"IMPACT OF THE EASTER DECISION ON THE DISTRICT OF COLUMBIA"

by

Richard J. Tatham
(D.C. Department of Public Health)

This is Richard J. Tatham, Chief of the Office of Alcoholism and Drug Addiction Program Development, for the District of Columbia Department of Health. I've been asked to relate to you some of our recent experiences in the District of Columbia which have resulted from a U.S. Court of Appeals decision last March 31, 1966, in the case of DeWitt Easter vs the Court of Columbia. As many of you know, the result of this court decision was a reversal of court decisions which found DeWitt Easter to be guilty of the crime of intoxication, in spite of the fact that he had clearly established that he was a chronic alcoholic. This decision was appealed to the U.S. Court of Appeals and it was found that alcoholism is an illness and that it would constitute cruel and unusual punishment for a sick person to be convicted and punished for exhibiting a symptom of his illness in public, and it was further established that the essential common law element of criminal intent is lacking when an alcoholic becomes intoxicated. As a result of this case, the Court of General Sessions began utilizing the Alcoholic Rehabilitation Act of 1947, which authorized that court, in the District of Columbia, to suspend criminal hearings whenever a defendant was suspected of having an alcoholism problem and to commit that person to the Department of Public Health for diagnosis, classification, and treatment. The 47th Statute had been used on the average of 100 times each year between the years 1950 and 1963, and was, therefore, nothing new to the court or to the Health Department. However, in more recent years its use was discontinued as the court began to develop its own probation program for alcoholic offenders. Last year the U.S. Court of Appeals strongly urged the District of Columbia to use its 47th Statute once again and as a result of this admonition some 3500 individuals have been adjudicated under the 47th Statute to be chronic alcoholics and the majority of these have been committed to the Health Department for treatment. At the time of the Easter Decision, the D.C. Health Department operated three alcoholism treatment facilities; namely, an outpatient clinic, known as the Alcoholic Rehabilitation Clinic; a hospital unit for intensive medical care at the D.C. General Hospital; and, a brand new comprehensive in-patient, out-patient unit at our Area C Mental Health Center. However, the latter facility was only in its beginning phases with a skeleton staff and was not really able to participate appreciably to handle a court alcoholic problem. Likewise, the in-patient facility at D.C. General Hospital concentrated on the short-term intensive treatment for delirium tremens, hallucinosis, and other serious complications of alcoholism, and so very few of the court-committed alcoholics were eligible for this service. The only remaining treatment facility is our out-patient clinic. Now in the month immediately following the Easter Decision, only six patients were committed to the Health Department. In the month of May, the number jumped up to 100 and by June, 300 new patients were committed to us. By this time, patients were being transported from the court to the out-patient clinic by the busload with as many as 50 or more arriving at a time. The out-patient clinic had no choice but to accept these in spite of the fact that the clinic was not designed to accommodate the needs of the patients we were receiving. Utter chaos followed. All attempts to utilize existing Health Department resources resulted only in the addition of a few part-time people on an over-time basis in order that the clinic could operate evenings and Saturdays. Now, nine months after the Easter Decision, the same situation prevails with one exception - we now have an additional facility - a 425-bed, extended-care rehabilitation center located just outside the District of Columbia in Occoquan, Virginia. This facility opened November 14, 1966, and was filled to

capacity in less than six weeks, so once again the Health Department is unable to accommodate all the patients who require in-patient treatment and these patients are once again going to our out-patient clinic.

A recent article in the Washington Post indicated that the Director of this out-patient clinic is threatening to leave the Health Department unless the situation is alleviated somehow. The patients are still coming to clinic in droves. While they are there, they have entered into fights with other patients, members of the clinic staff have been assaulted, patients have urinated and expectorated in the clinic and this has created a situation which threatens the entire survival of a treatment program that has been in existence since 1949.

