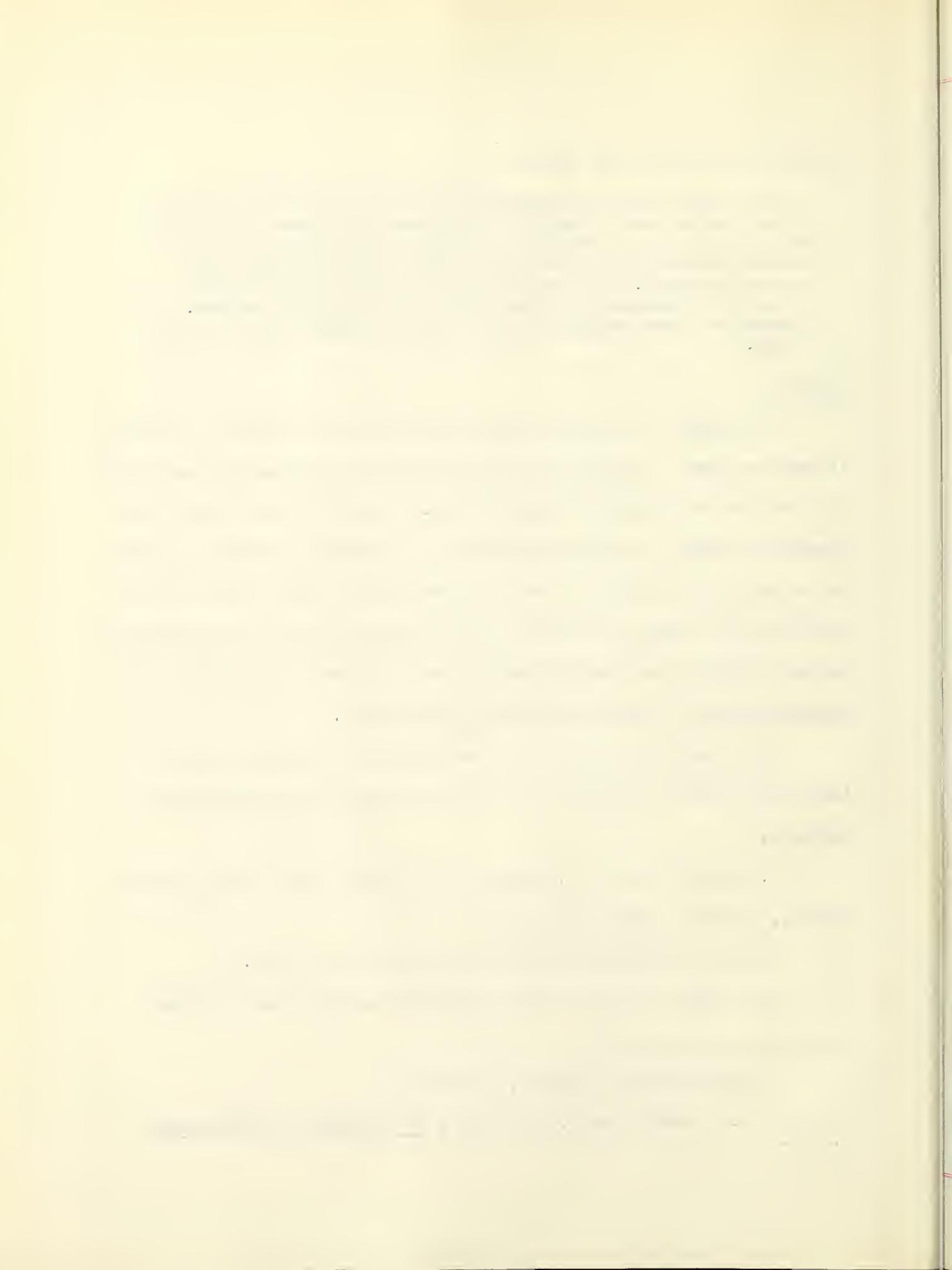
H. E. Barnes and N. K. Teeters, authorities in the field of criminology, gives the present day view:

"Chronic alcoholism should not be considered a crime."⁵

The opinion that the chronic, excessive drinker does not drink

4 Commonwealth v. Whitney, 71 Mass. 85.

5 H. E. Barnes and N. K. Teeters, New Horizons in Criminology, p. 880.



excessively voluntarily is becoming general.

Recognition is becoming general that the excessive use of alcohol is due in a large number of instances to forces over which the patient has little or no control. While in some instances social factors may be prominent, many cases come to the attention of the psychiatrist in which indulgence in alcohol provides a temporary escape from emotional conflicts and unpleasant instinctual drives. The fundamental treatment, therefore, would appear to be based upon a recognition of these psychological factors.⁶

Nature of Alcoholism

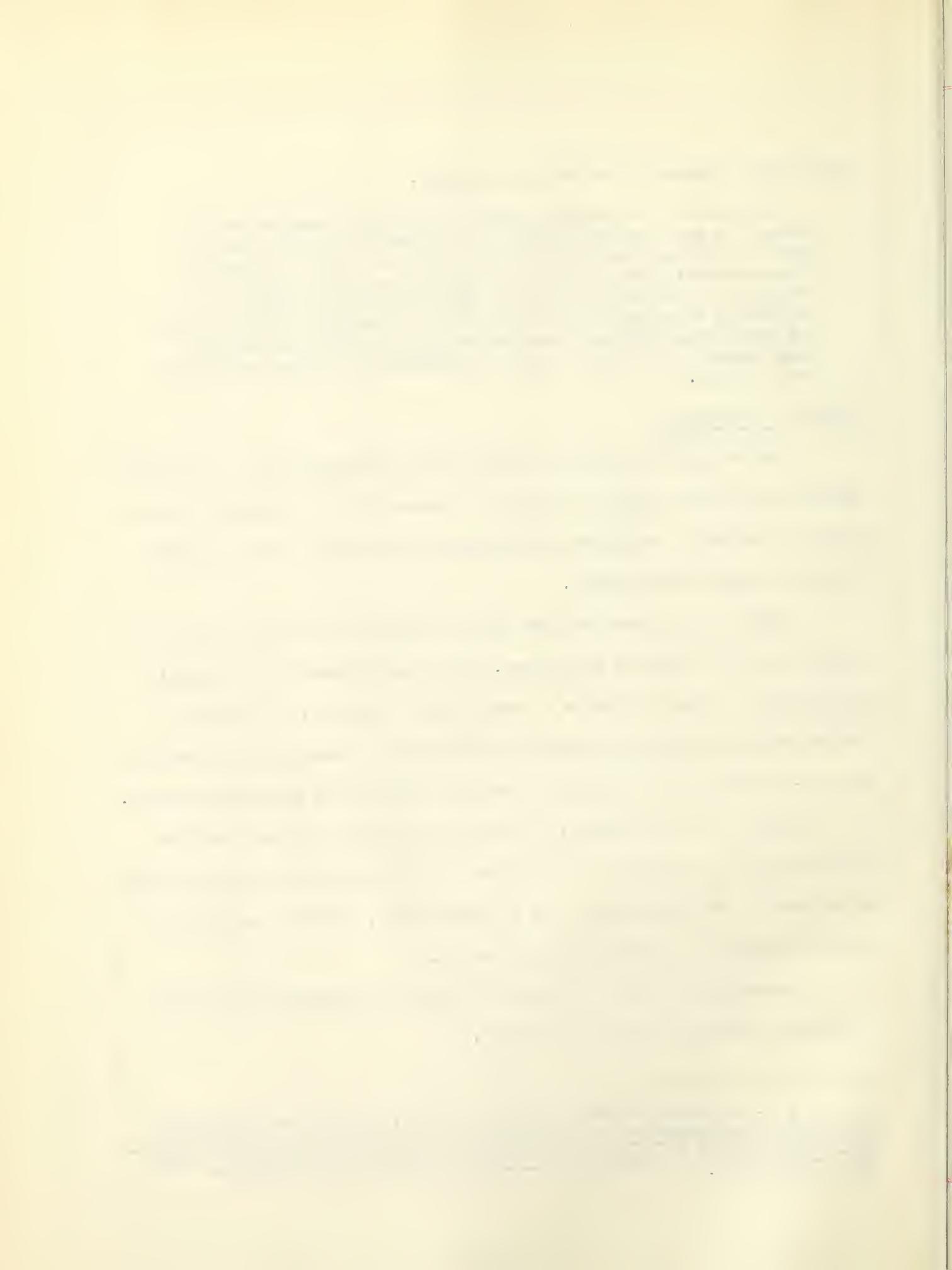
Most authorities take the position that alcoholism has an emotional background and they assign a variety of reasons such as emotional instability, immaturity, character deficiency, lack of will power, escapist complex or other idiosyncrasy.

Psychiatrists have not been able to single out any one factor and assign it as the cause of alcoholism. The cause appears to be multiple and complex. It may be due to a combination of factors. Personality traits which are strong in alcoholics are found in non-alcoholics and yet the non-alcoholic goes through life without becoming an excessive drinker.

Social and environmental conditions contribute in some cases to alcoholism while in other cases external conditions seem to have no effect on a person's drinking habits. As a general rule, however, alcoholism is more prevalent in urban than rural areas.

Alcoholism, on the other hand, does have very definite and often disastrous effects on social conditions.

6 A. T. Lyman, Winfred Overholser and H. D. Chadwick, Report of the Special Commission on the Advisability of Establishing Public Clinics, Etc. for Treatment of Persons of Confirmed Habits of Intoxication, House 167, 1935, p. 11.



It is well recognized that there is a significant relationship between alcoholism and broken family relationships; alcoholism and crime; alcoholism and accidents; alcoholism and industrial efficiency.⁷

The part that personality plays in the making of an alcoholic is stated by O. S. English, M.D. and Gerald H. J. Pearson, M.D.:

Every person with an alcohol problem has a personality difficulty. Every alcoholic is an immature, insecure, oversensitive and anxious person who is suffering from marked feelings of inferiority, unable to meet people and to enjoy people socially or unable to get on with his work without the support of alcohol in fairly large quantities.⁸

The same authors stress the importance of instinctual drives in the alcoholic:

The urge to seek gratification by oral means - to allay tension thereby - is seen in later life in alcoholism, in the enjoyment of food, in drinking, in smoking, or in chewing gum. These things are tension reducers.⁹

The characteristic of being dependent is common to the alcoholic and he very often marries the type of woman who fosters this characteristic.

Grown people cannot remain dependent in attitude if they are to be successful with life's problems. It is the attitude of dependency that is present in the relation of the alcoholic who marries a maternal type of woman. He senses that she is going to excuse him and take care of him.¹⁰

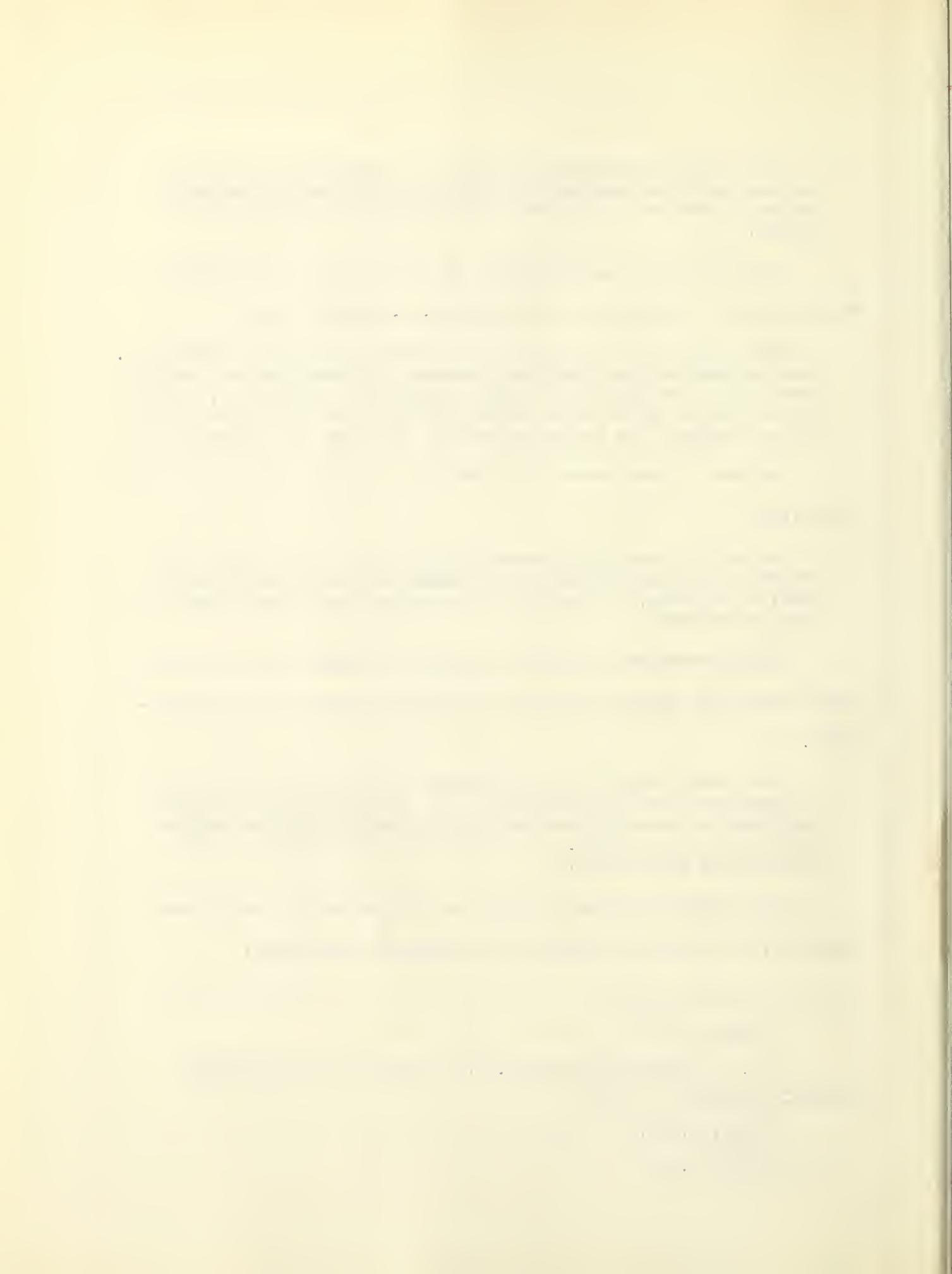
The alcoholic is often unconsciously attempting to escape from anxieties, fears and situations in his immediate environment.

7 Ibid, p. 12.

8 O. S. English, M.D. and G. H. J. Pearson, M.D., Emotional Problems of Living, p. 356.

9 Ibid, p. 26.

10 Ibid, p. 358



An individual faced by conflicts, unhappiness and anxieties may attempt to cope with or escape them through the narcotic effect of these substances (drugs and alcohol). The narcotic effect of the alcohol enables the individual to forget fears and stresses. In the state of drunkenness, the external world is excluded.¹¹

Correspondingly the reasons for reverting to alcohol are either the existence of external frustrations, that is states of misery one would like to forget and replace by pleasurable fantasies, or internal inhibitions, that is, state in which one dare not act against the superego without such artificial help; among these inhibitions, depressive inclinations are of the greatest importance. When the (external or internal) misery is at an end, the drinking may or may not be at an end. Persons in whom it is not are called alcoholic.¹²

Association, environment, identification and imitation may be important elements in excessive drinking.

"External factors are important. For example, contact with groups which drink heavily or use drugs give a person an opportunity and inclination to do likewise."¹³

There is considerable variation in the ability of persons to handle liquor. Some persons can tolerate only a small quantity of alcohol before becoming intoxicated.

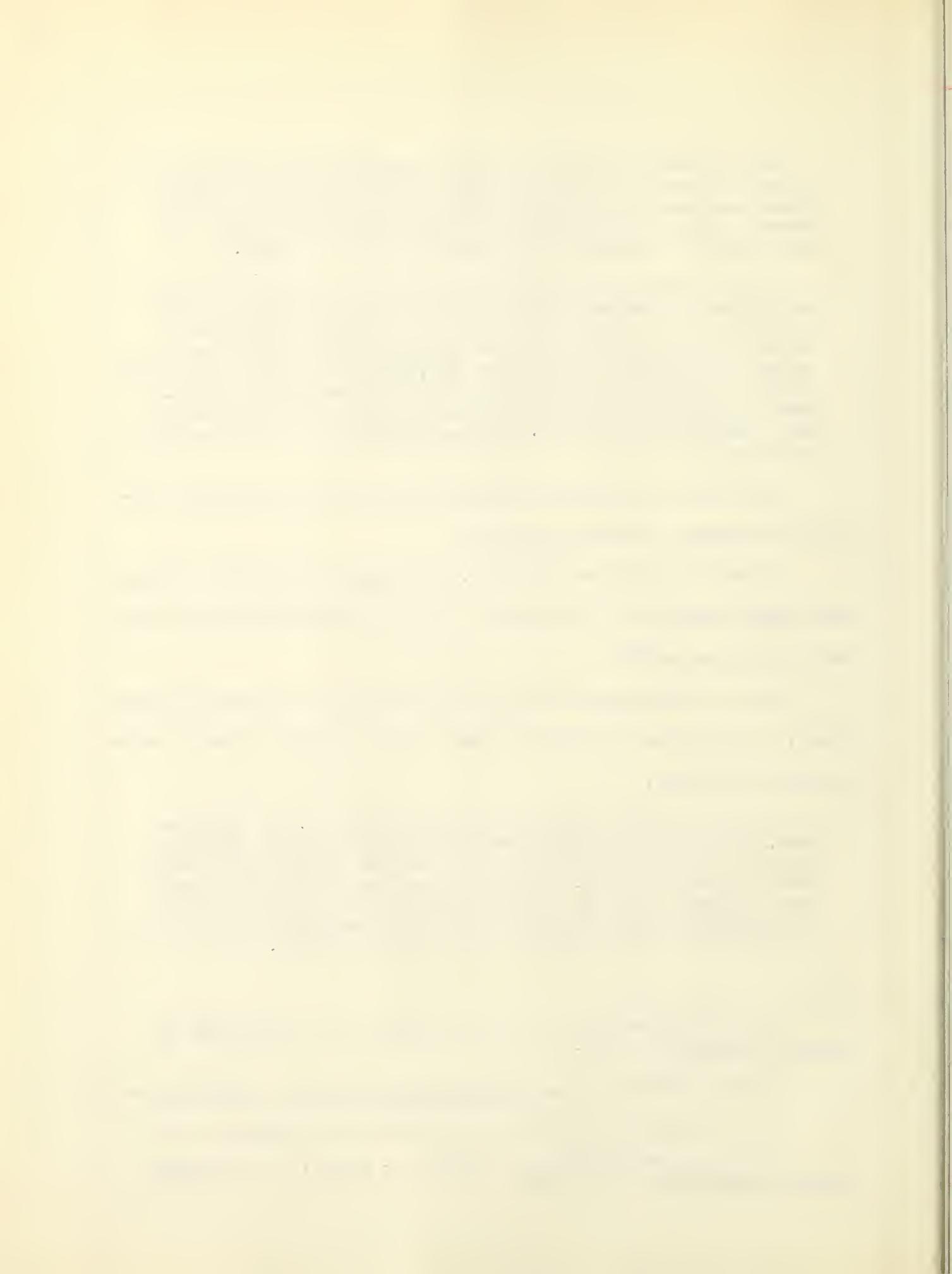
Not all alcoholic individuals develop psychoses. On the other hand, all of the above group contribute cases to the psychotic reaction, the picture varying with the previous psychobiologic experience of the individual. The nutritional and the physical status are important factors and when considered with the general personality pattern of the individual explain the seemingly wide variation in tolerance to alcohol seen in any group of patients.¹⁴

11 A. H. Maslow, Ph.D. and B. Mittlemann, M.D., Principles of Abnormal Psychology, p. 512.

12 Otto Fenichel, M.D., The Psychoanalytic Theory of Neurosis p.379.

13 A. H. Maslow, Ph.D. and B. Mittelmann, M.D., op.cit., p. 512.

14 E. A. Strecker, M.D. and Franklin G. Ebaugh, M.D. Practical Clinical Psychiatry, pp. 238, 239.



The analytic school of psychiatry places great emphasis on the sexual maladjustments of the alcoholic.

The unconscious impulses in alcoholics are not only oral but homosexual in nature. It is only necessary to call to mind the numerous drinking customs to find confirmation of this fact. That latent homosexuals, seduced by social frustrations, are particularly fond of alcohol is more probable than that alcohol through its toxic effectiveness would be conducive to homosexuality.¹⁵

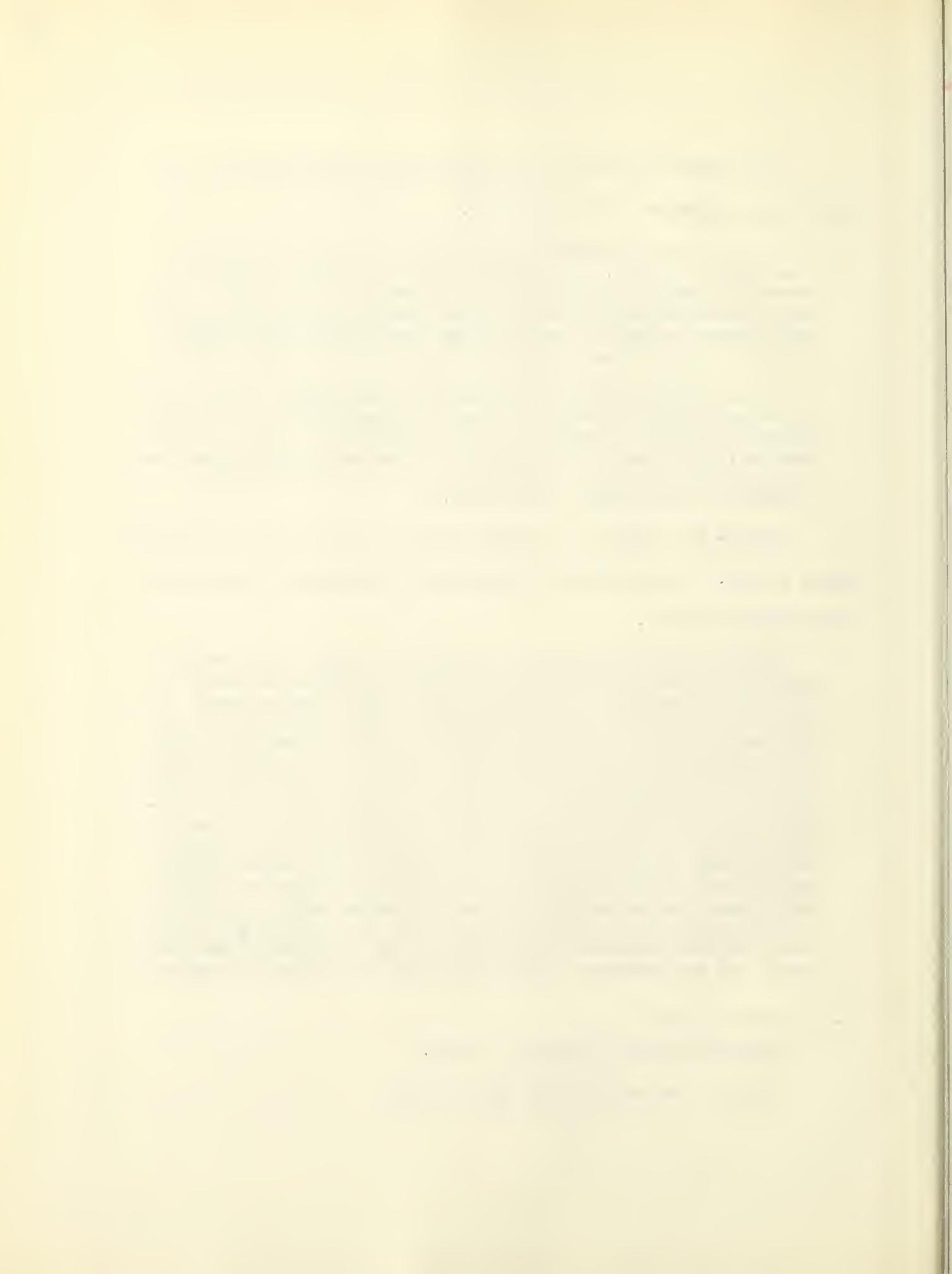
It has been asserted that all excessive and chronic drinking is rooted in a strong homosexual drive, inadequately repressed, yet not becoming overt in behavior. This assertion is open to serious question; the formula is too simple to cover all possibilities seen in the psychopathology of these cases. In fact, the essential mechanism in most cases is not known.¹⁶

Chronic alcoholism is a symptom rather than the cause of abnormal mental states. It is often the indication of pre-psychotic states and even psychotic states.

Alcoholism as a psychiatric abnormality is symptomatic of an underlying personality illness or disorder and must be treated as a psychiatric problem. That the alcohol addict does not stop drinking in spite of painful experiences which include loss of job and prestige, physical torment and other related miseries should be adequate evidence that underlying factors are literally driving him to drink and he is psychiatrically ill. No emotionally healthy individual deliberately does that which causes him to suffer, provided that he is aware that suffering will result from his behavior. The alcoholic addict is, therefore, either unaware, is not sufficiently aware or does not want to be aware of the serious harmful consequences of his drinking to do anything constructive about his addiction. The reasons for this lack of insight are to be found in the unconscious and may be associated with such defined psychiatric groups as the feebleminded, the organic, the psychopath, the psychotic and the neurotic. Physiologic factors involved include cell

15 Otto Fenichel, op. cit., p. 380.

16 L. G. Lowrey, M.D. op. cit., p. 139.



changes and lowered resistance to the drug.¹⁷

Classification

R. V. Seliger, M.D. says that in general the alcoholic addicts may be classified into the following distinct groups:

1. Those who because of constitutional inadequacies (genogenic) are unable to meet life's responsibilities and in addition to their drinking habits have other poor life habits. These individuals may eventually become deteriorated or asocial, requiring permanent mental hospitalization. 2. Those who are not strongly endowed intellectually and emotionally and who suffer psychic frustration with underlying psychiatric disorders (manic depressive swings, schizophrenic reactions) which cause them to seek escape from life reality by means of alcohol. 3. Those who drink to flee from unpleasant life situations they can not or do not wish to face and meet - the neurotic or psychogenic personality. 4. Those who relieve various combinations of feeling of inadequacy, self consciousness, sexual maladjustment and the like. 5. Those who drink to narcotize physical and psychiatric pain. 6. Those who as a result of habit plus time and body changes and added strains and griefs of life develop from social drinkers into alcohol addicts.¹⁸

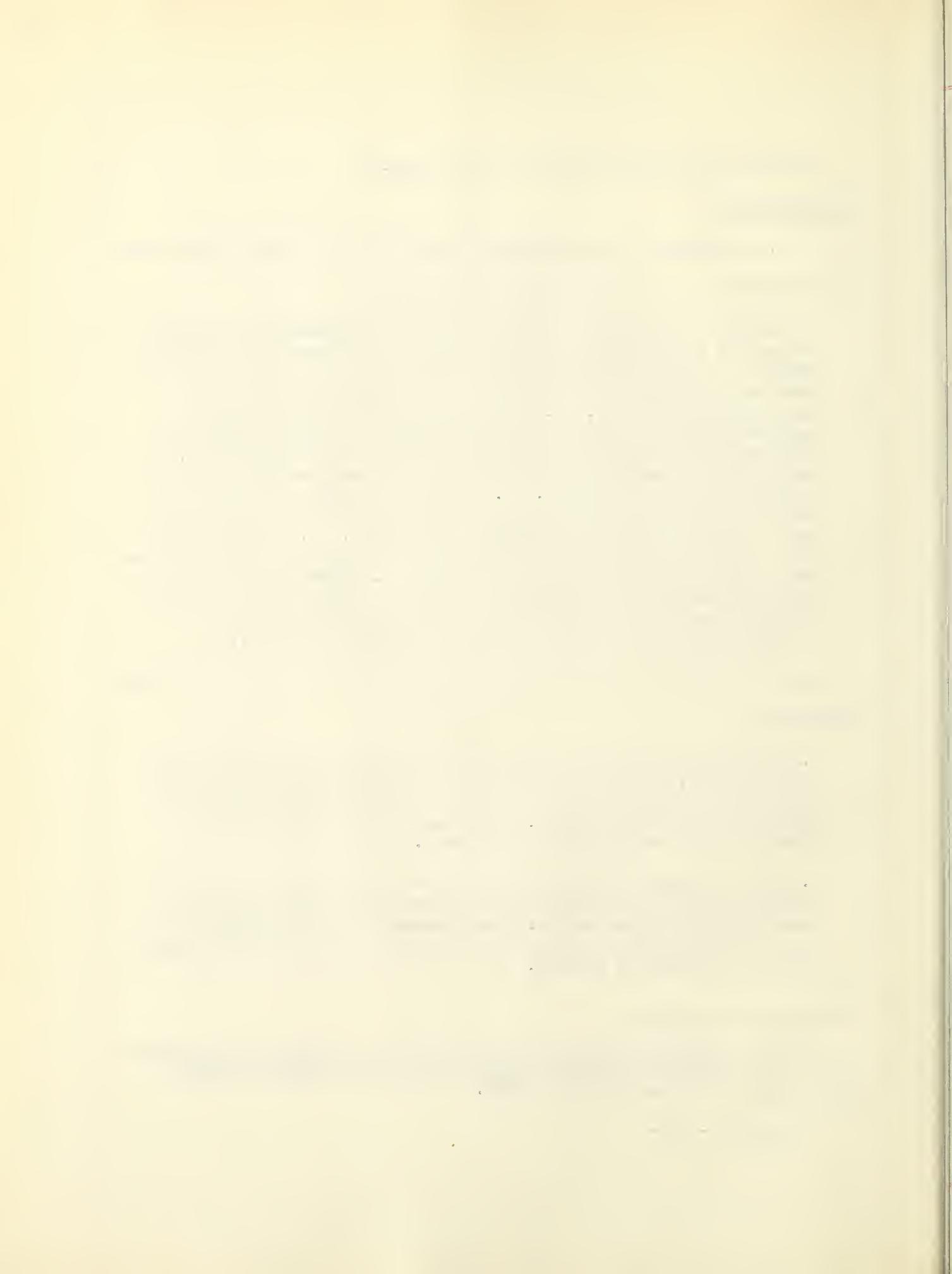
The same author discusses the type of treatment for the various classifications:

1. The individual who desires to abstain but who is unable to do so by himself. This patient has the desire to abstain and his life habits and contacts are not too bad; he has good intelligence and some maturity in his make-up. This patient is to be handled in outside office practice type of therapy.

2. The individual who desires to abstain but is unable to do so by himself, who has poor habits and contacts, good intelligence and some maturity in his make-up. This patient should be placed in a rest home farm where psychotherapy including help and guidance away from his contacts is started.

17 R. V. Seliger, M.D. and Victoria Cranford, "Psychiatric Orientation of the Alcoholic Criminal," The Journal of the American Medical Association, 129:421, October 6, 1945.

18 Ibid, p. 422.



3. The individual with good intelligence, with rather immature make-up, who should abstain but does not desire to do so. Most of this group have poor habits and contacts, although some do not. This patient should be placed on an alcohol farm, sanitarium, or hospital under the Inebriate Act, for a definite length of time.
4. Korsakow's psychosis and alcoholic deteriorated patients should be treated in mental hospitals permanently.
5. Individuals with delirium tremens and acute hallucinosis should be placed in acute psychopathic hospitals and then studied in the way described for future handling.
6. Feeble-minded individuals with history of repeated commitments to the workhouse or the house of correction, after careful examination, should be handled by the penal system.¹⁹

Therapy

In 1936, the then Commissioners of Correction, Mental Health and Public Health, Arthur T. Lyman, Winfred Overholser, M.D. and Henry D. Chadwick, M.D., as the result of a study for the legislature, reported:

"It would be entirely logical for the General Court to authorize the care of inebriates, as was the case prior to 1922."²⁰

In 1942, Clifton T. Perkins, Commissioner of Mental Health, made a study of alcoholism and he reported to the legislature:

"As stated in House No. 167, in 1936, it would be entirely logical for the General Court to authorize the care of inebriates by the Department of Mental Health."²¹

¹⁹ R. V. Seliger, M.D. "The Psychiatric Treatment of the Alcohol Addict," Journal of Criminal Psychopathology, III:1: 78, July, 1941.

²⁰ Commonwealth of Massachusetts, Report of the Special Commission on the Advisability of Establishing Public Clinics, Etc. for the Treatment of Persons of Confirmed Habits of Intoxication, House No.167, 1935, p.20.

²¹ Commonwealth of Massachusetts, Special Report of the Department of Mental Health on the Advisability and Expense of Establishing a Bureau for the Care of Inebriates, House No. 1276, 1942, p. 18.

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In the 1942 report to the legislature Commissioner Perkins advances a program for the treatment of chronic alcoholics which program shows the importance of medical care for the chronic alcoholic:

The treatment of the chronic alcoholic may be divided into the physical and mental aspects. Many chronic alcoholics enter hospitals with acute alcoholic symptoms. The incidence of fractures and other trauma is high among this group. Due to faulty habits of eating many of these patients show symptoms of mineral and vitamin deficiency. The necessary minerals and vitamins are given to the patient both in special diets and separately. Most psychiatrists are agreed that to be entirely successful a patient must entirely renounce alcoholic beverages. There are still differences of opinion as to whether there should be immediate complete or gradual withdrawal of alcohol. Sedatives may be given for the withdrawal symptoms. Benzedrine has been used to combat the depression which sometimes follows the withdrawal of alcohol.²²

The value of classification and the need for careful selection of patients for treatment is indicated by Dr. Perkins. There is a need for several types of treatment and treatment must be fitted to the alcoholic rather than the alcoholic being given a standardized treatment. Dr. Perkins implies that the hospital cannot benefit certain types of alcoholics, such as the psychopaths, and that some other method of handling the untreatable is necessary.

All patients who are treated for alcoholism do not recover. The selection of patient for whom treatment may be successful is a problem even for the experienced psychiatrist. There are various types of inebriates with different basic reasons for development of the drinking habit, and treatment, therefore, cannot be standardized. Each patient is an individual problem. Patients with a basic underlying psychopathic personality do not respond well to treatment.

It is generally conceded that the patient must develop insight into his problem, that he must be moderately intelligent and must

22 Ibid, p. 16.

THE HISTORY OF THE UNITED STATES

OF THE

REPUBLIC

OF

AMERICA

BY

W. H. RAY

NEW YORK

1854

THE

AMERICAN

BOOK

COMPANY

NEW YORK

1854

THE

AMERICAN

BOOK

COMPANY

NEW YORK

1854

have the desire to get over his habit. He must be convinced that living without alcohol is better for him than living with it, and must act on this belief. The statement of patients as to insight regarding the matter cannot be relied on entirely. The psychiatrist's experience in evaluating the possible prognosis in a given case is most important in the selection of a case for treatment. The arbitrary forcing of patients to accept treatment is psychologically not too sound. It is true, however, that legal restraint must be used in many cases.²³

The need for a thorough social, economic, and occupational history of the patient is recognized. This is a field in which the social case worker would be of great value. Such a history is needed in treatment as well as diagnosis and would be of special value in planning for the return of the patient to the community.

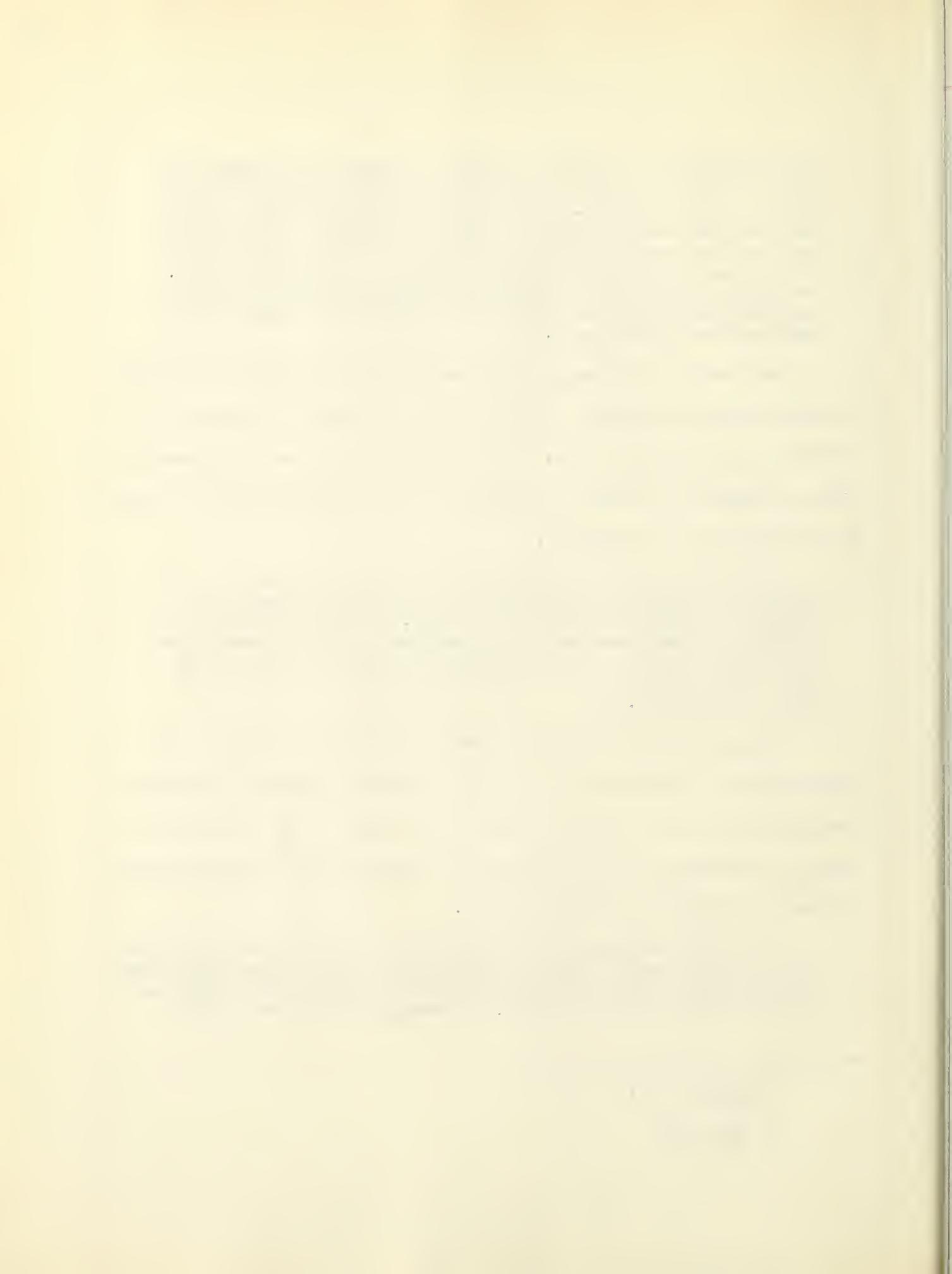
The psychiatrist must obtain and retain the confidence of the patient. A thorough investigation of the social, economic and occupational life of the patient is made. A thorough personality inventory is necessary and the psychotherapy which follows thereon is most important. The psychiatrist attempts to find out the why of the drinking, and to take proper steps to counteract the causes of drinking.²⁴

Treatment requires something more than hospital buildings and psychotherapy. Occupational therapy, pre-vocational training, duties at the institution are an important part of the program. The institutions caring for inebriates must have sufficient land, buildings, machinery and equipment to furnish a balanced program.

In the institutional type of treatment, efforts are made to establish a schedule which keeps the patient busy at all hours either with treatment (psychotherapy), occupation or recreation. This requires personnel and special equipment. Gardens and farms, wood lots,

23 Ibid, p. 17.

24 Loc. cit.



opportunities for physical as well as mental work, must be provided.²⁵

The desirability of establishing membership of an active type in religious, temperance and social welfare type while the alcoholic is being treated in the institution is pointed out by Dr. Perkins. Although he does not mention the organization, an introduction to the work of Alcoholics Anonymous while at the institution might be helpful in treatment and of assistance to the alcoholic after his return to the community.

"Certain individuals are able to utilize socially acceptable substitutes for inebriety-religious and social welfare have proven adequate substitutes for some."²⁶

One of the greatest benefits to come from a specialized institution with a staff specializing in the treatment of alcoholics would be the scientific research and experimental work which could be carried on in conjunction with the work of the institution. It is only necessary to point out the work of the Washingtonian Hospital in this respect to indicate the values which might come from a public hospital specializing in the treatment of alcoholics.

"Good reports have recently been recorded for the so-called 'conditioned reflex' treatment of alcoholism. Gradually an aversion to alcoholic beverages is created through this form of treatment."²⁷

25 Loc. cit.

26 Loc. cit.

27 Loc. cit.



The commitment to an institution or a treatment program for alcoholism should be on an indeterminate basis such as mental hospital commitments are at present. The staff should decide if the alcoholic has reached the maximum point of improvement or if further institutional care will be more harmful than beneficial. First aid treatment should be done in the community at mental hygiene clinics.

It has been demonstrated repeatedly that short periods of hospitalization are of little value in the treatment of inebriates. Repeated hospitalization is the rule when short periods are used. Six months to a year of hospitalization is more nearly a proper period of institutional treatment in most cases.²⁸

Commissioner Perkins also indicates the need for preventive measures and the establishment of clinics.

"Preventive measures should be emphasized. Both in-patient and out-patient general hospital clinics for the treatment of acute and chronic alcoholism should be encouraged."²⁹

Summary

While there are still differences of opinion as to whether chronic alcoholism is a disease or a crime, the weight of expert opinion is that chronic alcoholism is a psychiatric illness or a symptom of a psychiatric disorder and that alcoholism should now be treated as a medical rather than as a penological problem. Even the present day authorities in criminology are in accord with the psychiatric opinion that excessive drinking is due in a large proportion of the cases to forces over which the drinker

28 Ibid, p. 18.

29 Ibid, p. 19.

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has little or no control.

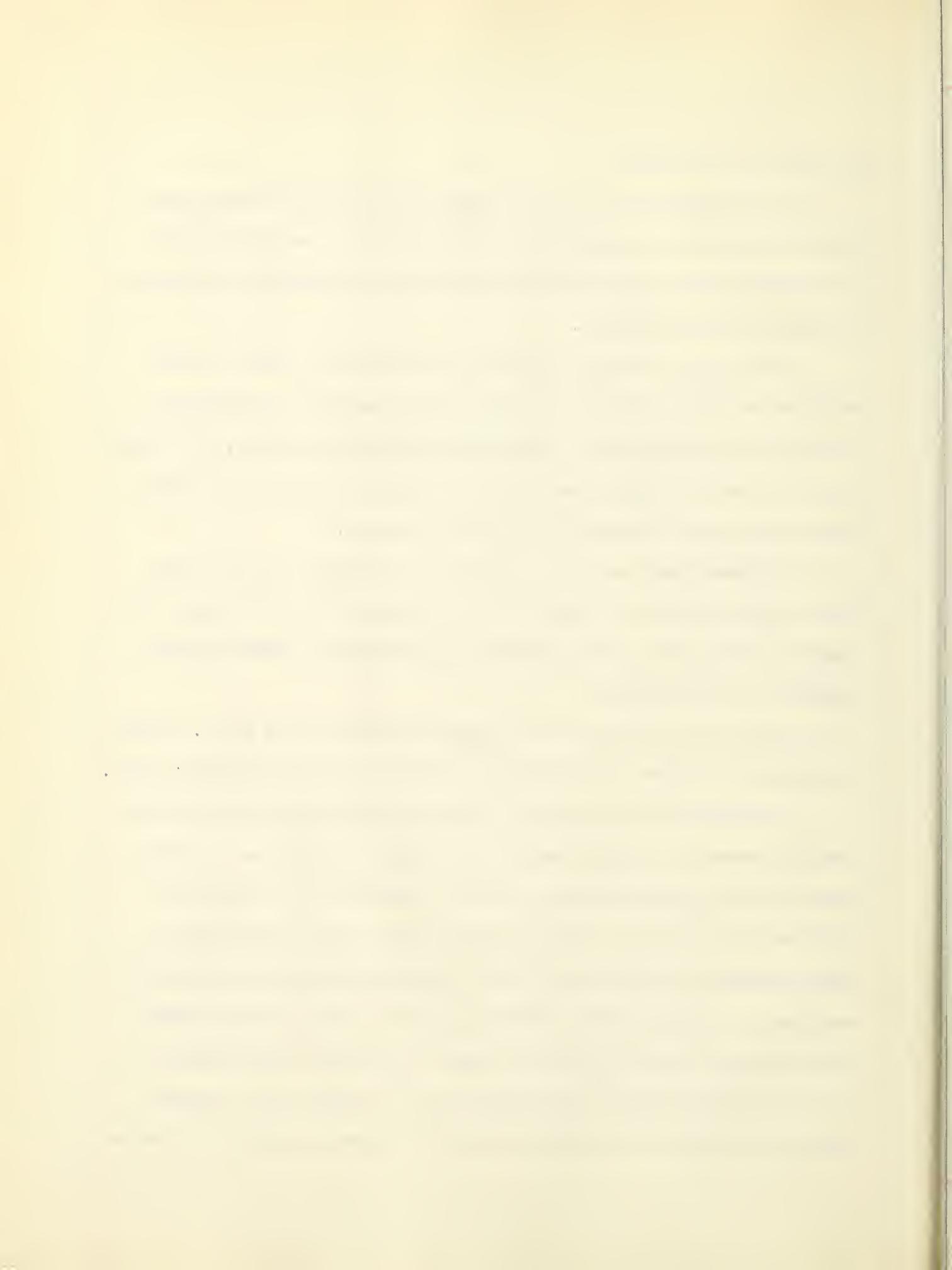
The psychiatrist has not been able to single out any single cause of alcoholism but he has been able to determine what personality traits are commonly found in alcoholics and has developed mechanisms to overcome disposing personality traits.

It has been found that alcoholics are immature, insecure, oversensitive and anxious people who suffer marked feelings of inferiority and they have a need to seek gratifications through oral means. The alcoholic is often a dependent person and is frequently attempting to escape from conflicts within himself or in the environment.

Environmental factors are important. Contacts with groups which drink heavily furnish an opportunity and an inclination to imitate. The analytic school places much emphasis on the existence of sexual maladjustments in the alcoholic.

Care must be taken not to accept the symptom for the cause. Chronic alcoholism is often the indicator of psychotic and pre-psychotic states.

All alcoholics do not present the same problem and the probabilities of successful treatment vary with the type of alcoholic. For this reason careful classification of cases for treatment and a variety of resources for meeting the problem are necessary. Penal institutions, mental hospitals and social case work in the community are all important resources, each being useful in certain types of cases or in the treatment of several types at different stages. A thorough investigation of the social, economic and occupational life of a patient and a complete personality inventory are pre-requisites for accurate diagnosis and treat-



ment.

To assist the court in determining the proper disposition of early cases of alcoholism and to aid probation officers and case workers in the handling of alcoholics and the prevention of chronic alcoholism, mental hygiene clinics in accessible locations are urgently needed.



CHAPTER III

PROCEDURE FOR CONTROLLING THE ALCOHOLIC

Criminal CommitmentHistorical

The criminal or penological approach is the oldest public method of attempting to control the alcoholic problem. Early in the colonial history of the Commonwealth drunkenness was declared to be a crime and punishable by the modes of punishment then generally used and intoxication has continued to be a crime in this jurisdiction to the present day.

"Drunkenness and its related offenses were present in no mean volume in spite of the fact that severe penalties and restrictive measures were constantly applied."¹

As early as 1630 a Colonial law permitted the 'seizure of strong water' because 'great quantities thereof' had been sold 'to several men's servants which was the occasion of much disorder and misdemeanor'. Fines for 'drunkenness and distemperring oneself with strong water' were of frequent occurrence.²

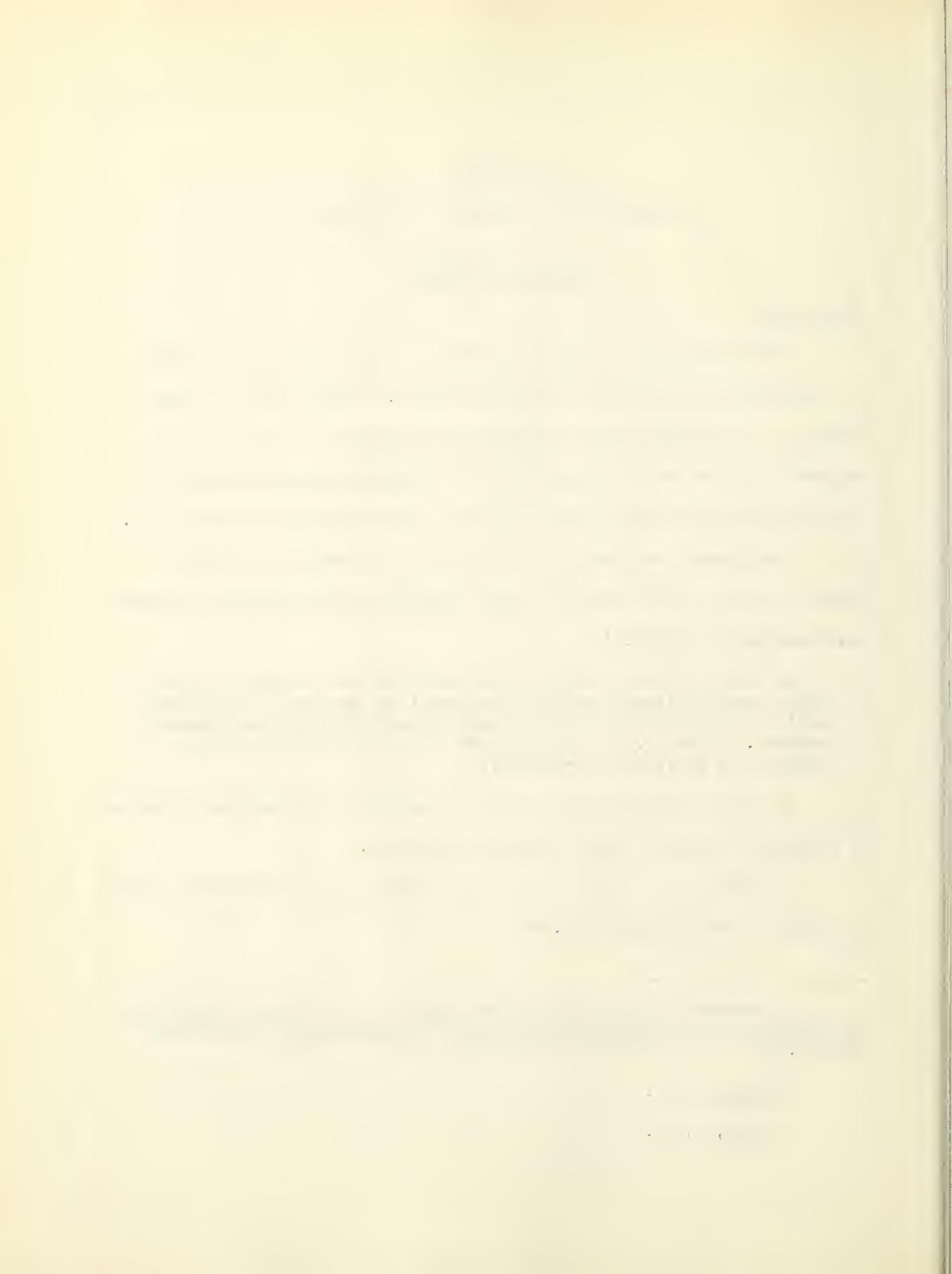
In 1636 licensing of dispensers of alcoholic beverages was attempted as a method of reducing the volume of drunkenness.

"In 1636 it was enacted 'that none allowed to be victuallers without the leave of the General Court.'³

1 Commonwealth of Massachusetts, Report of the Special Commission to Investigate the Problem of Drunkenness in Massachusetts, House 2000, 1945, p. 80.

2 Ibid, p. 81.

3 Ibid, p. 83.



In the same year the General Court also defined drunkenness.

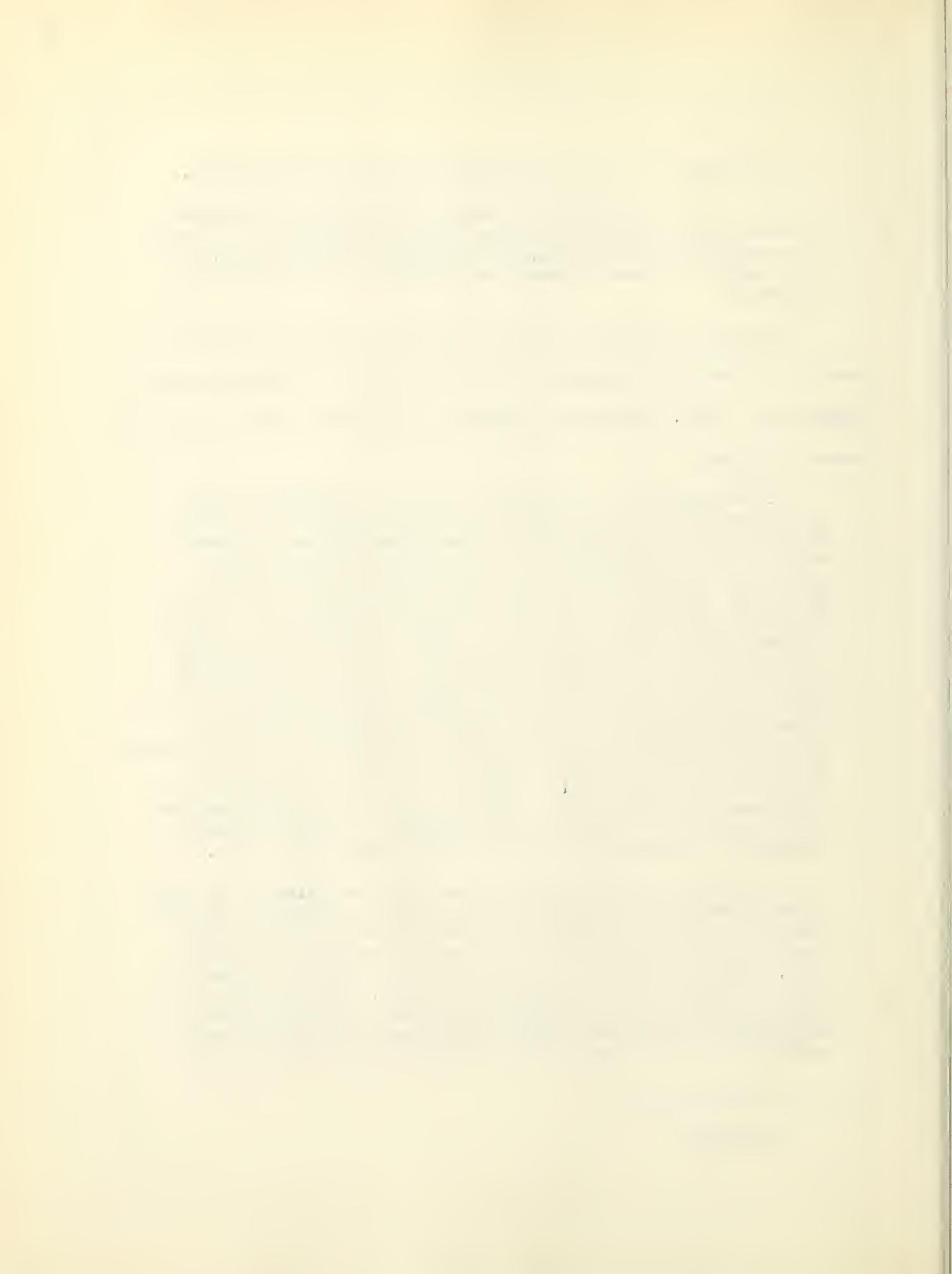
This act also defined drunkenness thusly: 'And by drunkenness is understood a person that either lisps or falters in his speech by reason of over much drink, or that staggers in his going, or that vomits by reason of excessive drinking or cannot follow his calling'.⁴

The extent of the problem and penological method of attempting to meet it is shown in the preamble to the revision of the Plymouth Colony Laws in June, 1671. The chapter relating to drunkenness and intoxication reads as follows:

25. Forasmuch as it is observed, the sin of Drunkenness doth greatly abound, to the dishonor of God, impoverishing of such as fall into it, and grief of such as are sober minded; for prevention and it may be suppression of that growing and prevailing evil; it is enacted by this Court and authority thereof, that whatsoever person shall be found drunk at any time in any tavern, ordinarie, alehouse or elsewhere in this Government, or be legally convict thereof, he or they shall for the first default be fined five shillings, to the countries use; for the second default ten shillings, and if he or they will not pay or can not pay the fine, then to be set in the stocks not exceeding two hours; for the third transgression to be bound to the good behavior, and if he transgresses a fourth time to pay five pounds or be publicly whipped, and so from time to time as often as they shall be found to be transgressors in that kind; by drunkenness is to be understood one that lisps or falters in his speech by reason of overmuch Drink or that staggers in his going, or that vomits by reason of excessive drinking or that cannot by reason thereof follow his calling.

26. Whereas, notwithstanding all the care and endeavors of this Court to prevent that great and raging sin of drunkenness; yet many goe on in it; Therefore this Court doth further enact, that the names of such as are found to be common drunkards in this Government, shall be enrouled or recorded, and that whatever person or persons, whether ordinarie keepers or others, shall give, sell or lend either directly or indirectly any strong liquors or wine or strong beer unto any such person or persons, shall forfeit ten shillings to the informer, and the names of such persons as are

4 Loc. cit.



found in any town, shall be set up in some publik place.⁵

Putting drunks into a cage is nothing new. In the following year (1693), by chapter 20 of the Province Laws, it was provided that drunkards who could not pay the fines might be sentenced 'by setting in the stocks, or putting into the Cage not exceeding three hours or by imprisonment twenty-four hours, or by whipping not exceeding ten stripes, as the case may deserve'.⁶

The failure of the laws to meet and adequately solve the alcoholic problem is indicated by the following excerpt from the report of a special commission making a study of the problem for the legislature of Massachusetts:

From the year 1712 to that of 1832 there were no substantial changes in the laws designed to prevent or suppress intemperance. The natural inquiry is, How successful were they in carrying out the desired objective? There is an abundance of literature to the effect that corruption and fraud and bribery combined to render all legislative enactments ineffective.⁷

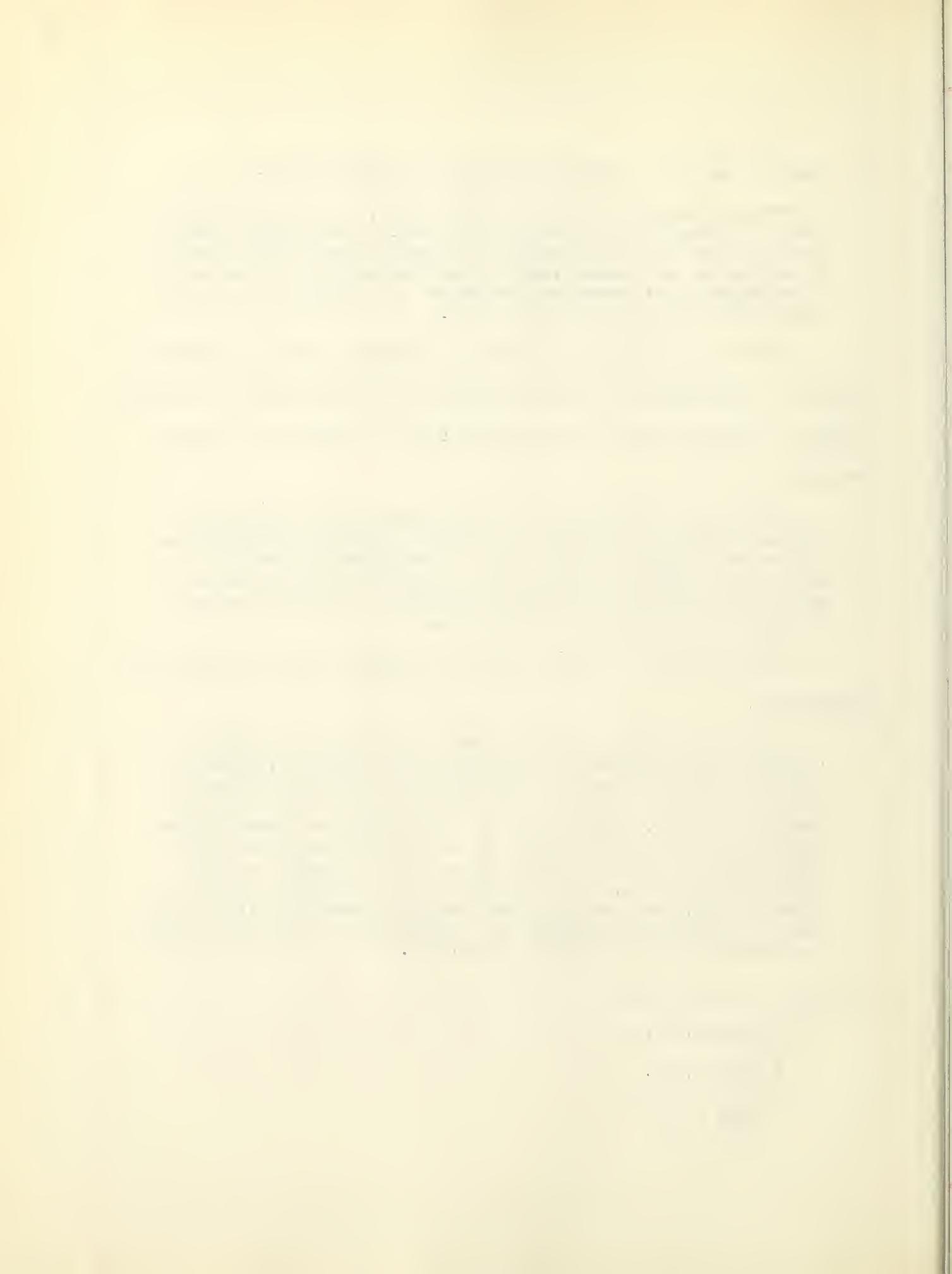
With the failure of other regulatory methods came the trend toward prohibition.

Then came the Acts of 1838, chapter 157, commonly called the 'fifteen gallon law,' which in substance made penal all sales of spirituous liquors less than fifteen gallons; licensed only apothecaries to sell for medicine and the arts; and punished sales for beverage purposes. This brought up the question of 'prohibition'. The act was contested in the courts of our Commonwealth as unconstitutional but was not decided before it was repealed in 1840 without reservations. The Supreme Court of our Commonwealth decided in 1840, that the repeal revived the pre-existing laws (chapter 47 of the Revised Statutes and chapter 242 of the Acts of 1837). See *Commonwealth v. Churchill*, 2 Met. 118.

5 Ibid, p. 85.

6 Ibid, p. 86.

7 Ibid, p. 88.



These acts forbade sales without licenses; forbade sales to minors; and on the Lord's day; and prohibited sales of liquor imported into the State by persons other than the importer, and then only in the original package. Strong penalties were provided for infractions. The cases were strongly contested, and in 1847 reached the United States Supreme Court. They were the so-called famous 'License Cases'. In a long and well reasoned opinion the Court decided that the States had the right to pass 'license laws' prohibiting the sale of liquor imported into the State 'by persons other than the importer' and 'then only in the original package.' See *Thurlow vs. The Commonwealth of Massachusetts*, 57 Howard, 256.⁸

Although licenses could have been granted to sell intoxicating liquor, none were in fact granted between 1837 and 1847. Massachusetts in 1852 and again in 1869 passed prohibition laws but neither law was properly enforced or observed. When strict enforcement was attempted, repeal set in and license was restored.

The legislature passed many perfecting laws to strengthen the enforcement such as that making the seller liable for damages caused by persons he made drunk and making the seller liable to the husband, wife, parent, child, guardian or employer of any person who became "addicted" after notice was given not to sell him.

The prohibition law of 1869 was repealed in 1875 and a new law enacted which provided for licenses to sell all kinds of alcoholic beverages, based on local option.

During the years 1875 to 1890, local option was instrumental in stopping the sale of alcoholic beverages in many cities and towns of the State. In 1890 over 82 per cent of the local communities were legally

⁸ Ibid., pp. 90, 91.

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"dry" and the number of licenses and the conditions under which liquor could be sold was greatly restricted in the license or "wet" communities.

Between 1890 and 1917 the legislature passed many laws designed to strengthen license or to relieve the licensee of burdens but there was no major or drastic legislation.

In 1917 Massachusetts had national war time prohibition and this was followed by the 18th Amendment and the Volstead Act which gave national peace time prohibition. Prohibition continued in force until 1933 when the 18th Amendment was superseded and the Volstead Act ended.

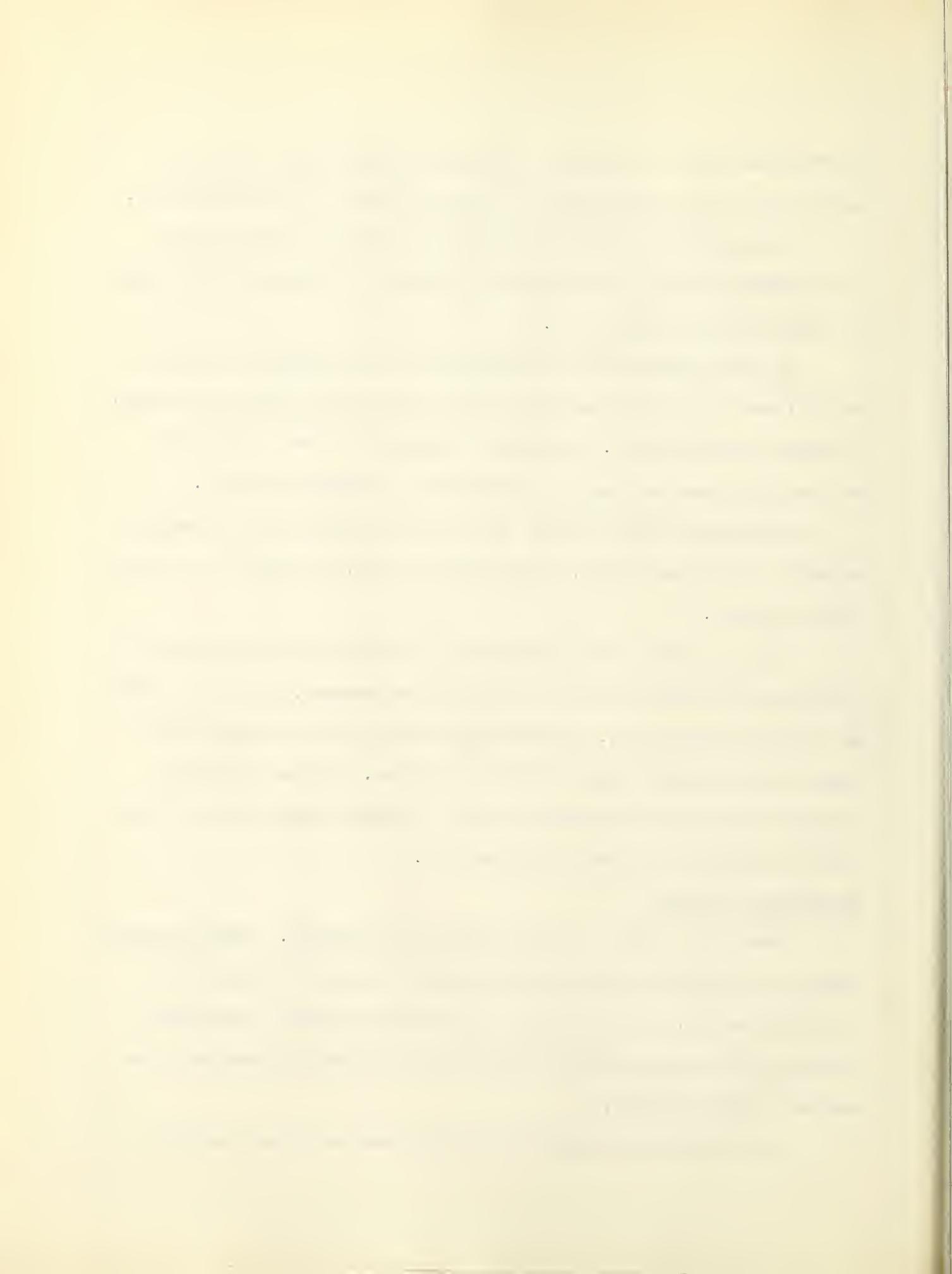
Massachusetts then returned to the local option plan of licensing the sale of packaged liquors, light wines and beer, and liquor to be drunk on the premises.

It will be seen that Massachusetts has used practically all types of regulatory measures, short of licensing the consumer, from "free trade" to state wide prohibition. Penological treatment also has varied from minor fines to lengthy commitments and whippings. Neither regulatory methods or penological treatment has been completely successful or effective in controlling the problem permanently.

Penological Treatment

There is no panacea for the problem of alcoholism. Both the penologist and psychiatrist differ as to the proper method of treating the chronic alcoholic. The following quotation from Professor Jerome Hall indicates that some psychiatrists feel that the chronic alcoholic is not suffering from a disease:

It is frequently assumed that there exists sufficient knowledge



to treat inebriates scientifically . . . But the major point is that there is no uniform medical opinion as to the best treatment for all the various types of alcoholism. To cite only one instance, consider the views of Dr. Olaf Kinberg, a distinguished Swedish psychiatrist. He argues that only in a small minority of cases is hospitalization for an extended period appropriate. He asserts that 'the alcoholic should not and cannot generally be considered as suffering from a disease. A treatment in any sort medical will therefore not be indicated. On the contrary, the treatment should be based on the opinion that the alcoholic is a man who in the majority of cases can abstain from ethylic drinks if you only give him sufficient motives'.⁹

H. E. Barnes and N. K. Teeters offer a solution in a new penal program.

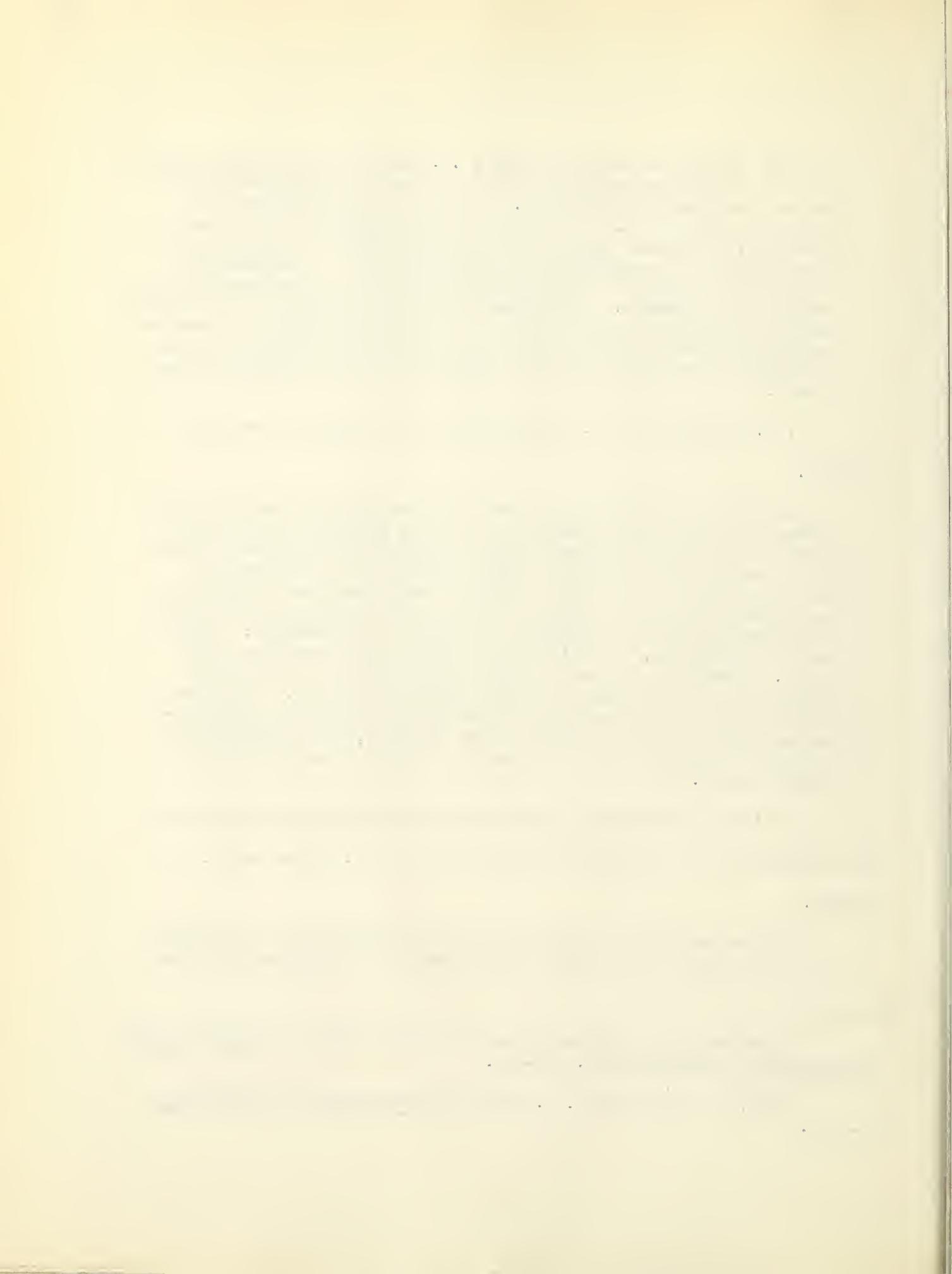
The solution offered by the new penal program includes the development of a number of colonies of the farm, forestry or work-camp type on indeterminate sentence basis. Scientific treatment primarily by medical men should be carefully worked out. The victims should have adequate housing, plenty of wholesome food, recreation and relaxation, a work program suited to their needs and potentialities, and medical and psychiatric analysis and treatment. Custody should be provided, but this is not a serious problem with such cases. Inmates should not be released until they are materially helped and then only under careful parole supervision. Only when alcoholism is considered a problem in public health and mental hygiene, rather than law breaking to be punished, will any definite progress be made. Present treatment is a sheer waste of the taxpayers' money.¹⁰

The lack of scientific facilities, either penal or hospital, for the treatment of the alcoholic is indicated by H. E. Barnes and N. K. Teeter.

When we survey the facilities of the country that are available for the scientific treatment of the alcoholic or dipsomaniac, from

⁹ Jerome Hall, Drunkennes as a Criminal Offense, Journal of Criminal Law and Criminology, pp. 297-309.

¹⁰ H. E. Barnes and N. K. Teeters, New Horizons in Criminology, P. 883.



the moment he is arrested until he is finally released, we find practically nothing. The judge sentences him to jail for a few days where he rarely receives any treatment at all but is demoralized by the conditions surrounding him. He is looked upon as a common drunk but he may be suffering from a serious disease which only a psychiatrist can cure.¹¹

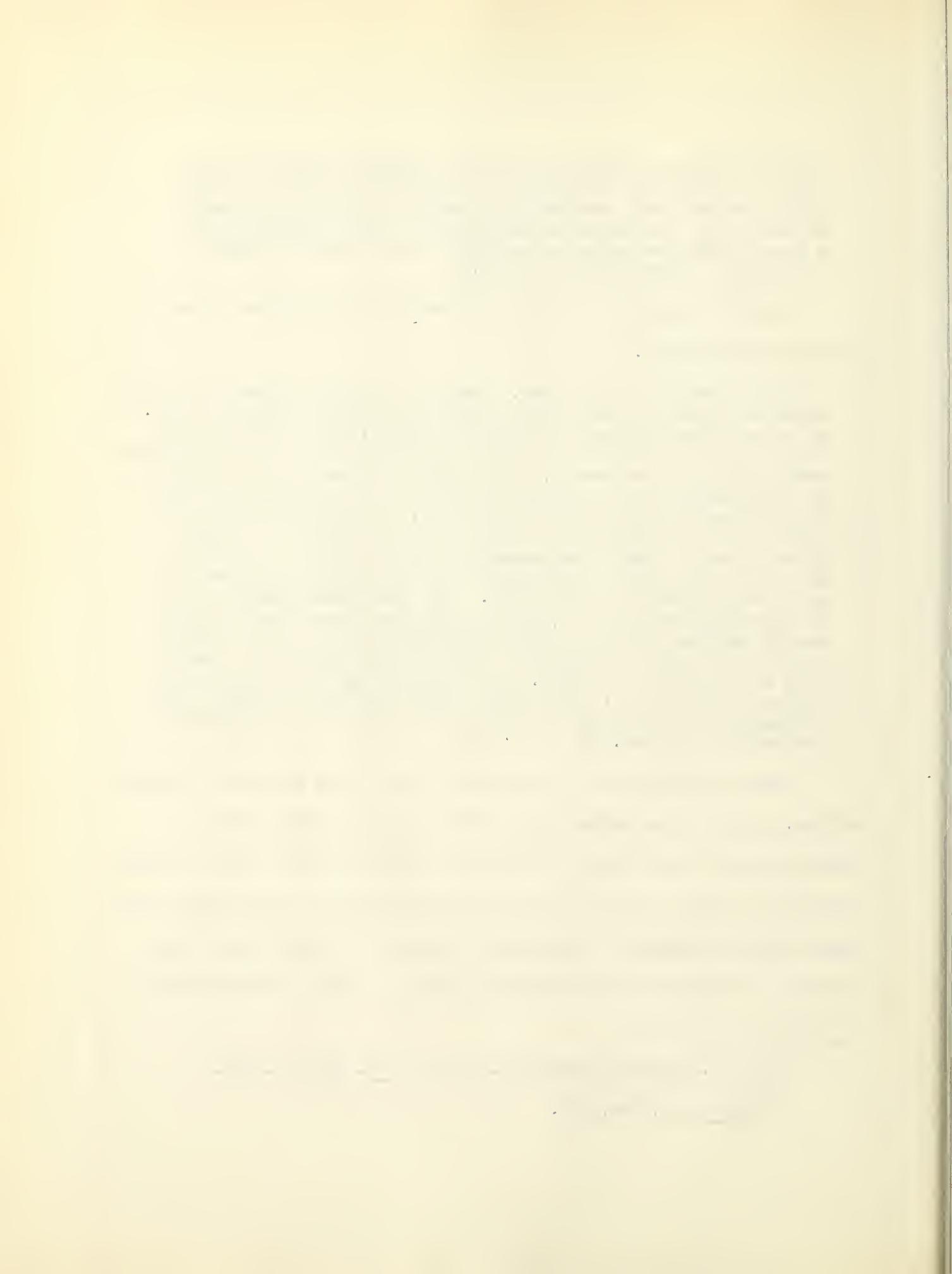
The same authors discuss the work done with alcoholics at the Bridgewater State Farm.

The picture is black indeed. Even the so-called misdemeanor farms attached to city or county jail systems do little therapeutic work. It is too often assumed that merely a month or two at hard work in the open air will cure the inebriate of his habit. Two institutions, mentioned by Mr. MacCormick, that attempt some scientific treatment of these cases are the Bridgewater State Farm in Massachusetts and the Indiana State Farm, near Greencastle. Bridgewater has resident physicians and psychiatrists (for it also handles the criminal insane)--but, to quote MacCormack 'no informed person could claim for Bridgewater that it has an adequate and effective program of care and treatment for alcoholics. Its chief advantages are that the alcoholics serve relatively long sentences under better living conditions than ordinary jails provide--with some sort of medical service that cares for physical conditions and psychiatric treatment in acute cases at least.' He adds that the officials at the Indiana institution, 'very honestly admit that they recognize the inadequacy of their program, especially in view of the shortness of the sentence imposed.'¹²

There is great need for more statistics on this large and important problem. While Massachusetts has a better reporting system than most states, there is still much to be desired. There is also a need for individual case studies such as those privately compiled by Judge Zottoli and reproduced in the Report of the Special Commission to Investigate the Problem of Drunkenness in Massachusetts, March 7, 1945, of which commis-

¹¹ H. E. Barnes and Negley K. Teeters, op. cit., p. 880.

¹² Ibid., pp. 880, 881.



sion Judge Zottoli was chairman.¹³

Austin MacCormick, nationally known penologist, has recently pointed out the complete lack of intelligent insight prevailing in the police, court, and correctional institutional treatment of chronic and ordinary drunks.

We do not know how many persons are arrested in the course of a year; we merely have sample statistics most of which come from the Federal Bureau of Investigation, and those are not comprehensive. We do not know how many of those arrested are convicted, or what disposition is made of their cases; suspended sentences, probation, fine, jail sentence, state farm and so on. We do not know, except in general terms to what institutions they are sent, what these places are like, what care and treatment they receive there, what medical services are available. We do not know what those arrested, or even sentenced, are like; their age, race, education, employment history, familial status, social and economic backgrounds. We do not know where they come from, or where they go upon release, or how many, if any, show signs of having been benefited. We do not know how much the penal and correctional process of dealing with the alcoholic costs.¹⁴

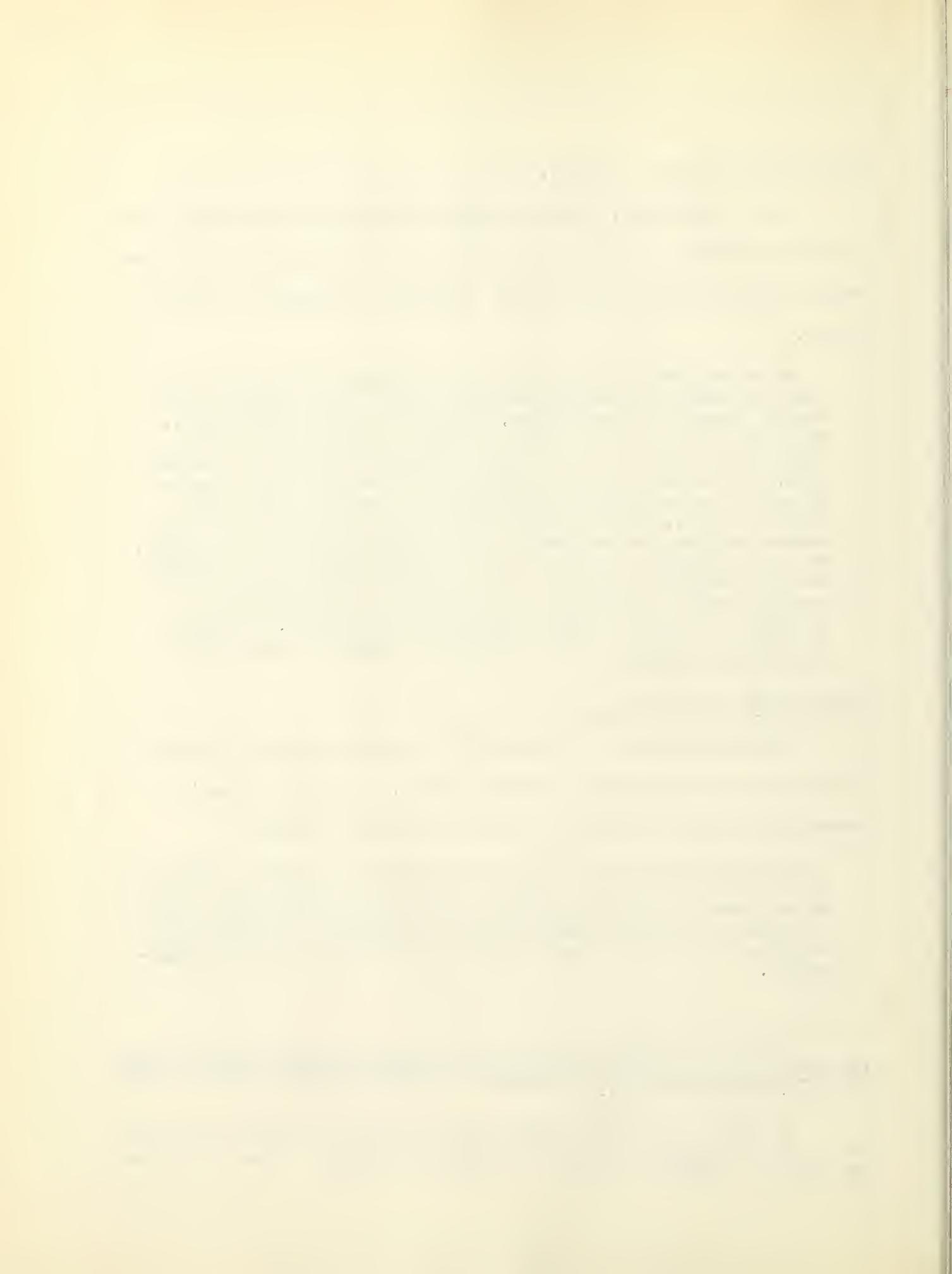
Criminal Laws and Proceedings

The legislature in the exercise of its police power has enacted a statute making intoxication a criminal offense. This may be found in General Laws, Chapter 272, Section 44, which reads as follows:

Whoever is found in a state of intoxication in a public place or is found in any place in a state of intoxication committing a breach of the peace or disturbing others by noise, may be arrested without a warrant by a sheriff, deputy sheriff, constable, or police officer and kept in a suitable place until he has recovered from his intoxication.

¹³ Commonwealth of Massachusetts, Report of The Special Commission to Investigate the Problem of Drunkenness in Massachusetts, House No. 2000 1945, pp. 220-258; 356-381.

¹⁴ Austin MacCormick, "Penal and Correctional Aspects of the Alcohol Problem," Quarterly Journal of Studies on Alcohol, Volume II, September 1941, pp. 243-259.



The foregoing section provides the basis for the penal treatment of the intoxicated person. It is designed to protect the intoxicated person from physical harm and loss of his property as well as to remove an obnoxious person from public places.

As the intoxicated person is in the act of committing a crime he may be arrested without a warrant and taken into custody without prior authorization of the criminal court.

After the intoxicated person has recovered he may, or may not, be held for court depending upon the number of previous arrests for intoxication charged against him within a year of the current offense. It is to be noted that the standard is not the number of times that the intoxicated person has been previously in an intoxicated condition, but the number of times that he has been arrested in such a condition. In practice, the alcoholic may be intoxicated from one to ten or more times before he is taken into custody under arrest. The personality of the intoxicated person while in that state has much to do with the likelihood of the alcoholic being arrested. If the alcoholic is boisterous and belligerent rather than quiet or euphoric, he is more likely to be taken into custody. However, from a medical viewpoint the number of intoxications rather than the number of arrests is more important.

If the offender has not been arrested four times for drunkenness during the prior year, the court, trial justice, probation officer or the officer in charge of the lock-up must release the intoxicated person upon his request after he has recovered.¹⁵ Until the current session of the

¹⁵ Mass. G. L., Ch. 272, s. 45 (Amended 1946, Ch. 274).



legislature, court officials had discretionary authority as to whether the intoxicated person should be released, but it is now mandatory that the recovered alcoholic be released if he has not been released four times within a year of the current arrest.

The provision of the "release law" must be specifically called to the attention of the recovered intoxicated person so that he may make written application for release.¹⁶

In order that information will be available as to whether a person has been previously arrested, courts and trial justices are required to keep records of persons released without trial.¹⁷

The law also provides for the exchange of information concerning persons charged with drunkenness by police, correctional institutions and probation officers.¹⁸

Of more practical importance is the provision for the reporting of all arrests to the central index operated on a state wide basis by the Board of Probation. This central index assists probation officers in determining if the intoxicated person has been arrested and released by one or more of the numerous district, municipal or trial justice courts of the Commonwealth.¹⁹

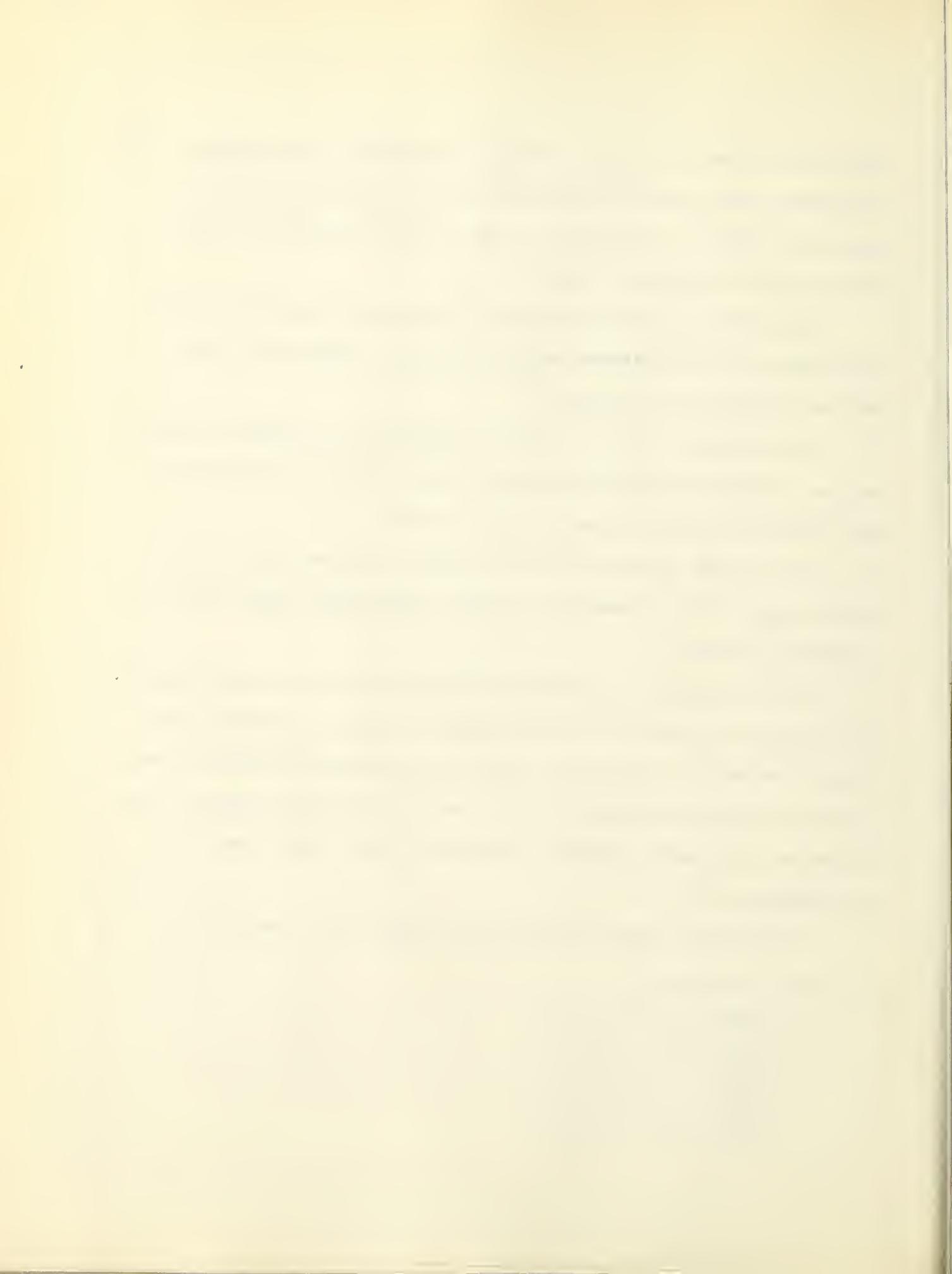
If the intoxicated person has been released four times for the

16 Ibid., Ch. 272, s. 46.

17 Ibid., Ch. 272, s. 47.

18 Ibid., Ch. 272, s. 50.

19 Ibid., Ch. 276, s. 99.



same offense within a year of the current offense, he must be arraigned before the court. At that time he is required to plead "guilty" or "not guilty" to the charge. Unless the intoxication is coupled with some other criminal charge, such as driving a motor vehicle while under the influence of liquor, the trial is held without delay and in a summary manner. Some judges seem to take pride in the speed with which the number of drunk cases can be disposed of so that they can reach the more serious or more important criminal and civil cases.

The evidence of guilt is usually given by the arresting officer and can seldom be successfully contested by the person arrested for intoxication. The substance of the evidence is that the defendant was incoherent, staggered, had a strong odor of alcohol on his breath, had glassy eyes and in the opinion of the arresting officer was drunk.

If the defendant pleads guilty or is found guilty the judge requests the arresting officer to state the conditions surrounding the arrest of the defendant, the emphasis being on whether the offender gave the arresting officer any trouble, caused a public disturbance or damaged any property.

The judge very seldom attempts to investigate causation and it can be seriously questioned if a public court room is the proper place to examine into the reasons for excessive drinking.

The next step is the furnishing of defendant's criminal record by the probation officer. The record is usually obtained from the central index operated by the Board of Probation and shows if the defendant is on probation or suspended sentence in any other court. The record will also

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show if the defendant is on parole from any penal institution. The practice is to notify the court or parole authority of the existence of the new charge so that the defendant may be surrendered for probation or parole violation if the court or parole authority is disposed to act. The probation officer may make a recommendation to the trial court as to disposition.

The sentence which a court may impose for conviction on the charge of drunkenness is specified in the statutes. The defendant may be fined, placed on probation, given a suspended sentence or sentenced to a jail, house of correction, reformatory or the State Farm.²⁰ Under the provisions of the suspended sentence law the offender is sentenced to pay a fine or to serve time in an institution but the sentence is not immediately executed, that is the defendant does not pay the fine or start serving time, instead the execution is postponed to some future date when the court may revoke or alter the original sentence. Commonly the court attaches the same conditions as probation and if the defendant satisfactorily meets these conditions, the original sentence is revoked and the case filed.²¹

The maximum fine which may be imposed is fifteen dollars and the maximum term of imprisonment is one year. Sentences to the State Farm are on an indeterminate basis, but sentences to other institutions are

20 Ibid., Ch. 272, s. 48.

21 Ibid., Ch. 279, s. 1.

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for a stipulated term.

The suspended sentence is often used by the lower courts to reduce appeals to the Superior Court. If a person guilty of drunkenness is given a regular sentence to an institution, except a very short sentence in the county jail, he will ordinarily take an appeal with the probability that he will get a shorter sentence in the Superior Court or that his case will be nol-prossed or placed on file. By suspending the execution of the sentence the lower court can often induce the defendant to accept the disposition and avoid the appeal to the Superior Court. The acceptance of the suspended sentence gives the offender his liberty immediately while the taking of the appeal often means that he will have to remain in jail because of the lack of bail until the appeal reaches or is heard in the Superior Court. The suspended sentence is generally coupled with probation, one of the conditions being that he remain sober. In so using the suspended sentence the court is aware that the offender will soon violate the terms of the suspended sentence and the original sentence can then be placed in operation without a right of appeal. The use of this method makes it appear that probation case work is ineffective in connection with drunkenness and statistics on the value of probation must be interpreted with this practice in mind.

The device of probation is an important part of the penal method for the control of the alcoholic. Probation originated in Massachusetts and was largely developed by the courts and legislature of this state. This Commonwealth's claim to the title of "the home of probation" rests upon the initial development in the practice of its criminal courts of a

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discrimination in the disposition of cases, by which the offender was placed under supervision in the community rather than in confinement. The practice of probation ante-dated the statutes, which have progressively clothed the courts with authority and have placed upon them definite duties in carrying out a broadly humane but still strongly correctional policy. The statutes have been mainly the record of an implemented idea, giving it legal operation and extending its effect into a uniform system.

Probation has been defined as the method of allowing a person convicted of an offense to go at large during good behavior under suspension of a sentence, usually under the supervision of an officer of the court. The term comes from the Latin word *probatio*, meaning test on approval, and it is said to have been first used by John Augustus, who introduced the practice as well as the word. It is interesting to note that this Boston shoemaker, who fathered the movement, first became interested in the idea as the result of his efforts to assist the common drunks who were in jail or were in the danger of being sent to jail because of an inability to pay their fines.²²

Probation generally follows conviction but it may be employed before conviction. It is optional with the offender as to whether he will accept it in preference to some other sentence or appeal. The terms of probation are entirely within the discretion of the court. Probation is not the final disposition of any case. At the end of the term of probation, sentence may be imposed, probation may be extended over a further

22 H. E. Barnes and N. K. Teeter, op. cit., p. 374.



period, new conditions imposed, the case may be filed or the person discharged.

Probation is a special field within the general field of social work and the probation officer a case worker. Probation officers have been handicapped in their work with alcoholics by excessive case loads which do not permit the intensive case work treatment that is necessary for successful therapy.²³ Probation officers have also been handicapped by lack of resources within their communities for psychiatric consultation and treatment. This is especially true of public psychiatric consultation and treatment resources. Private resources are giving some leadership in the field of alcoholic treatment. Recently a meeting was held at the Washingtonian Hospital for the probation officers of the Commonwealth. At this meeting it was decided that the probation staffs could refer a very limited number of cases each week for treatment, it being stipulated that referred cases must be persons with a sincere desire to overcome alcoholism.

Absence of high educational requirements and qualifying experience prior to appointment, the lack of a system for making non-political appointments on a merit basis, and the failure of the Board of Probation to conduct adequate staff training programs, in the opinion of the writer, has reduced the effectiveness of probation case work with alcoholics.

²³ Commonwealth of Massachusetts, Report of the Special Commission to Investigate the Problem of Drunkenness in Massachusetts, House No. 2000, 1945, p. 186.



All this manifestly means that judges, probation officers and district attorneys must be carefully selected and appointed. Here lies the cause of the failures of personnel. The best material one can find is none too good to start with.

How can the man who has little or no penological training before his election or appointment, all at once be expected to be a good penologist? And how can the man without a 'backbone' avoid the pressure that every one connected with the administration of justice in the penological fields knows is brought to bear upon him? We all know enough about probation to realize that it is a splendid preventive and salvaging system when properly operated . . . and that when not so operated it can be 'a harbor of refuge' for racketeers who have made up their minds to get the kind of living they want, 'no matter how.' Many of the so-called 'rounders' of the inebriate field come within this class. They escape proper punishment 'by the inherent weakness' of all good systems, - improper persons operating the penological machinery. There is a need for integrated action, to be sure, but there is no valid reason why all needed information for proper evaluation and disposition of inebriates beyond the 'beginner class' cannot be obtained for the court or district attorney, if it is so desired, except, perchance, that the 'case load' is too heavy for the number of probation officers now employed, if all the pertinent fields above referred to were to be thoroughly explored.²⁴

Judge Zottoli in the above statement points out many of the difficulties in the present penological system for handling alcoholics. Judge Zottoli recognizes a need for integrated action but his recognition is apparently limited to penological system. It is of interest to note that this learned authority on the treatment of alcoholism in this state feels that the legal machinery is not efficiently meeting the problem.

In sentencing to institutions there is considerable variation between the lower and Superior Court, between lower courts in various parts of the Commonwealth and even between judges in the same court. The judge has discretion to sentence from a portion of a day to one year. Common

24 Loc. cit.

sentences are seven, ten, fourteen, thirty days and three and six months. Sentences can be made to the various types of penal institutions, except the State Prison. Some judges are sentencing to institutions which they have never visited and therefore have little idea what the sentence will accomplish or fail to accomplish.

Before final conviction by the Superior Court the District Attorney may "nol-pros" the drunkenness complaint without the approval of the court. Nol-pros or nolle prosequi is the right of the District Attorney to state that he is unwilling to further prosecute that particular charge. This is commonly done in the Superior Court after the entry of an appeal from the conviction or sentence in the District Court.

The power of nol-pros is often abused in the case of persons charged with drunkenness. In some counties, especially Suffolk, a high percentage of the appealed drunkenness cases are nol-pros or filed so that few persons who are found guilty and are given sentences in the lower court, with the hope of aiding in their rehabilitation, actually are exposed to any type of treatment.

A survey of the disposition of drunkenness cases appealed from the Municipal Court of the City of Boston during 1940 shows that out of a total of 510 cases appealed 374 were nol-pros, 39 were placed on probation, 39 were filed, 49 had their sentences reduced and only 9 sentences of the lower court were confirmed. Of the 510 cases appealed, 452 never received any type of rehabilitation treatment on that particular offense and only 58, or 11.7 per cent, served a sentence, and of the 59 serving a sentence 49 had the sentence reduced upon taking an appeal. The survey

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shows that the reversals applied substantially equally to all the judges of the lower court. In 78 cases the reversal of the lower court required the concurrence of a justice of the Superior Court, as in the placing of 39 cases on file and the reduction of sentence in 49 cases.²⁵

The failure of the District Attorney and the Superior Court to uphold the work of the lower courts, except in those cases where the judgment of the lower court is obviously incorrect, is extremely discouraging to the judiciary of the lower court who are conscientiously trying to make the penal system effective.

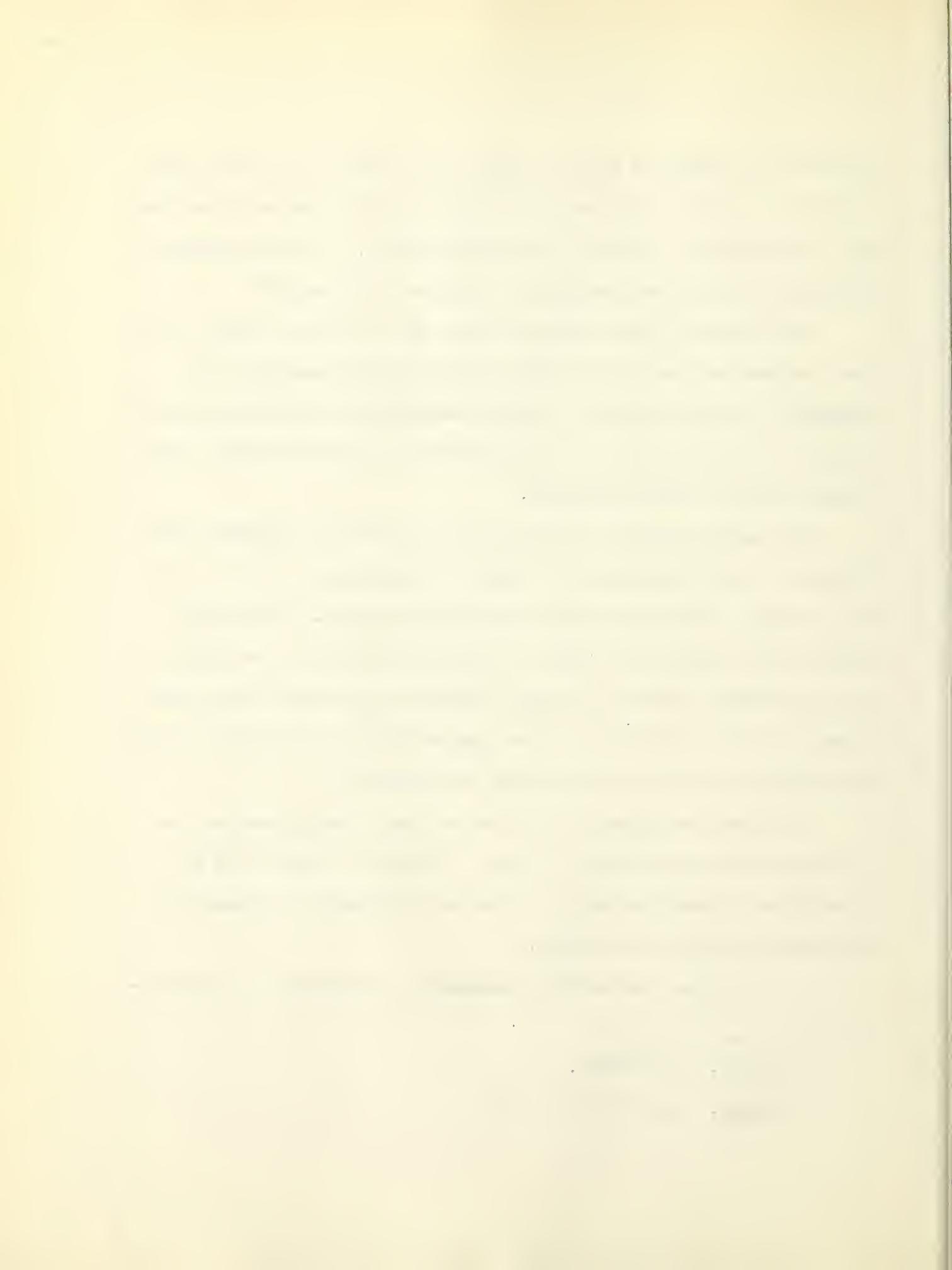
The appeal from the District or lower court to the Superior Court is given so that the offender may have his constitutional right to trial by jury which is obtainable only in the Superior Court. The right to appeal to the Superior Court must be specifically called to the attention of the defendant. During the period between his conviction in the lower court and trial in the Superior Court the defendant may be held in custody or released on bail or on his personal recognizance.²⁶

On appeal the Superior Court can make any disposition which the lower court could have made in the case. There is no appeal from the Superior Court except on matters of law and law appeals on drunkenness complaints are seldom encountered.

If the person charged with drunkenness is sentenced to an institu-

25 Ibid., pp. 226-227.

26 Mass. G. L., Ch. 278, s. 18.



tion, he may serve only a part of the term provided by his sentence. Paroles or permits to be at liberty may result in the alcoholic person being released long before the completion of his sentence.²⁷

About 10 per cent of those arrested are sent to institutions to serve a period of time, usually short, as a sentence.²⁸

Definite term sentences are given to jails and houses of correction but the sentences to the State Farm are on an indeterminate basis with a one year limit. The general practice has been for the Board of Parole to release from the State Farm at the end of three months persons serving sentences for drunkenness.

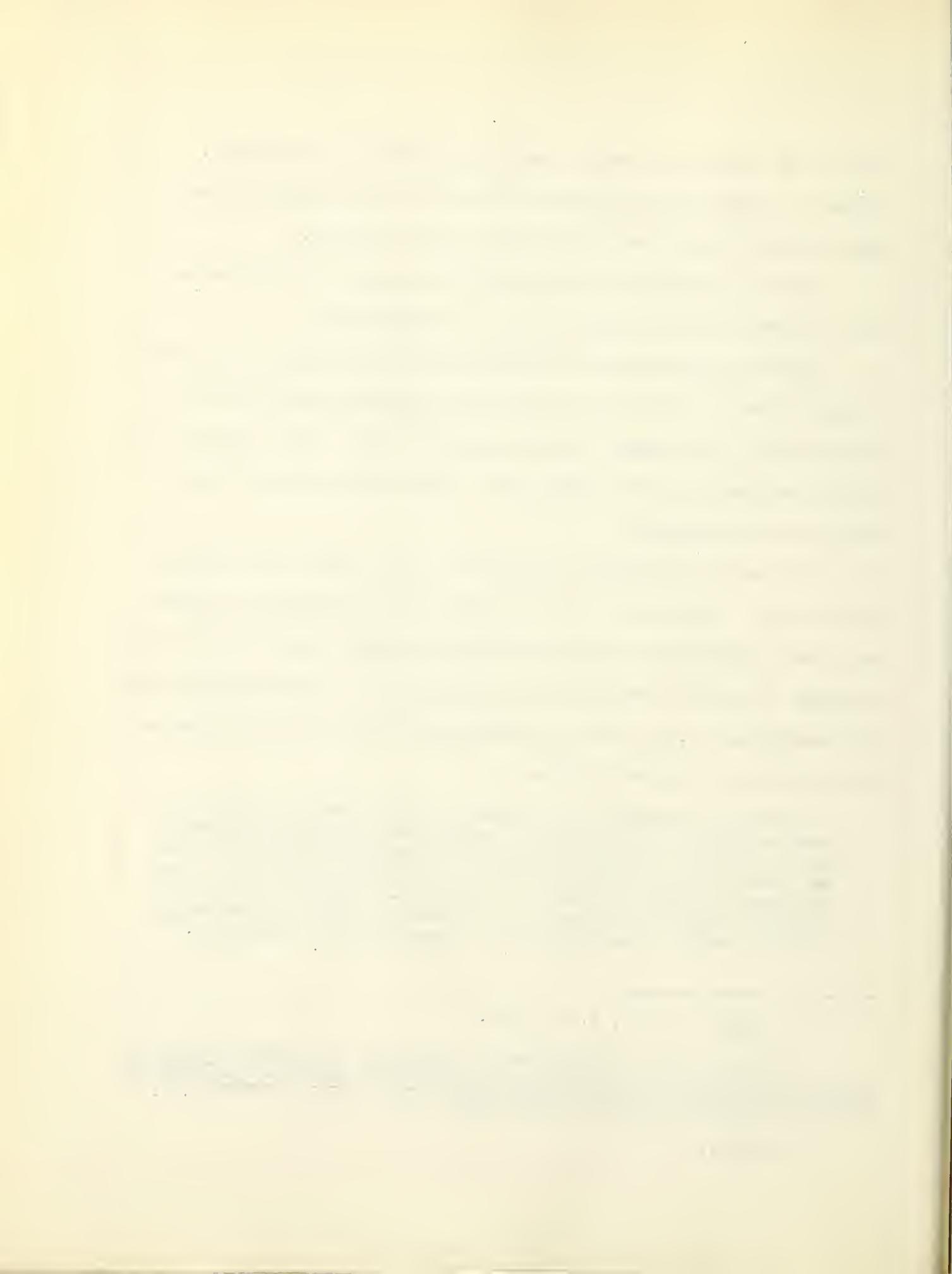
The rate of recidivism in the case of those convicted of drunkenness is high. A study made by the Division of the Examination of Prisoners of the Massachusetts Department of Mental Health covering five thousand convicted prisoners in county jails indicated that of the men serving terms for drunkenness, 48.3 per cent had served four or more previous sentences nearly always for the same offense.

In brief, it seems quite reasonable to state that the method of short sentences on the charge of drunkenness accomplishes extremely little, except to give the prisoner an opportunity to recover from the acute effects of alcoholism; there is nothing curative in a very considerable number, at least, of the cases. On the other hand, it is fairly certain that many of the persons arrested for drunkenness would not profit by commitment to an institution for inebriates.²⁹

27 Ibid., Ch. 127, s. 128, 140.

28 Commonwealth of Massachusetts, Report of the Special Commission on the Advisability of Establishing Public Clinics, Etc. for Treatment of Persons of Confirmed Habits of Intoxication, House No. 167, 1935, p. 9.

29 Ibid., p. 10.



Alcoholics released from jails and houses of correction receive no case work service. Because of the inadequacy of parole staffs, alcoholics paroled from the state institutions receive but limited supervision and real therapy is not possible. Efficient and effective parole costs considerably less than institutional treatment.³⁰ But effective and efficient parole is not possible without trained supervisors. Parole supervisors should have at least a college degree with case work experience and the personal qualities that are necessary for leadership and to inspire and motivate the alcoholic to abstain from alcohol. Parole officers should be well paid and have the protection of civil service status in the performance of their work. The ideal case load for a trained parole officer should be between fifty and seventy five cases even in urban Massachusetts in the opinion of the writer.

The following table shows arrests in Massachusetts for the years immediately preceding and following the repeal of the Volstead Act in 1933. The table also reflects, to an indeterminable extent, the effect of the economic conditions on alcoholism. The table represents the number of arrests for alcoholism and not the number of persons arrested, some alcoholics appearing several times a year in the totals. On the other hand, the number of arrests greatly understates the amount of alcoholism as many alcoholics are intoxicated numerous times without being arrested and there are great differences between various communities in the enforcement of the law.

30 H. E. Barnes and N. K. Teeters, op. cit., p. 10.

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TABLE I

ARRESTS FOR DRUNKENNESS IN MASSACHUSETTS, 1931-1940*

Year	Arrests
1931	76,042
1932	72,292
1933	75,279
1934	97,216
1935	93,151
1936	95,685
1937	97,930
1938	89,109
1939	84,863
1940	83,698

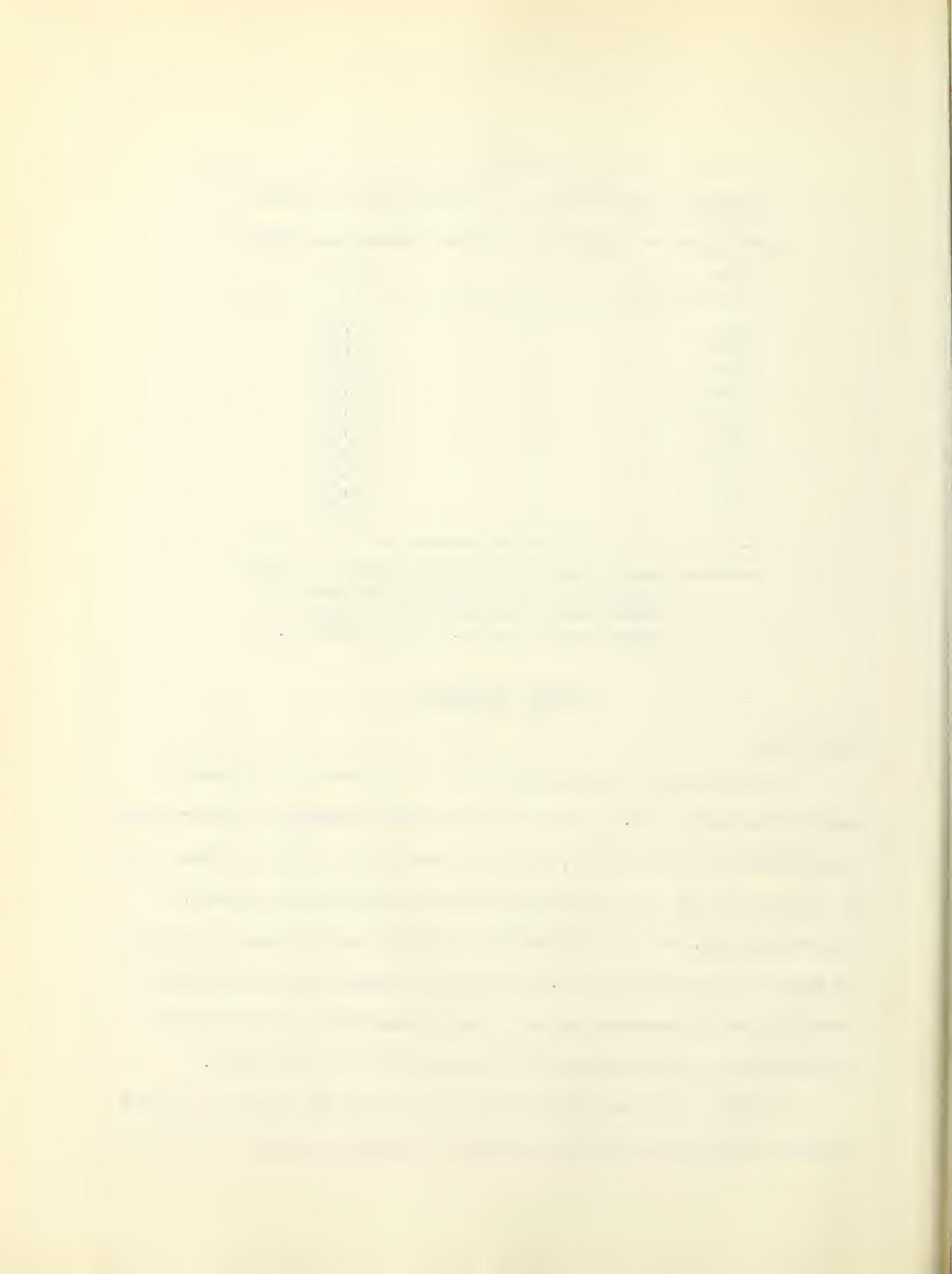
*Source: Special Report of the Department of Mental Health on the Advisability and Expense of Establishing a Bureau for the Care of Inebriates, House No. 1276 of 1943, p. 9

Medical Commitment

Historical

The concept that the alcoholic is a sick person and in need of medical care is not new. As early as the second century of the Christian era, Ulpian, the Roman jurist, urged the necessity of treating inebriates as sick persons and in special surroundings and with special means. In this country, Dr. Rush of Philadelphia in 1790 urged the need of treating the inebriate as a sick person. In 1833, Dr. Woodward of the Worcester Insane Asylum in Massachusetts urged that alcoholism be recognized as a disease and that special hospitals be provided for its treatment.

In 1858, there was established in Boston the "Home for the Fallen," a private institution for the treatment of alcoholics largely by religious



and moral suasion. This was followed by the Washingtonian Home which was incorporated in 1858. The "Massachusetts experiment" was watched by many other states and private homes, hospitals and retreats were established as the result of the glowing reports of the Washingtonian Home as to the effectiveness of its treatment. In 1871 the Washingtonian Home established a plan for the out-patient and community treatment of inebriates.

During the period 1858 to 1889 there was considerable public opinion in favor of hospitalization for inebriates but the legislature favored specialized institutions of the penological type as the State Workhouse and the Reformatory.

In 1885, the legislature provided for the commitment of habitual drunkards to asylums for the insane. This was the first legal recognition of the theory that alcoholism was a disease. The legislature stipulated in the law permitting alcoholics to be committed to mental hospitals that the judge must be furnished evidence that "such person is not of bad repute or of bad character, apart from his habits of inebriety." It was soon apparent that there were objections to this method of handling the alcoholics. The inebriates returned to a sane condition shortly after commitment and they constituted an objectionable element in the mental hospital and it was felt that their confinement in the mental hospital was detrimental to the alcoholic as well as the psychotic patients.

In 1889 the legislature authorized the establishment of "The Massachusetts Hospital for Dipsomaniacs and Inebriates" and provided for a two year commitment for treatment. The new hospital was constructed in Foxborough and was opened in 1893. Originally it was intended to treat men



and women but later this plan was changed so that commitments to the hospital were limited to males. The cottage plan was adopted in order to give a better classification of patients.

The first serious difficulty encountered was the escape of patients. The hospital was not intended for custodial cases and it was found that many of the alcoholics would not remain in confinement voluntarily, the hospital not providing for security against escape.

Although the courts were sending many undesirable cases to the hospital, the institution was not operated at capacity. There was a lack of occupational and recreational facilities. Patients obtained liquor and became intoxicated. The hospital became filled with incurable cases and the trustees in 1897 asked for and received from the legislature permission to discharge patients who were found not suitable.

In 1904, the trustees felt that there was a need to get cases much earlier than was the practice and that salvageable cases could be obtained if alcoholics were permitted to enter the hospital voluntarily and for a period of time agreed upon by the patient and the hospital.

In 1905, it was felt that many alcoholics in the "beginner class" were not inclined to enter the hospital because of its name and the trustees petitioned for a change of name. In the same year the hospital was renamed the Foxborough State Hospital and began to receive chronic mental patients as well as inebriates. During this year the hospital had discharged 67, or 21.26 per cent, of the admissions of that year as unsuitable. Few of these had criminal records other than alcoholism, but their unfitness consisted in being of a type of alcoholic in whom improvement was

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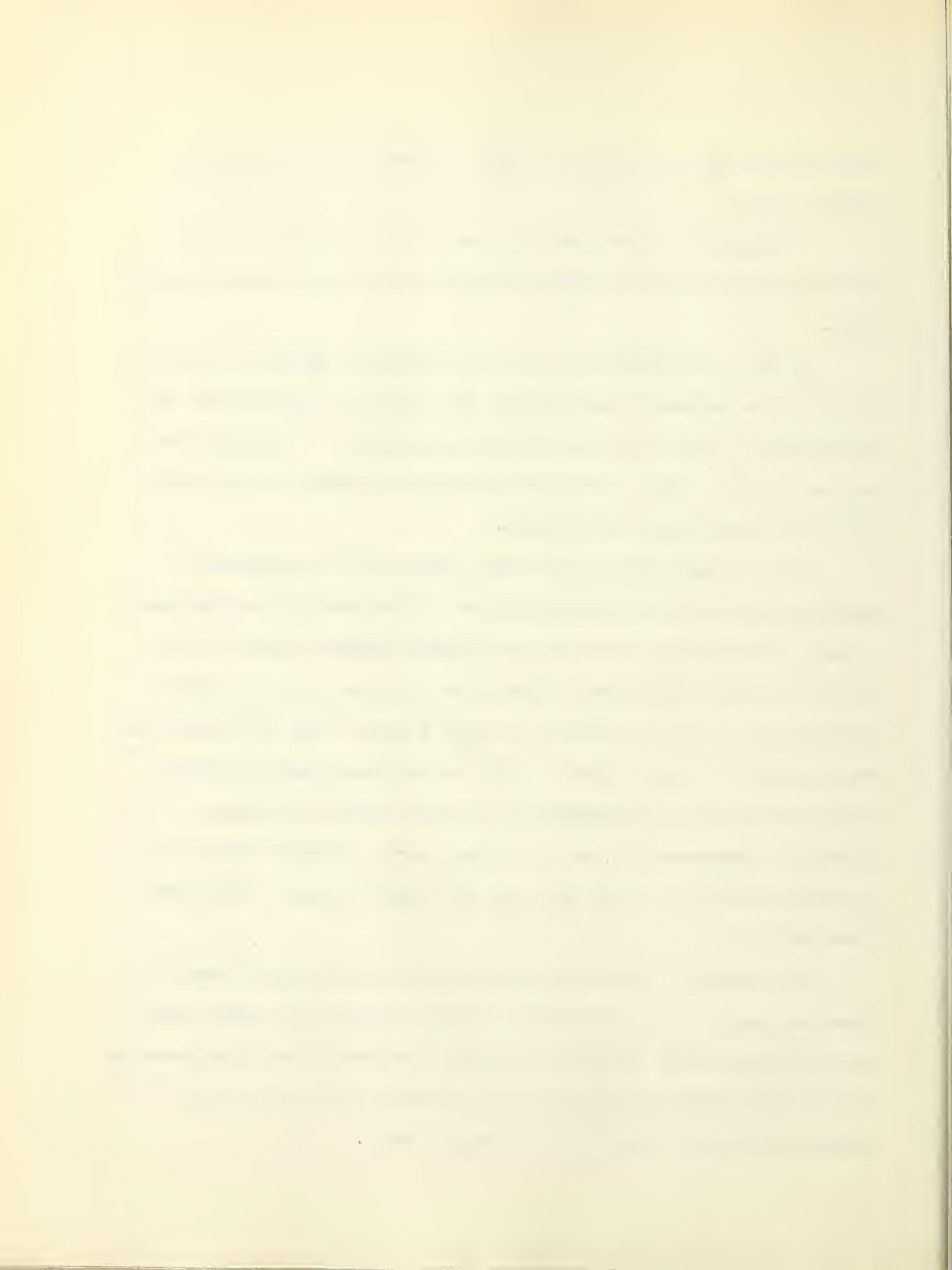
improbable and who were, therefore, better suited to penal rather than hospital care.

In 1906, the trustees requested and received permission to take voluntary patients but the number received did not reach the number anticipated.

In 1907, an entirely new Board of Trustees was appointed and after a study of the problem it reported that the location of the hospital was inappropriate, that the hospital area was too limited for healthy outdoor work and that the hospital received all classes of inebriates and cared for them in practically a single body.

In 1908 a new superintendent was elected and he introduced the general employment of discharged patients in minor positions and the abandonment of the closed wards. The new trustees complained that the hospital was receiving unfavorable cases. Out of 405 commitments received between April 1, 1908 and November 1, 1909, a total of 244 were classed as "unfavorable", it being understood that the term meant that the patient was unlikely to receive permanent benefit from hospital treatment. Of these 405 commitments, 259, or 64 per cent, were thirty-five years of age or older; and 208, or 51 per cent, had used liquor in excess for fifteen years or more.

The problem of the state hospital in securing young and hopeful cases was caused to a large extent by the fact that private homes, hospitals and retreats for alcoholics, working in cooperation with the probation officers and courts, received the early alcoholics leaving the older, chronic and advanced cases for the state to handle.



In 1909 the Trustees of Foxborough State Hospital were requested to make a complete survey of the problem of drunkenness in Massachusetts and in 1910 the trustees filed their report with the legislature, House No. 1390 of 1910. This report recommended the abandonment of the Foxborough State Hospital and the building of a new hospital which would provide sufficient land for agricultural purposes, sufficient plant for industrial training, and an opportunity for segregation of diverse cases.

In 1910 the legislature authorized the establishment of a new "Hospital for Inebriates" as a colony of the Foxborough State Hospital and in 1914 the colony was made a separate institution under the State Board of Charity instead of the State Board of Insanity, as it was formerly, and named the Norfolk State Hospital. During the years that Norfolk State Hospital was in use, female inebriates continued to be admitted to state mental hospitals.

Because of the reduced commitments due to prohibition, the Norfolk State Hospital was closed as a hospital for inebriates in 1919.

In 1922 provision was made to care for male and female inebriates at the Bridgewater State Farm. In 1933 the care of female inebriates was transferred from the State Farm to the Reformatory for Women.

At the present time there are no tax-supported institutions devoted entirely to the treatment of alcoholism, although at one time New York City, Massachusetts, Iowa, Minnesota and Connecticut operated public institutions of the hospital-farm-colony type for the care and treatment of alcoholics. The close of these institutions fairly closely coincided with the Volstead Act, except in the case of the Inebriate Farm in Connecticut



which did not cease to operate until 1941.³¹

Laws and Proceedings

The present statutes permit treatment in a State mental hospital of advanced cases of alcoholism which have developed into a psychosis. The public hospitals, therefore, will not receive a patient unless he is insane as well as an inebriate.

Some inebriates are admitted to public mental hospitals while in a temporary psychotic condition due to alcoholism. Because of the legal limitations, public mental hospitals today have only the most advanced cases of alcoholism and consequently have very poor material on which to effect a rehabilitation by psychiatric methods.

The person suffering from a psychosis due to alcohol comes to the care of a public mental hospital through a proceeding known as a commitment. Commitment to a mental hospital is non-criminal in nature and is therefore not surrounded by the constitutional and other legal safeguards which surround the defendant in a criminal court.

The commitments are made to regular mental hospitals, no attempt is made to segregate those suffering from a psychosis due to intoxication. The state mental hospital to which the patient is sent is determined by legal residence in various communities, the length of residence and communities being served by a hospital being changed from time to time. The

³¹ Commonwealth of Massachusetts, Report of the Special Commission to Investigate the Problem of Drunkenness in Massachusetts, House No. 2000, 1945, pp. 263-288.

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry should be supported by a valid receipt or invoice. This ensures transparency and allows for easy verification of the data.

In the second section, the author outlines the various methods used to collect and analyze the data. This includes both primary and secondary research techniques. The primary research involved direct observation and interviews with key stakeholders, while the secondary research focused on reviewing existing literature and reports.

The third section details the findings of the study. It highlights several key trends and patterns observed in the data. For example, there was a significant increase in the use of digital services over the period studied. Additionally, the study found that customer satisfaction levels were generally high, but there were some areas where improvement was needed.

Finally, the document concludes with a series of recommendations for future research and practice. It suggests that further studies should be conducted to explore the long-term impact of the observed trends. It also provides practical advice for organizations on how to leverage the findings to improve their operations and customer experience.

Department of Mental Health has broad powers to transfer patients between institutions for any purpose, one of which might be specialized treatment.

At the present time there is no segregation of alcoholics within the regular mental hospital, that is, they are treated as part of the total population without any special attempt to group those suffering from a psychosis due to alcohol or a psychosis to which alcoholism is a contributing factor. There are only limited attempts to apply group therapy and re-education; and individual therapy for the alcoholic is negligible. There is no specialization by members of the staff who have special aptitudes or knowledge of alcohol hygiene.

The alcoholic psychoses are organic rather than functional. It does little good to clear up the organic situation leaving the emotional and personality pattern unchanged and active in returning the patient to drinking and public support in a mental hospital.

It will thus be seen that the efforts of the Department of Mental Health and its funds are largely spent, so far as alcoholism is concerned, in an attempt to cure the least hopeful cases rather than in the prevention of mental disease in those that can be saved. In comparison with the total work of the department, only limited effort and funds are employed in alcohol hygiene.

How does the alcoholic become a patient in a mental hospital? The usual provisions for the commitment of other types of mental illness are applicable to those having a psychosis due to alcohol. Most of the alcoholically psychotic are committed or admitted under the provisions of Sections 51, 77, 78 and 79 of Chapter 123 of the General Laws. Persons

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suffering from an alcohol psychosis may also reach a public mental hospital under the provisions of Sections 99, 100 and 100A of the same chapter.

The most commonly used provision for admission is Section 79 of Chapter 123 which is intended to provide temporary care for a psychotic or apparently psychotic person. It is frequently referred to as a "ten day paper" and it is sometimes called a police commitment, although it is a non-criminal procedure and persons other than the police are entitled to use it, i.e., a physician or an agent of the institutions department of the City of Boston. It will be observed that this section recognizes drunkenness as a mental derangement but excludes non-psychotic drunkenness cases from treatment by the hospital.

Until recently state mental hospitals refused to accept delirium tremens cases with the result that such cases were treated in general hospitals and returned to the community without a court appearance or the supervisory social service which would be available if they had been treated and committed to a state mental hospital.

The superintendent is given discretion to determine if the person sent to the hospital under Section 79 shall be admitted.

It is the duty of the superintendent to have the patient examined by two physicians, qualified as to education and experience, to determine if the patient is committable as an insane person. It is the practice to have the examination made by physicians not connected with the hospital staff as a protection to the patient and to reduce the possibility of suits against the superintendent charging that the patient was "railroaded" and is being illegally detained in a mental hospital.

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Within a ten day period application for commitment is made to the court or the patient is discharged. A justice of the Superior Court or a justice or a special justice of a District court except the Municipal Court of Boston, and the judges of probate for Suffolk and Nantucket counties are given authority to commit.

A commitment for a forty day period of observation is sometimes used for the person with a psychosis due to alcohol. While it has more formality in the early stages, it has the advantage of giving the hospital a longer period to observe the patient and to detect psychotic conduct which might not be observed during the ten day admission under Section 79. It is to be noted that this is a court commitment in contrast to the custody under Section 79 which is without previous authorization of the court. If the person is not insane, he must be discharged within thirty days and a report made to the committing judge. If the person is insane, the superintendent shall report that fact to the committing judge with his recommendation that he be regularly committed or discharged to responsible supervisors.

The provision for a five days temporary care of a person violently and dangerously insane without an order of court has been made obsolete by the provisions of the ten day admission which requires only one physician instead of the two required by the five day provision. Another disadvantage to the five day provision is that the burden of perfecting the commitment is upon the applicant while in the case of a ten day paper the responsibility for perfecting the commitment is upon the superintendent of the hospital. The law covering five day admissions is found in Section

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78 of Chapter 123.

The so called regular commitment is provided for in Section 51 of Chapter 123. The certificates of two physicians are required. Physicians must meet certain standards of education and experience. Legal proceedings are completed before the patient is admitted to the hospital.

Medical commitments are non-criminal in nature and they are not limited and restricted by the unscientific definition of "insane" which was laid down in the English criminal case of M'Naughten in 1843 and which is substantially followed by Massachusetts courts sitting on criminal cases.

While there is a provision permitting the judge at his discretion to summon a six man jury to hear the issue of alleged insanity, this is never used. There is no statutory provision for an appeal from an order of commitment as an insane person although the commitment can be challenged by other methods.

Commitment to a mental hospital is for an indefinite period of time and in this respect is similar to the indeterminate sentence in criminal cases. If a person suffering from an alcoholic psychosis is committed to a hospital he does not spend a stated period of time or the maximum permitted for that particular type of illness and then be released regardless of whether he is cured or not. The mental patient can be held until he is cured regardless of the length of time.

This commitment is an improvement over the penal commitment under which a person is sentenced to serve a definite time such as seven, ten, fourteen or thirty days, three or six months and then is released regard-

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less of whether he would be benefitted by further treatment. The mental commitment is similar to the state farm indeterminate sentence without the maximum of one year.

In the case of penal sentences, treatment, if any, may be cut short by parole or permit to be at liberty and the alcoholic must be released regardless of whether he has reached his maximum improvement.

There are two methods of terminating a mental hospital commitment. The first and more generally used method in the case of those committed for alcoholic psychoses, is the trial visit for a year. At the end of a year, unless the alcoholic has in the meantime been returned to the hospital, the patient is automatically discharged from commitment.

During this trial visit the patient is required to report once a month for a talk with the doctors and there is a token supervision in the community by a numerically inadequate social service staff. Despite the volume of work required, the hospital social service staff probably renders more varied and effective services to the alcoholic than do probation and parole officers in penal cases.

The second method is by discharge. The discharge may be granted by the superintendent of a mental hospital, the Department of Mental Health or the Probate Court in the county where the hospital is located or where the patient had a residence at the time of commitment, or any judge of the Superior Court. The provisions relative to discharge are found in Section 89 of Chapter 123.

Any person may make written application to a justice of the Supreme Court requesting the discharge of a person who should not be confined to

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a mental hospital. This provision of law is found in Section 91 of Chapter 123.

The trial visit method of discharge is the generally used provision for ending a commitment to a mental institution. It is the "probation or parole" of the mental hospital approach. It is sometimes referred to as release on "parole", which term is more generally applied to a release from a penal institution before the termination of sentence, and the use of the term should be limited to penal proceedings.

Release on trial visit is made to legal or natural guardians of the patient or to some other person with the consent of the legal or natural guardian. If the legal or natural guardian of the patient opposes a release on trial visit, a ten day advance notice is given so as to permit the guardian to take legal steps to prevent the release. The provisions covering trial visit are found in Section 88 of Chapter 123.

Civil Commitment

Historical

As was stated in the section on Medical Commitments, Massachusetts was the first state to recognize alcoholism as a disease and to provide for non-criminal commitments to mental hospitals under the provisions of chapter 339, Acts of 1885.

After the opening of The Massachusetts Hospital for Dipsomaniacs and Inebriates, later called Foxborough State Hospital, non-psychotic male alcoholics were committed to that institution, but female alcoholic addicts continued to be committed to the regular mental hospitals until 1922 when

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the care of female alcoholics was taken from the mental hospitals and transferred to the State Farm at Bridgewater. In 1933 the department for female inebriates was transferred from the State Farm to the Reformatory for Women where it has since remained.

Persons with alcoholic psychoses, such as pathological intoxication, delirium tremens, Korsakoff's psychosis, acute hallucinosis and alcoholic deterioration, continued to be committed to the regular mental hospitals.

Under the present laws, the commitment cannot be made to a public mental hospital unless the alcoholic is insane as well as inebriate. Commitments can be made to private mental hospitals and other private institutions licensed by the Department of Mental Health, even if the person committed is not insane, provided the alcoholic is adjudged to be addicted to the use of alcohol.

Civil Laws and Proceedings

The procedure for the commitment of a dipsomaniac or inebriate is a combination of the criminal process and the commitment for mental treatment.

It is interesting to note that the judiciary authorized to commit under the civil procedure is the same as those authorized to make mental hospital commitments with the addition of the judges of the Municipal Court of the City of Boston. It is also interesting to observe that the judges of Probate in Suffolk and Nantucket may commit to the department for inebriates in the State Farm and the Massachusetts Reformatory for Women, penal institutions, although such courts are not considered to be



administering criminal law.

On the other hand, the inebriate commitment has many of the attributes of criminal process. There is an appeal from an order of commitment to the Superior Court sitting for criminal business. The appellant has the right to demand the framing of issues and the submission of issues to a jury as in the criminal case. This is in contrast with the provisions in the law governing mental commitment giving the judge discretionary authority to submit issues to a jury. For custodial security, the commitment is made to a penal institution and there is a definite term which can be reduced by the Board of Parole. In mental commitments there is no term, discharge depending upon recovery.

The statutes governing the commitment of inebriates to public and private hospitals are found in Sections 62 to 65 of Chapter 123. The order of commitment must be accompanied by the certificate of two qualified physicians that the person committed is subject to dipsomania or inebriety either in public or in private, or is so addicted to the intemperate use of habit forming stimulants as to have lost the power of self control.

The Massachusetts laws also provide for temporary care of alcoholics without court proceedings. The maximum detention without commitment by a court is fifteen days. Application for temporary care of an alcoholic may be made by a physician, police officer, member of a board of health, wife, husband, guardian or next of kin of the alcoholic. Most of the cases treated under this provision are cared for in private hospitals. The provisions governing temporary care are found in Section 80 of Chap-



ter 123.

It will be recalled that the maximum penal term for drunkenness is one year while the civil commitment has a maximum term of two years.

Relatively few persons have been committed to the department for dipsomaniacs and inebriates in the penal institutions under the provisions of Section 62 of Chapter 123. One reason may be the fear that the alcoholic will be held for the maximum term of two years but more important reasons are the lack of public and official knowledge of the existence of civil commitment and the failure of the state to provide a well-located, equipped and staffed institution for the care and treatment of the alcoholic. The failure of the legislature to place responsibility for the use of the civil commitment upon one or more public officials is also a factor in the provisions for civil commitment being a dead letter in the statutes.

It would appear that the District and Municipal Courts, especially in those counties where an appeal from a conviction for drunkenness results in a nol-pros or the filing the charge in the Superior Court, to the detriment of the defendant in need of treatment, could have police officers, probation officers or agents of the board of public welfare, make the required application.

Responsibility for addicts committed under civil commitment is divided. The alcoholic is committed to an institution under the Department of Correction, but the Department of Mental Health under the provisions of section 3 of chapter 123 of the General Laws is given "general supervision of all public and private institutions for insane, feeble-minded or epileptic persons, or for persons addicted to the intemperate use of



narcotics and stimulants."

The Board of Parole, an independent body within the Department of Correction, may parole inmates of the department for dipsomaniacs and inebriates, confined there on civil commitment, on such conditions as the Board deems best and may at any time during parole recall to the institution any inmate released on parole.

The Department of Mental Health has not effectively called to the attention of the judiciary and court officials the desirability of using civil commitment in selected cases, neither has it provided a psychiatric consultation service which might determine the alcoholics likely to profit from such a commitment.

The writer in 1941 had occasion, in connection with his duties in a public welfare agency, to advise and handle legal proceedings on two civil commitments of fathers of families who were supported by public funds. The men involved had been repeatedly arrested for drunkenness and given probation, fines, short sentences and long sentences to various institutions to no avail. Within a short time of the starting of the sentences the alcoholics would be returned home generally on the pleading of their wives. Social conditions in the home made it necessary that more effective measures be taken to improve the home and to attempt rehabilitation of the alcoholics and the men were committed on a civil commitment.

It was apparent that the court officials were not familiar with the procedure, some had never heard of the civil commitment, and it was necessary for the writer to procure the printed application blanks to



institute the proceedings.

One case showed great improvement as the result of the treatment; the other was released too early to gain from the treatment except in a physical way. In both cases, the home situation improved during the longer absence of the alcoholics.

The following table shows how little used is the provision for the civil commitment of dipsomaniacs and inebriates.

TABLE II

COURT COMMITMENTS FOR INEBRIETY TO MASSACHUSETTS PUBLIC INSTITUTIONS AND PRIVATE HOSPITALS, 1923 to 1941.*

Year	No. of Commitments	
	Male	Female
1923	16	2
1924	24	4
1925	32	6
1926	20	1
1927	23	2
1928	17	1
1929	25	-
1930	33	-
1931	22	3
1932	25	3
1933	18	1
1934	30	2
1935	39	2
1936	42	12
1937	51	5
1938	40	9
1939	41	10
1940	38	10
1941	32	3

* Source: Department of Mental Health

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Date	Description	Amount
1890	Jan 1	100.00
1890	Feb 1	200.00
1890	Mar 1	300.00
1890	Apr 1	400.00
1890	May 1	500.00
1890	Jun 1	600.00
1890	Jul 1	700.00
1890	Aug 1	800.00
1890	Total	3500.00

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Table III shows the number of inebriates admitted to private hospitals and institutions for a maximum of fifteen days of temporary care, voluntary admission for longer treatment and for commitment as an inebriate. There is some duplication in the figures as one inebriate might be reported one or more times in each classification.

TABLE III

ADMISSIONS OF INEBRIATES TO PRIVATE HOSPITALS UNDER
THE JURISDICTION OF THE MASSACHUSETTS DEPARTMENT OF
MENTAL HEALTH FOR THE YEAR ENDING SEPTEMBER 30, 1941.*

Temporary Care (Ch. 123, s. 80)	614
Voluntary Care (Ch. 123, s. 86)	570
Committed (Ch. 123, s. 62)	9
Total	1,193

* Source: Department of Mental Health

Summary

This chapter indicates that alcoholism has been a serious problem since early colonial times; that Massachusetts has tried, without success, various regulatory measures; that criminal laws have been used since the beginning of the Commonwealth without notable success; that penalties have fluctuated from one extreme to another, from minor fines to long sentences and whippings; that its jails and houses of correction and even the State Farm has not adopted a constructive and successful program for the rehabilitation and cure of the alcoholic; that the courts in their handling of the alcoholic apply the penal laws in a punitive and summary manner; that

in some counties there is an abuse by the district attorney of the right to nol-pros drunkenness complaints; that the judges of the Superior Court too often accept the recommendation of the district attorney to file drunkenness complaints or to reduce sentences often to the detriment of the alcoholic; that therapeutic action is not started early enough; that the effectiveness of probation is handicapped by an inadequate and in some cases insufficiently trained probation staff; that the sentence is often too short to do effective therapy and that there is a need of revising the penological program to secure more effective results.

The chapter also indicates that the attempt of Massachusetts to treat alcoholism as a medical illness was premature, being in advance of scientific progress; that the hospital provided lacked the facilities to utilize the time and energy of the alcoholic and to provide training; that the selection of cases for treatment was improperly placed in the various courts rather than with specialists who could make a decision after complete investigation; that the program of hospitalization was handicapped by diverting to private institutions the young and hopeful cases; that mental hospitals today attempt to rehabilitate the most deteriorated alcoholics instead of salvageable cases; that the Department of Mental Health has not established a classification system for alcoholics either within its state mental hospital system or within the individual institutions; that greater effort and more funds should be devoted to prevention and hygiene; that the focus should be on community rather than institutional care; that the alcoholic should be released from mental hospital at the end of a year or when therapy ends and there is need for revising the



civil and mental hospital commitments to secure more effective results.



CHAPTER IV

SUMMARY AND CONCLUSIONS

The material of Chapter II indicates that basically alcoholism should be considered a psychiatric rather than a penal problem, although at the present time scientific knowledge is not sufficiently advanced in this field to insure successful treatment in all types of alcoholics.

The entire problem of the treatment of alcoholics cannot be transferred bodily from the penal system to the mental hospital. As was shown in Chapter II, there are many alcoholics, such as the psychopaths, who cannot be helped by mental hospital treatment to a complete cure and whose presence in the mental hospital present administrative difficulties and poor utilization of the efforts of the staff.

The importance of classification was pointed out in that chapter as was the need for a variety of resources, institutional and otherwise, to meet the varying problems. Classification should be flexible to permit a change in treatment when inaccuracies in original diagnosis or improvements due to treatment make it desirable.

The study of personality and emotional factors and environmental conditions involved in alcoholism shows that cases selected for treatment must be examined by experts and that proper selection cannot be made in a summary or routine manner by a large number of judges, no matter how sincere or conscientious they may be.

Chapter II answers our first question as to whether alcoholism is a crime or a disease. The involuntary nature of chronic alcoholism removes it from the field of criminal law where intent is an important pre-requi-

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site in common law crimes as distinguished from statutory crimes. Voluntary, non-chronic, alcoholism should continue to be treated as a crime.

The second question was whether Massachusetts is now using the most effective methods for controlling the problem.

Chapter III points out the machinery for meeting the problem is largely legalistic and penal in philosophy and that it is failing to meet the problem.

It does too little to prevent the development of the social drinker into the chronic alcoholic. As was pointed out in Chapter III, the "release law," which has much to commend it in the case of the social drinker who once or twice a year goes beyond the borderland of social drinking, should not be an instrument to permit a person to become a chronic alcoholic before treatment is begun. The recent change making four "releases" mandatory does not appear sound. A better plan would be to make release mandatory on the first two arrests and discretionary on the third and fourth arrests.

As was pointed out in Chapter III, there is a real abuse of the power of the District Attorney to "nol-pros," especially in Suffolk County, and the law should be changed to require the concurrence of a justice of the Superior Court to the entry of a nol-pros.

Dr. Clifton T. Perkins, Commissioner of Mental Health, pointed out, as shown in Chapter II, that there is a definite need for the establishment of clinics to aid in the prevention of chronic alcoholism. These clinics should be coordinated with and supplement the work of the courts and institutions in the treatment of alcoholism. The writer recommends



that these clinics be held in evening hours and at accessible locations for the convenience of the employed alcoholic.

While the authoritative approach is not psychologically the best, courts would have to employ that approach in many cases to compel attendance at mental hygiene clinics for group therapy, re-education or individual treatment.

Courts should make a greater effort to treat the alcoholic in the community using the services of the mental hygiene clinic and skilled case workers. Demoralizing and futile sentences to jails and houses of correction should be avoided.

When institutionalization is necessary, the alcoholic should be sent to a penal or mental hospital specializing in the care of alcoholics. Classification or grouping would not increase the total population and specialization of staffs would not increase the total of those caring for the alcoholic.

Institution life should not be made so lazy, secure and attractive that the alcoholic "rounder" will prefer the institution to the making of a reasonable struggle for existence outside the institution.

Institutions must develop a definite program to utilize the time and energy of the alcoholic undergoing treatment. Occupational therapy, pre-vocational training or duties at the institution should develop work habits and a knowledge of some occupation so that the alcoholic will have the energy, knowledge and desire to be self-supporting and useful after he leaves the institution.

Where possible, the qualified recovered alcoholic should be given

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public employment without prejudice. Many private employers cannot be expected to cooperate in the employment of recovered alcoholics unless the Commonwealth by its example shows that recovered alcoholics can be successfully employed.

While in the institution, the alcoholic should be given the opportunity of becoming acquainted with religious, temperance, Alcoholic Anonymous and mental hygiene groups with whom he could associate upon release from the institution.

The present penal and medical approach to the problem is not sound. Too little is done and what is done is begun too late. There is a complete lack of an organized, integrated, uniform, continuous, flexible and individual program for treating the alcoholic. The penal method is used in cases when the medical method should be used and medical care is provided in some cases when penal care would be the proper solution. More money is spent on the hopelessly irreversible cases than on those potentially rehabilitable.

The writer would recommend the establishment of a "Classification and Treatment Board," patterned after the psychiatric staff conference in a mental hospital, to give a more scientific, integrated and continuous treatment to the alcoholic. The board should consist of five specialists drawn from the following professions with a limit of one from each field: judiciary or legal, psychiatry, psychology, social work, sociology, medical and penological. The board should be full time and the term of office for life or for such long period that political considerations would not be a factor in the work of the board. It might be desirable to give the

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board members the status of a judge in order to give it the constitutional protection accorded the judiciary.

The courts, District and Superior, would hold the excessive drinker for the "Classification and Treatment Board" in the same manner as the courts now hold for the grand jury. The reference would be made when the offender's drinking habits have exceeded a determined point, such as measured by arrests, or earlier if the conditions indicate a need. Recognizances and surety could be required as in appeals from inferior to superior courts. In the case of those not likely to remain available for handling by the board, provision could be made for commitment.

The board would cause a complete social investigation and medical and psychiatric examination to be made in those cases not investigated or examined within a reasonable period of time. With the aid of those reports and the personal appearance of the alcoholic, the board could make an initial classification and decide on a plan of treatment.

The objective should be to have the alcoholic remain in the community, preferably under the supervision of the board's own staff of trained social workers specializing in case work with alcoholics. If deeper therapy is necessary, the alcoholic could be ordered to attend hospital out-patient psychiatric clinics or mental hygiene clinics.

If treatment in the community has not been successful in the past in adjusting and educating the excessive drinker, or if it appears to be necessary at the time, the board could consider the case for institutional care. Institutional care should not be used except in those cases where the excessive drinker has not shown any improvement and is so deteriorating



that institutional care is necessary.

The board should be given authority to establish a classification system for institutional care using the existing facilities of the departments of Mental Health, Correction, Public Welfare, Public Health and city, town or county institutions. The board should have general supervision of the institutions or portions of institutions being utilized by it for the treatment of alcoholics.

If after diagnostic study or treatment in a hospital or penal institution, it appears that the case is one which would be better classified in some other hospital or penal institution, the board would have authority to make all necessary transfers at any time.

The release from institutional care should be on the trial visit plan used in mental hospitals so as to preserve the progress made in institutional care and to continue treatment in the community. Visits to psychiatric or mental hygiene clinics could be made a condition of release.

The board should be authorized to take an active part in the prevention of alcoholism. Its case work services might be offered to those who have been arrested and released. It might furnish printed literature interpreting the problem to the potential alcoholic. Factual evidence helpful to classification and treatment could be compiled. Even paid advertising advising moderation and urging the excessive drinker or those interested in him to use the mental hygiene clinics would be helpful in counteracting the large sums paid by the liquor industry in all forms of advertising.

The cost of the program should be a direct charge on the liquor



industry. The industry which produces the problem should provide the funds for the care of those who are its victims.

Under this plan the alcoholic would have the benefit of continuous study, balanced judgment by specialists, classification for treatment, flexibility in the choice of resources, uniformity in the handling in all parts of the Commonwealth, the elimination of the mixing of the alcoholic with the insane or the hardened criminal, more money spent in community treatment than in the building and operating of institutions, treatment rather than punitive measures and rehabilitation rather than punishment as a goal.

The third question raised was whether Massachusetts is making full use of social case work in meeting the alcoholic problem.

While Massachusetts has adopted the principle of social case work in many fields, in fact pioneered in the use of medical social work, psychiatric case work and probation case work, the extent of its use has been limited by the failure to provide sufficiently large trained staffs to do intensive and effective case work. The services of relatively a handful of case workers are dissipated over such a large number of cases and workers are so encumbered with administrative duties that it is practically impossible to do intensive case work.

In the larger staffs there should be one case worker specializing in vocational rehabilitation work. There is a definite need for one or more male social workers on the staffs of mental hospitals. Patients and prisoners should be supplied with a small grant, earned during treatment, paid at the time of their release on trial visit or parole as well as dis-

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charge to assist them to return to the community.

It is recommended that there be established a Division of Social Service in the Department of Mental Health to limit the work of the social service department in hospitals to case work functions and to strengthen the position of the social worker so that he will be a more equal member of the psychiatrist-social worker team. This Division should work for a raising of the entrance standards for case workers and should conduct a continuous training program for those already in the service.

Approved

A handwritten signature in cursive script that reads "Richard K. Conant". The signature is written in dark ink and is positioned below the word "Approved".

Richard K. Conant, Dean



APPENDIX

GENERAL LAWS OF MASSACHUSETTS

Chapter 123

Section 50. A justice of the superior court, in any county, and any of the judges of probate for Suffolk county, the judge of probate for Nantucket county, or a justice or special justice of a district court, except the municipal court of the city of Boston, within his county, may commit to any institution for the insane, designated under or described in section ten, any insane person, then residing or being in said county, who in his opinion is a proper subject for its treatment or custody; but such special justice may make such commitment only in case of the incapacity of the justice, his absence from the district, interest, or relationship to the applicant or to the person to be committed, or when specially authorized by the justice to act in the case, or when the justice is absent from the court building and the special justice is holding court in his place.

Section 51. No person shall be committed to any institution for the insane designated under or described in section ten, except the Walter E. Fernald state school, the Belchertown state school and the Wrentham state school, unless there has been filed with the judge a certificate in accordance with section fifty-three of the insanity of such person by two properly qualified physicians, nor without an order therefor, signed by a judge named in the preceding section stating that he finds that the person committed is insane, and is a proper subject for treatment in a hospital for the insane, and either that he has been an inhabitant of the commonwealth for the six months immediately preceding such finding or that provision satisfactory to the department has been made for his maintenance or that by reason of insanity he would be dangerous if at large. The order of commitment shall also authorize the custody of the insane person either at the institution to which he shall first be committed or at some other institution to which he may be transferred. Said judge shall see and examine the alleged insane person, or state in his final order the reason why it is not considered necessary or advisable to do so. The hearing, unless a jury is summoned, shall be at such place as the judge shall appoint. In all cases he shall certify in what place the insane person resided or was at the time of the arrest upon the charge for which he was held to answer such court. Such certificate shall, for the purposes of the preceding section, be conclusive evidence of the residence of the person committed.

Section 62. Any of the judges named in section fifty, or a judge of the municipal court of the city of Boston, may commit to the state farm, or to any other institution under the department of correction that may be designated by the governor, to the McLean hospital, or to a private licensed institution, by order of commitment, directed to the trustees, superin-



tendent, or manager thereof, as the case may be, made in accordance with section fifty-one and accompanied by a certificate, in accordance with section fifty-three, by two physicians qualified as therein provided, any male or female person, who is subject to dipsomania or inebriety either in public or in private, or who is so addicted to the intemperate use of narcotics, habit forming stimulants or sedatives as to have lost the power of self control. The judge receiving the application for such commitment shall examine on oath the applicant and all other witnesses, and he shall reduce the application to writing and cause it to be subscribed and sworn to by the applicant. He shall cause a summons and copy of the application to be served upon such person in the manner provided by section twenty-five of chapter two hundred and seventy-six. Such person shall be entitled to a hearing unless after receiving such summons he shall in writing waive a hearing, if he is of opinion that the person is a proper subject for custody and treatment in the institution to which he is committed. The commitment may be made forthwith, if the examining physicians certify the case to be one of emergency. A person committed as aforesaid may be detained for two years after the date of his commitment, and no longer.

Section 63. A person may appeal from the order of commitment as a dipsomaniac or inebriate, or as addicted to the intemperate use of narcotics or stimulants, to the superior court sitting for criminal business in the county from which he is committed, in the manner provided by section twenty-two of chapter two hundred and twelve, but he shall be held in such institution to abide the final order of the court until he recognizes in the manner provided in section eighteen of chapter two hundred and seventy-eight. Upon such appeal the judge who ordered the commitment may bind the witnesses by recognizance as provided by chapter two hundred and seventy-six, and shall make a copy of the order of commitment and other proceedings in the case and transmit the same with recognizance, if any, to the clerk of the superior court. If the appellant so requests, an issue or issues shall be framed and submitted to a jury in the superior court.

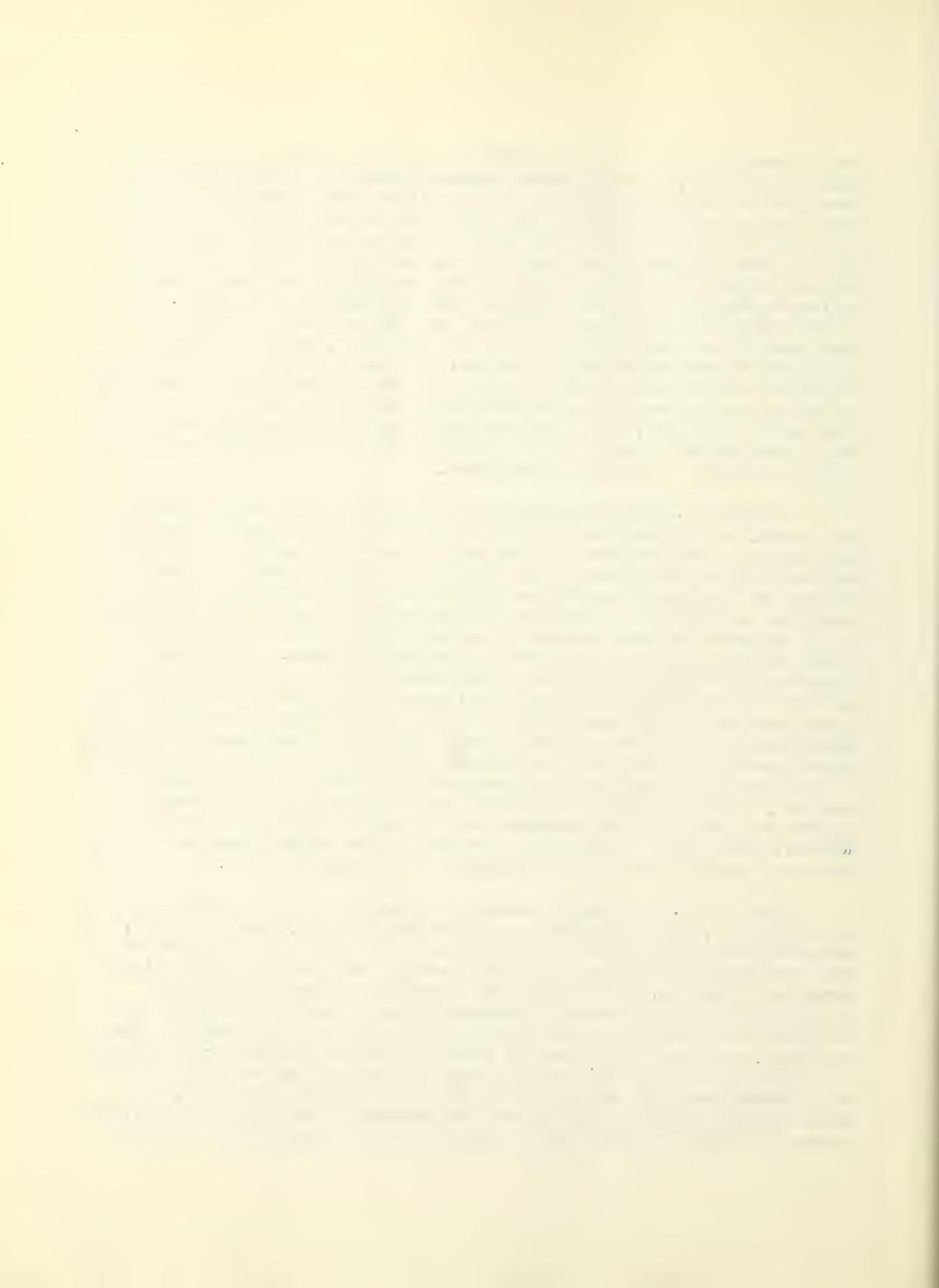
Section 64. If the appellant fails to enter and prosecute his appeal he shall be defaulted on his recognizance, and the superior court may enter an order in like manner as if he had been ordered committed by that court; and process may issue, if necessary, to bring him into court to be recommitted.

Section 77. If a person is found by two physicians qualified as provided in section fifty-three to be in such mental condition that a commitment to an institution for the insane is necessary for his proper care and observation, he may be committed by any judge mentioned in section fifty, to a state hospital, to the McLean hospital, or in case such person is eligible for admission, to an institution established and maintained by the United States government, the person having charge of which is licensed under section thirty-four A, for a period of forty days pending the determination of his insanity. Within thirty days after such commitment the superintendent of the institution to which the person has been committed

shall discharge him if he is not insane, and shall notify the judge who committed him, or, if he is insane he shall report the patient's mental condition to the judge, with the recommendation that he shall be committed as an insane person, or discharged to the care of his guardian, relatives or friends if he is harmless and can be properly cared for by them. Within said forty days the committing judge may authorize a discharge as aforesaid, or he may commit the patient to any institution for the insane as an insane person, if, in his opinion, such commitment is necessary. If, in the opinion of the judge, additional medical testimony as to the mental condition of the alleged insane person is desirable, he may appoint a physician to examine and report thereon. In case of the death, resignation or removal of the judge committing a person for observation, his successor in office, or, in case of the absence or disability of the judge committing a person as aforesaid, any judge or special justice of the same court, shall receive the notice or report provided for by this section and carry out any subsequent proceedings hereunder.

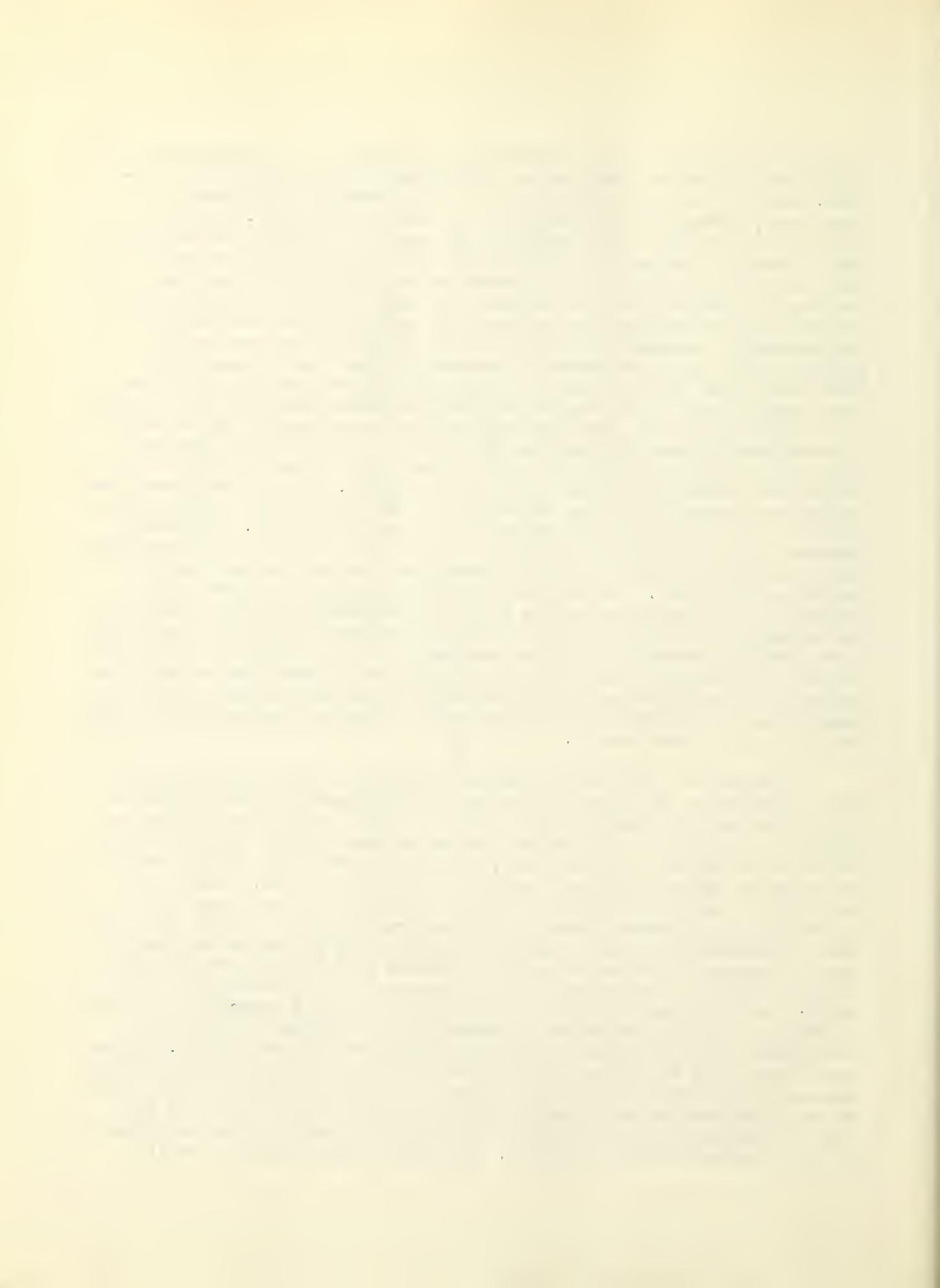
Section 78. The superintendent or manager of any institution for the insane, may without the order of a judge required by sections fifty and fifty-one, receive into his custody and detain in such institution for not more than five days any person whose case is certified to be one of violent and dangerous insanity or of other emergency by two physicians qualified as provided in sections fifty-three by a certificate conforming in all respects to said section, which certificate shall be filed with a judge, as the certificate required by section fifty-one. The officers mentioned in section ninety-five or any member of the state police shall, upon the request of the applicant or of one of said physicians, cause the arrest and delivery of such person to such superintendent or manager. The person applying for such admission shall within five days cause the alleged insane person to be committed or removed from the institution, and failing to do so shall be liable to the commonwealth, in the case of a state hospital, or to the person maintaining the institution, in the case of a private hospital, for the expenses incurred and to a penalty of fifty dollars, which may be recovered in contract by the state treasurer, or the person maintaining the private institution as the case may be.

Section 79. The superintendent or manager of any institution for the insane may, when requested by a physician, sheriff, deputy sheriff, member of the state police, police officer of a town, or by an agent of the institutions department of Boston, receive and care for in such institution as a patient, for a period not exceeding ten days, any person deemed by such superintendent or manager to be in need of immediate care and treatment because of mental derangement other than drunkenness. The physician shall be a graduate of a legally chartered medical school, shall be registered in accordance with chapter one hundred and twelve, or shall be a commissioned medical officer of the United States army, navy, or public health service acting in the performance of his official duties, and personally shall have examined the patient within twenty-four hours of



signing the request. Such request for the admission of a patient shall be put in writing and be filed at the institution at the time of his reception, together with the statement in a form prescribed or approved by the department, giving such information as it deems appropriate. Any such person deemed by the superintendent or manager not suitable for such care shall, upon the request of the superintendent or manager, be removed forthwith from the institution by the person requesting his reception, and, if he is not so removed, such person shall be liable to the commonwealth or to the person maintaining the private institution, as the case may be, for all reasonable expenses incurred under this section on account of the patient, which may be recovered in contract by the state treasurer or other person, as the case may be. The superintendent shall either cause every such patient to be examined by two physicians, qualified as provided in section fifty-three, and cause application to be made for his admission or commitment to such institution, or cause him to be removed therefrom before the expiration of said period of ten days, unless he signs a request to remain therein under section eighty-six. The officers mentioned in section ninety-five or any member of the state police may transport the patient, or cause him to be transported, to the institution. Reasonable expenses incurred for the examination of the patient and his transportation to the institution shall be allowed, certified and paid as provided by section seventy-four. In instances where an individual, deemed by the department to be entitled to care in this commonwealth, is being held in a mental hospital or other place of detention for mental patients in another state awaiting transfer to a state hospital in this commonwealth, and such transfer has been approved by the department, the commissioner or any other medical officer of the department may sign such request, without personal examination of the patient, to authorize his immediate hospitalization upon arrival in this commonwealth.

Section 80. The superintendent or manager of any institution to which commitments may be made under section sixty-two may, when requested by a physician, by a member of the board of health or a police officer of a town, by an agent of the institutions department of Boston, by a member of the state police, or by the wife, husband, guardian or, in the case of an unmarried person having no guardian, by the next of kin, receive and care for in such institution, as a patient for a period not exceeding fifteen days, any person deemed by such superintendent or manager to be in need of immediate care and treatment because he has become so addicted to the intemperate use of narcotics or stimulants that he has lost the power of self control. Such request for the admission of a patient shall be in writing and filed at the institution at the time of his reception, or within twenty-four hours thereafter, together with a statement, in a form prescribed by the department having supervision of the institution, giving such information as it deems appropriate. The trustees, superintendent or manager of such institutions shall cause to be kept a record, in such form as the department having supervision of the institution requires of each case treated therein, which shall at all times be open to the inspection of such departments and its agents. Such record shall not be a public

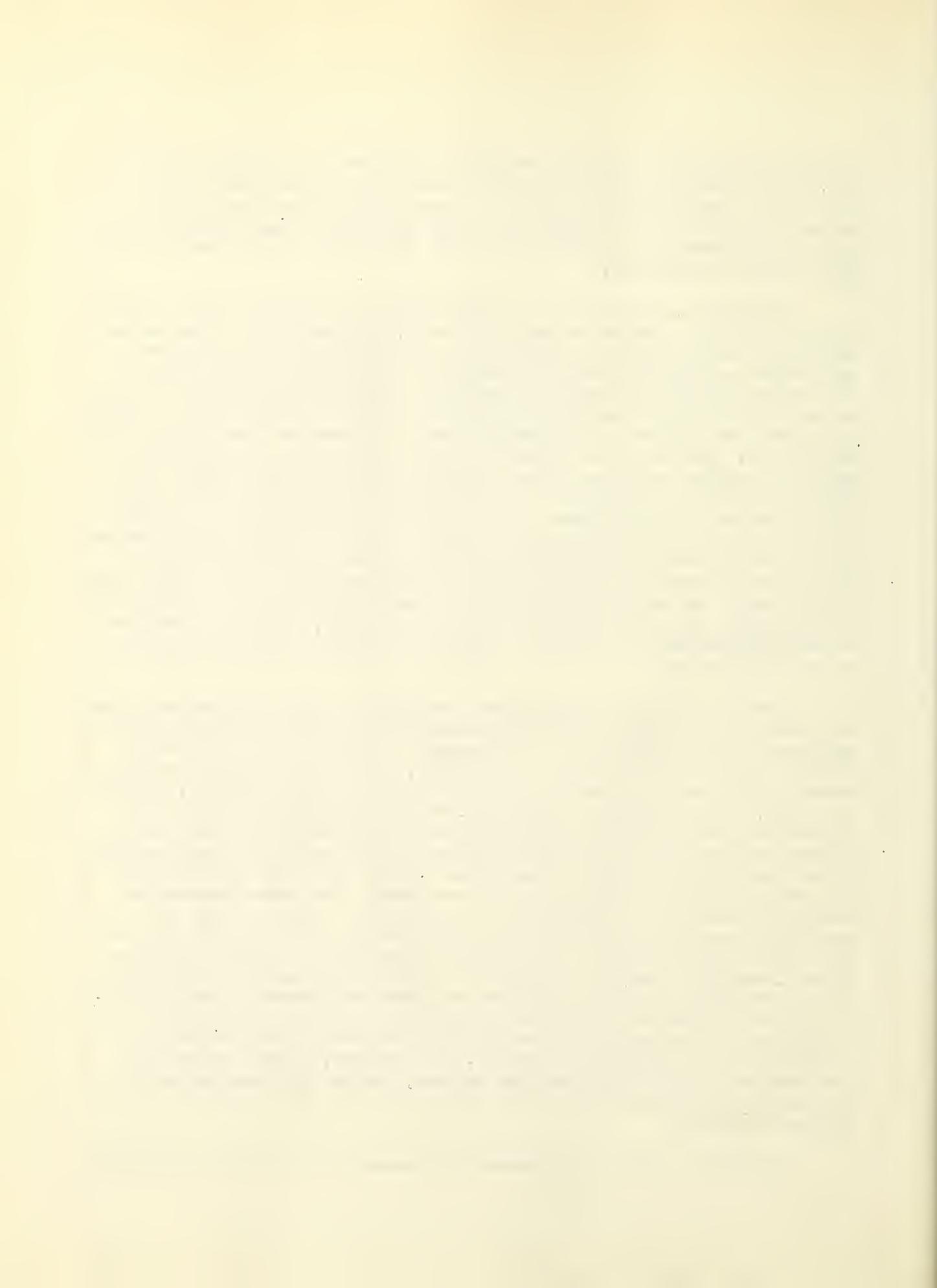


record, nor shall the same be received in evidence in any legal proceeding. The superintendent or manager of such an institution shall not detain any person received as above for more than fifteen days, unless, before the expiration of that period, such person has been committed under section sixty-two, or has signed a request to remain at said institution under section eighty-six.

Section 86. The trustees, superintendent or manager of any institution to which an insane person, dipsomania, an inebriate, or one addicted to the intemperate use of narcotics or stimulants, may be committed may receive and detain therein as boarder and patient any person who is desirous of submitting himself to treatment, and who makes written application therefor and is mentally competent to make the application; and any such person who desires so to submit himself for treatment may make written application. Except as otherwise hereinafter provided, no such person shall be detained more than three days after giving written notice of his intention or desire to leave the institution; provided that if his condition is deemed by the trustees, superintendent or manager to be such that further hospital care is necessary and that he is no longer mentally competent to be detained therein as a voluntary patient, or that he could not be discharged from such institution with safety to himself and others, said superintendent or manager shall forthwith cause application to be made for his commitment to an institution for the insane, and, during the pendency of such application, may detain him under the written application hereinbefore referred to.

Section 88. The superintendent or manager of any institution, after the examination required by section ninety-four has been made, may permit an inmate thereof temporarily to leave such institution in charge of his guardian, relatives, friends, or by himself, for a period not exceeding twelve months, and may receive him when returned by such guardian, relative or friend, or upon his own application, within such period, without any further order of commitment, but no patient committed under section one hundred and one shall be permitted temporarily to leave the state hospital without the approval of the governor and council, nor shall such permission terminate the original order of commitment. The superintendent or manager may require as a condition of such leave of absence, that the person in whose charge the patient is permitted to leave the institution shall make reports to him of the patient's condition. Any such superintendent, manager, guardian, relative or friend may terminate such leave of absence at any time and authorize the arrest and return of the patient. The officers mentioned in section ninety-five shall cause such patient to be arrested and returned upon the request of any such superintendent, manager, guardian, relative or friend. Any patient, unless he has been committed under section one hundred and one, who has not returned to the institution at the expiration of twelve months shall be deemed to be discharged therefrom.

Section 89. The superintendent or manager of a private institution



described in section three, the superintendent of the McLean hospital, or of any institution other than a state hospital to which commitments may be made under section sixty-two, when authorized thereto by the trustees of such institutions, the trustees of any such institution other than the state hospital themselves, the superintendent of a state hospital, the department having supervision of the institution, or, on written application, a judge of probate for the county where the institution is located, or where the inmate had his residence at the time of his commitment or admission, or a justice of the superior court in any county, after such notice as the said superintendent, manager, trustees, department having supervision, judge or justice, may consider reasonable and proper, may discharge any inmate if it appears upon examination that he will be sufficiently provided for by himself, his guardian, relatives or friends, or that his detention in such institution is no longer necessary for his own welfare or the safety of the public. If the legal or natural guardian or any relative of an inmate opposes such discharge, it shall not be made without written notice having been given to the person opposing such discharge. This section shall not apply to persons committed by court under any provision of sections one hundred to one hundred and four, inclusive, except as otherwise provided in section one hundred and five.

Chapter 127

Section 128. Permits to be at liberty may be granted as follows: to prisoners in penal institutions of the commonwealth or transferred therefrom to jails or houses of correction, by the board of parole; to prisoners in jails and houses of correction, except in Suffolk county, by the county commissioners; to prisoners in the jail and houses of correction in Suffolk county, by the penal institutions commissioner. All permits shall be issued by the board or officer granting them.

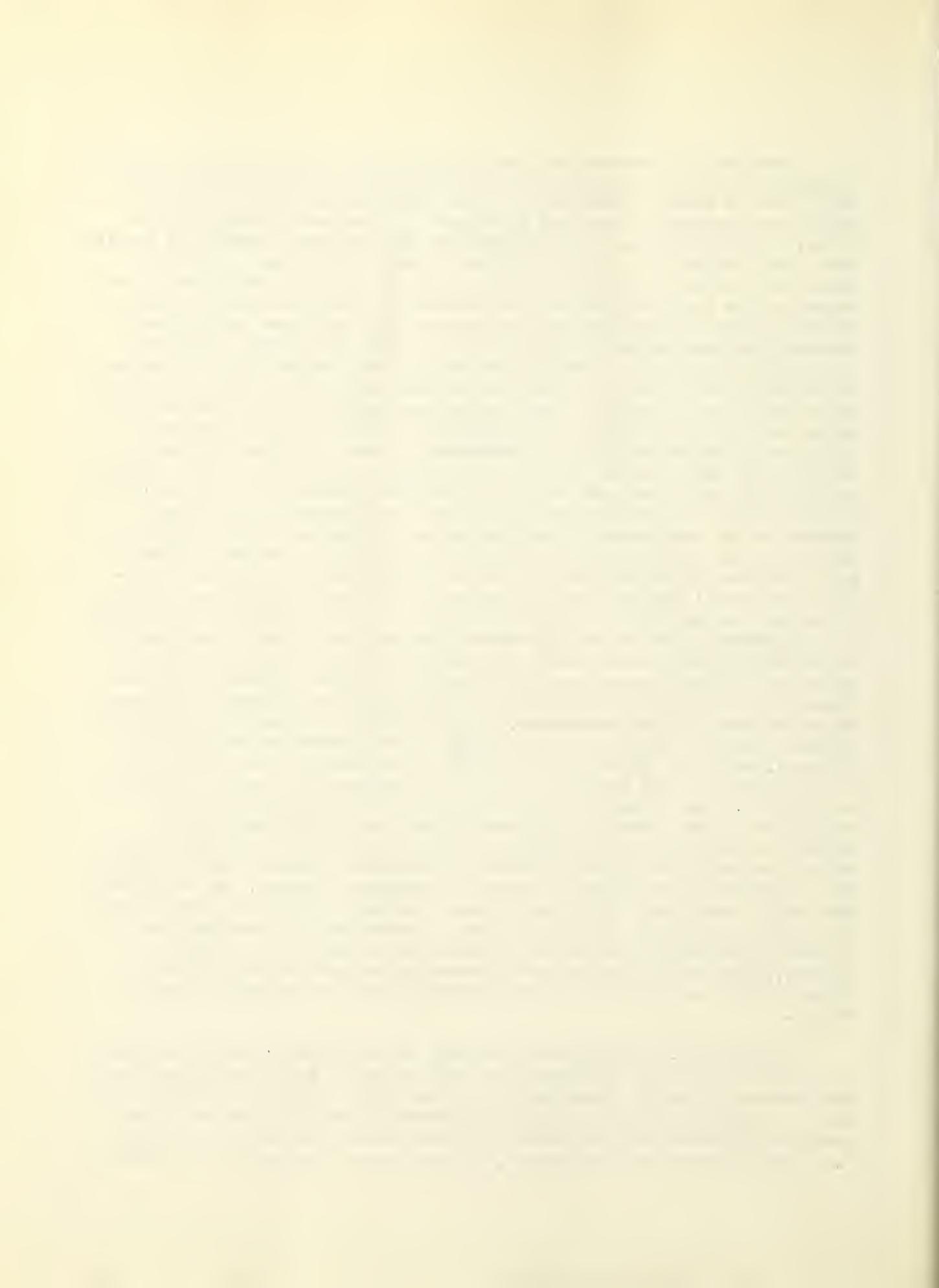
Section 140. If it appears to the county commissioners, or, in the county of Suffolk, to the penal institutions commissioner of Boston, that a prisoner in the jail and house of correction convicted of an offense named in section fifty-three of chapter two hundred and seventy-two or of drunkenness and sentenced for a term or for non-payment of a fine, has reformed and is willing or desirous to return to an orderly course of life, they may issue to him a permit to be at liberty during the remainder of his term of sentence.

Chapter 272

Section 44. Whoever is found in a state of intoxication in a public place, or is found in any place in a state of intoxication committing a breach of the peace or disturbing others by noise, may be arrested without a warrant by a sheriff, deputy sheriff, constable or police officer, and kept in custody in a suitable place until he has recovered from his intoxication.

Section 45. Whoever arrests a person for drunkenness shall make a complaint against him therefor at the next session of the court or of the trial justice having jurisdiction of the case; and such court or trial justice may proceed to hear and to dispose of the same according to due course of law; and may, if the accused has been released under this section, order the issuance of a warrant for the arrest, or a summons for the appearance, of the accused for trial, or if the court is satisfied by the report of its probation officer, or otherwise, or if the trial justice is satisfied upon inquiry that the accused has not four times before been arrested for drunkenness within a year, and that his written statement hereinafter mentioned is true, the court or trial justice shall thereupon direct that the accused, if still in custody, be released without arraignment; and if not in custody, that further proceedings in the case be suspended or that the complaint be dismissed. A person so arrested may, after he has recovered from his intoxication, make a written statement, addressed to the court or trial justice having jurisdiction of his offence, giving his name and address, setting forth what persons, if any, are dependent upon him for support, his place of employment, if any, and whether he has been arrested for drunkenness within the twelve months next preceding, and requesting to be released from custody; and may deliver said statement to the officer in charge of the place in which he is confined, who shall endorse thereon the name of the arresting officer, and if the arrest is made within the jurisdiction of a trial justice, his opinion of the probable truth of said statement for the use of such trial justice; and if the arrest is made within the jurisdiction of a court having a probation officer, the officer in charge of the place in which he is confined shall transmit such statement to said probation officer. Said probation officer, or his assistants, shall forthwith inquire into the truth thereof and shall investigate the record of said person as to previous offenses, and, for the use of the court having jurisdiction of the case, shall endorse on such statement, with his signature the result of his investigation. The officer for the time being in charge of the place of custody in a town where no probation officer resides forthwith shall release, and elsewhere the probation officer or assistant probation officer of the court having jurisdiction of the offence shall direct the officer in charge of the place of custody forthwith to release, and such officer so in charge shall thereupon release such arrested person pursuant to his request; provided, that the officer so releasing or directing the release believes that the person arrested has given his true name and address, that he will appear upon a summons, and that he has not four times before been arrested for drunkenness within the preceding twelve months.

Section 46. The officer in charge of the place of custody in which a person arrested for drunkenness is confined shall inform him, when he has recovered from his intoxication, of his right to make a written statement and request for release under the preceding section, and an officer making an arrest under the authority of said section shall not be liable for illegal arrest or imprisonment, if the person arrested is so released



at his request.

Section 47. A full record shall be kept by every court or trial justice of each case in which a person is released, as aforesaid, with the statement made by him.

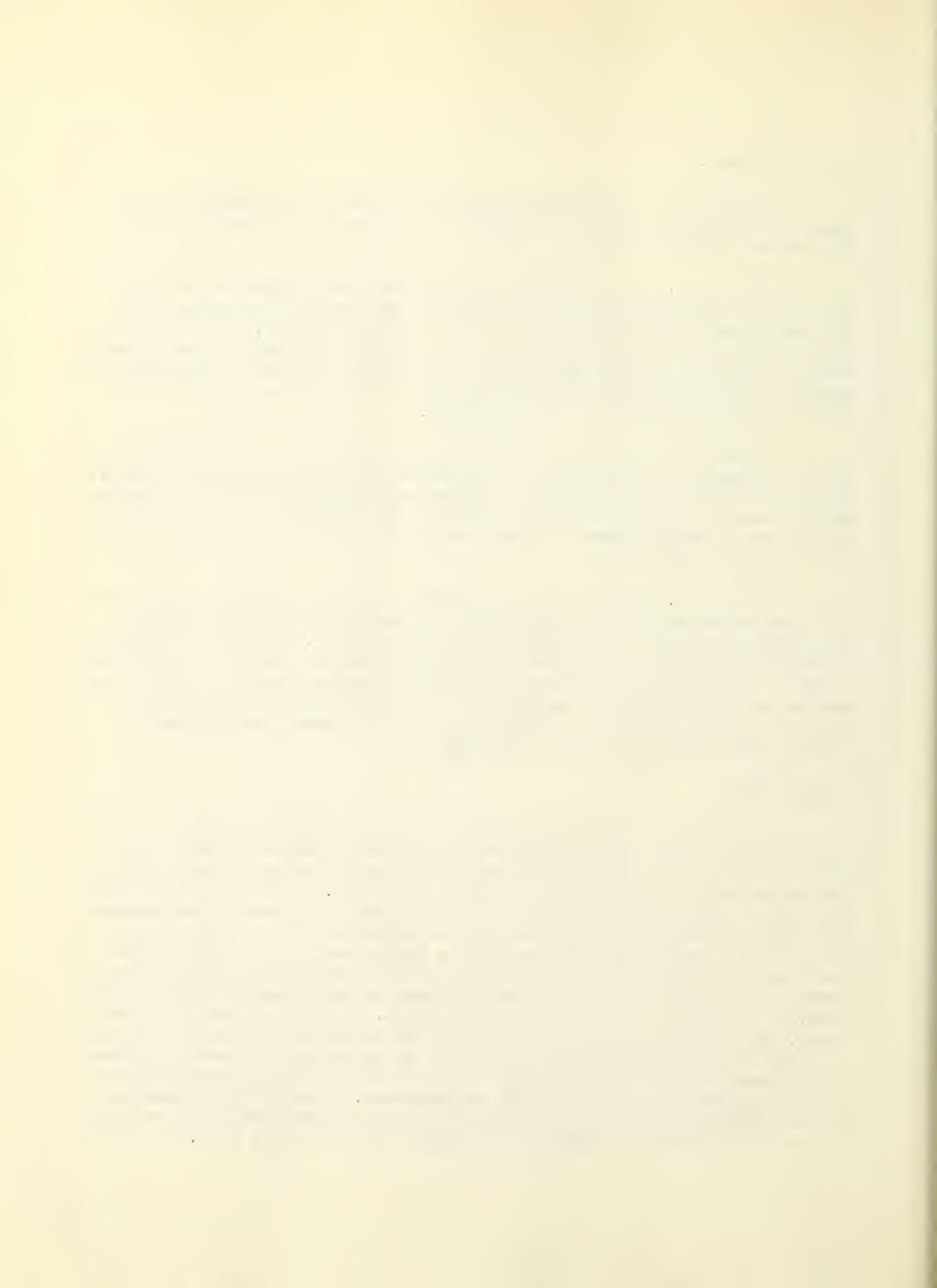
Section 48. If a person is convicted of drunkenness by the voluntary use of intoxicating liquor, he may be punished by imprisonment in jail or in any place provided by law for common drunkards, or, if a male, in the Massachusetts Reformatory, or, if a female, in the Reformatory for Women, for not more than one year; or by a fine of not more than fifteen dollars, or the court may place the case on file or place the defendant on probation and prescribe the terms thereof.

Section 49. Probation officers shall assist the courts appointing them by obtaining and furnishing information relative to previous arrests, convictions and imprisonments for drunkenness, and such other facts as the court orders relative to persons accused of drunkenness. They shall keep a full record, well indexed, of each case which they investigate, in such form as the court orders.

Section 50. Records and statements made under sections forty-five and forty-seven to forty-nine, inclusive, shall be at all times open to the police officials of the town of the commonwealth. The police commissioner of Boston, city marshals and chiefs of police, keepers of jails and masters of houses of correction shall on application furnish to each other and to probation officers, and probation officers shall on application furnish to each other, all information in their possession relative to persons whose cases are under investigation.

Chapter 276

Section 99. The board of probation shall prescribe the form of all records and of all reports from probation officers and of reports from trial justices, and shall make rules for the registration of reports and for the exchange of information between the courts. It shall provide for such organization and cooperation of the probation officers in the several courts as may seem advisable. To promote coordination in the probation work of the courts, the board may call a conference of any or all of the justices of the district courts and the Boston juvenile court, or a conference of any or all of the probation officers and assistant probation officers, and a member of the board shall preside. With the approval of the board, the commissioner of correction or the department of public welfare may hold a conference with any or all of the probation officers to secure their cooperation in keeping trace of the whereabouts of persons who are at liberty from the prisons of the commonwealth. The traveling expenses of said justices or officers in attending any conference herein named shall be paid as the other expenses of the respective courts are paid.

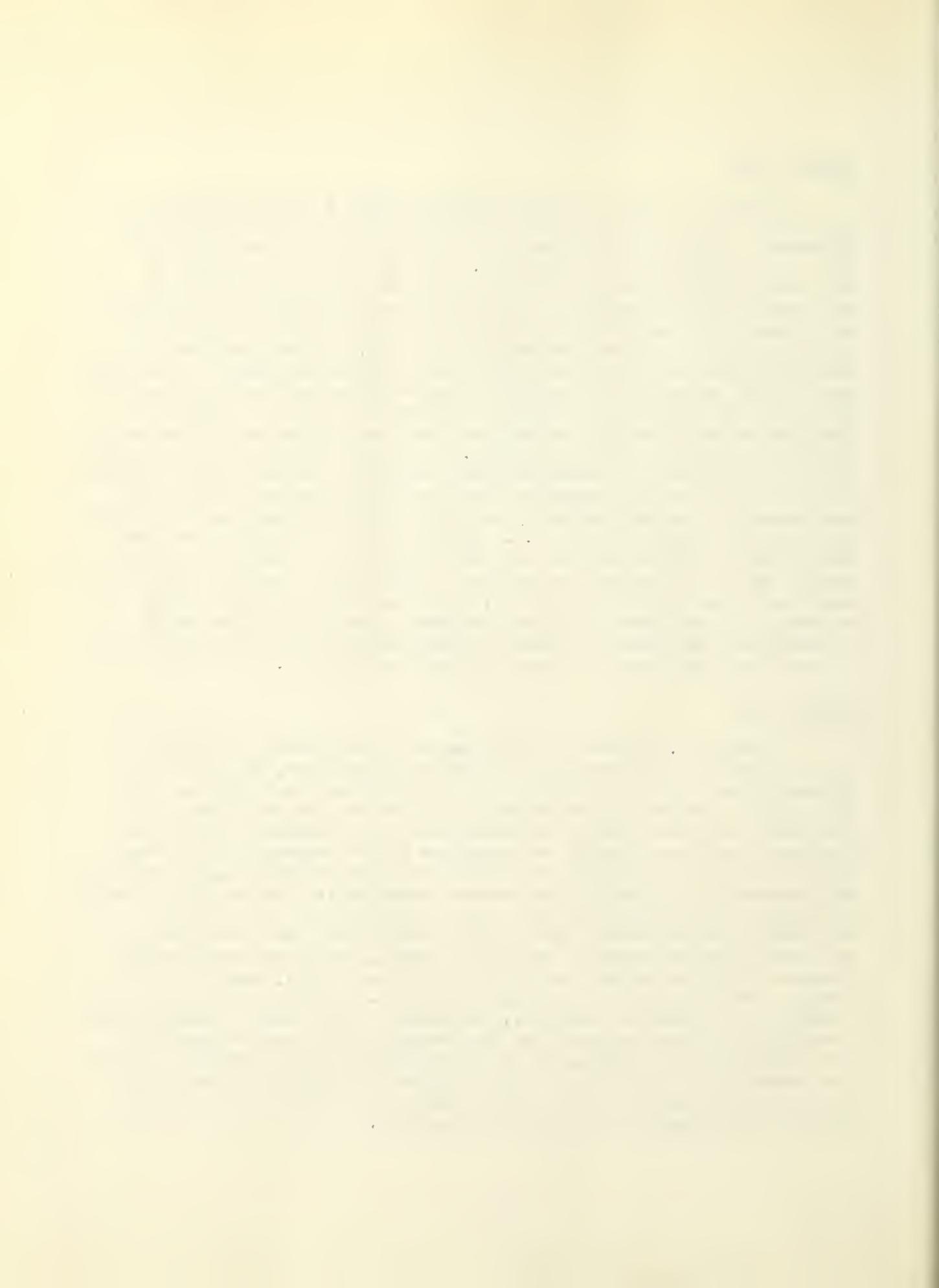


Chapter 279

Section 1. When a person convicted before a court is sentenced to imprisonment, the court may direct that the execution of the sentence be suspended, and that he be placed on probation for such time and on such terms and conditions as it shall fix. When a person so convicted is sentenced to pay a fine, and to stand committed until it is paid, the court may direct that the execution of the sentence be suspended for such time as it shall fix, and in its discretion that he be placed on probation on condition that he pay the fine within such time. If the fine does not exceed fifteen dollars and the court finds that the defendant is unable to pay it when imposed, the execution of the sentence shall be suspended and he may in its discretion be placed on probation, unless the court shall find that he will probably default, or that such suspension will be detrimental to the interests of the public. If he is committed for non-payment of a fine, the order of commitment shall contain a recital of the findings of the court on which suspension is refused. The fine shall be paid in one payment, or in part payments, to the probation officer, and when fully paid the order shall be void . . . If during or at the end of said period the probation officer shall report that the fine is in whole or in part unpaid, and in his opinion the person is unwilling or unable to pay it, the court may either extend such period, place the case on file or revoke the suspension of the execution of the sentence. When such suspension is revoked, in a case where the fine has been paid in part, the defendant may be committed for default in payment of the balance . . .

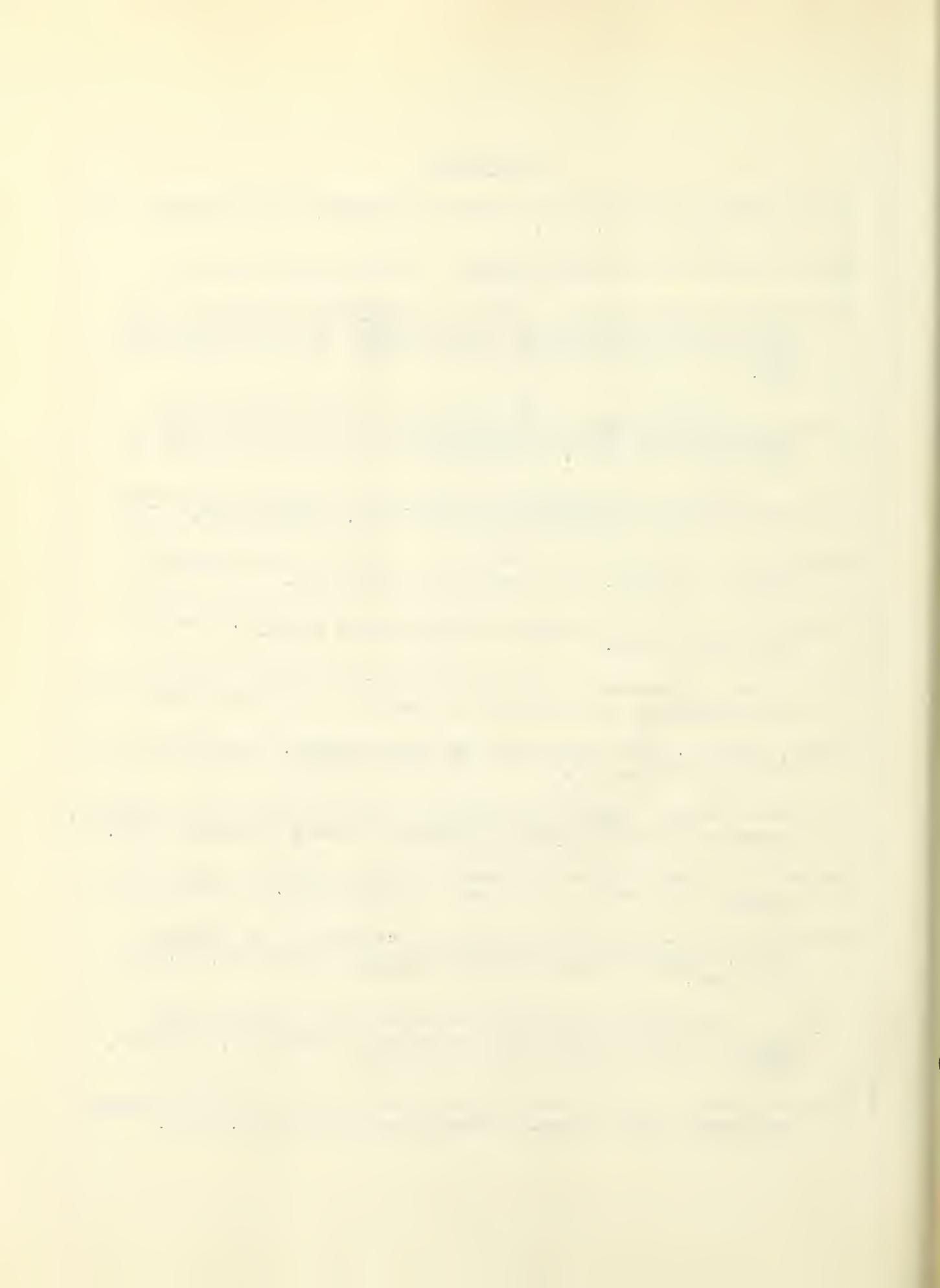
Chapter 278

Section 18. Whoever is convicted of a crime before a district court or trial justice may appeal to the superior court, and at the time of conviction shall be notified of his right to take such appeal. The case shall be entered in the superior court on the return day next after the appeal is taken, and the appellant shall be committed to abide the sentence of said court until he recognizes to the commonwealth, in such sum and with such surety or sureties as the court or trial justice requires, with condition to appear at the superior court on said return day and any subsequent time to which the case may be continued, if not previously surrendered and discharged, and so from time to time until the final sentence, order or decree of the court thereon, and to abide such final sentence, order or decree, and not depart without leave, and in the meantime to keep the peace and be of good behavior. If the appellant is committed for failure to recognize, the superior court shall thereupon have jurisdiction of the said case for the purpose of revising the amount of bail required as aforesaid. In cases of misdemeanor the appellant may, in the discretion of the court or trial justice, be held on his own recognizance. The appellant shall not be required to advance any fees upon claiming his appeal or in prosecuting the same.



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