The solution of this problem is not a simple one. One might believe that the Health Department had not anticipated the reversal in the Easter Case; however, this is not true. Well in advance of the Easter Decision, the Health Department, along with representatives from Vocational Rehabilitation, Correction, Administration, and Welfare Departments prepared an ad hoc report dealing with the possible impact of an Easter Decision. This report clearly pointed out some of the problems which might arise and also outlined certain new services and facilities which might be needed. However, no action was taken by our Board of Commissioners. The reason for this included the fact that the Commissioners had no assurance that the Easter Case would be reversed and even if it would be reversed they had no assurance that the impact would be great. For example, even though the Easter Case would be reversed, the judges in our local courts might insist that the question of alcoholism would have to be introduced by the defendant himself and many alcoholics appearing in court, of course, would choose not to introduce the problem of alcoholism. By avoiding the question of alcoholism they could return to their workhouse where they have been long-time residents - they knew that they would serve an average of 21 days and then could be released without any parole or any other obligations. However, if they should bring up the question of alcoholism, they might very well be committed to the Health Department for 90 days with a possibility that a second 90-day committment would follow. With this in mind, there was much speculation that the courts would not use the Easter Decision as a base of future action in very many cases. In addition to this, the problem was complicated by the fact that the corporation counsel, known in other cities as a prosecuting attorney, felt very strongly that according to the definition of our 1947 Statute, there could not possibly be more than 20 or 30 chronic alcoholics in the entire District of Columbia. Activities since then have proven quite the contrary. The problem has become so great that it was necessary to set up a court-coordination program and patient control system in order to just keep track of the multitude of patients being committed to us by the court. The situation became so bad that the Health Department was instructed that it must cut off all voluntary patient admissions at its treatment facilities in order to make room for the court-committed patients.

In evaluating the problems that have occurred since the Easter Decision, the Department has consistently fallen back on its basic comprehensive community mental health plan, which points out the needs for various facilities ranging from the extended care rehabilitation center we now operate to mental health center alcoholism units providing both in-patient and out-patient treatment to detoxification centers to residential facilities such as hostels and half-way houses. The big problem, obviously, is the magnitude of the program which we have proposed and the fact that one or two components of the program still do not alleviate the problem of handling court-committed patients. Until a complete

system is available and operating which can provide all of the services needed by this particular patient population, there will be chaos in treating the chronic court offender. If we do not have community based residential facilities, then we will either have to expand our in-patient hospital at Occoquan, Virginia, or we will have to substitute out-patient treatment with all its inadequacies for this homeless patient group.

The District of Columbia is presently spending approximately $3,000,000 per year on the alcoholic patients seen by the Health Department. Of this figure, approximately $1,000,000 a year is expended on the care of alcoholics having psychosis who are admitted to St. Elizabeths Hospital and paid for by the Health Department on a contract basis. The other $2,000,000 accounts for our present services at the rehabilitation center, at the Area C alcoholism unit and at our out-patient clinic. Also, the figure includes the cost of providing our court coordination and patient control system, a small alcoholism TB Program at Glendale Hospital, and our new demonstration detoxification unit.

As we are busily trying to expand our services to accommodate the needs of the court-committed patients, we are faced with a new problem which has come to light within the past few weeks in Washington. Our information indicates that two new bills are to be introduced to Congress this session. One by the administration, a second by Congressman Hagan from Georgia. Each bill would introduce a new concept in law enforcement as each would remove intoxication from the criminal code entirely. This would mean that if either of these bills was passed, an individual could not be arrested for being intoxicated only in the District of Columbia. It would mean that if an intoxicated person is helpless, has no place to go, he could be escorted by a police or Health Department official to a health facility for detoxification. He would be kept in such a detoxification faciltiy until his blood alcohol content returned to the legal limits of sobriety and then could be continued in treatment for alcoholism as a voluntary patient or released outright. This would mean that our attention to the problems of getting sufficient hospital care resources for court-committed alcoholics would shift almost immediately to the problem of obtaining sufficient in-patient detoxification resources within the community itself. I think this is an excellent example of how dynamic the field of alcoholism has become as a public health problem and indicates the importance of planning coupled with flexibility; and, above all, it impresses with the importance of the magnitude of the problem. Most communities have never accepted the full impact of the statement that alcoholism is the nations third or fourth public health problem. We have mouthed this saying without realizing the financial impact that it carries. As I said earlier, our community is expending approximately $3,000,000 a year on alcoholics. Now I'm talking about the Health Departments budget - I'm not adding to this figure what the Police Department, what the courts, what the Department of Corrections, and other departments are allocating to the care of alcoholics - just the Health Department. This $3,000,000 figure, in our estimation, will probably have to be doubled to a $6,000,000 annual figure just to take care of the immediate emergency problems arising from the Easter Decision and the possible new legislation which would remove intoxication from the criminal code. Now, in creating these new services, of course we would hope any new program would be considered an additional resource for voluntary patients also; but, it's interesting to note that our 1947 Statute and the Easter Decision and the possible new statutes removing intoxication from the criminal code, all focus on the alcoholic who is a law offender and quite often the most important patient in this group is the chronic drunkenness offender with fifty or more previous arrests for drunkenness. This means that today, alcoholism, even though a public health problem, is reaching the public's attention through the judicial activities of the community and of the nation; that a complete

revision of some rather well established principles is being questioned; and that new approaches are being encouraged; and that these new approaches will require new funds of considerable magnitude unless the community is satisfied that the treatment of the chronic alcoholic offender should consist of removing him from the streets only - and I think this is a very real problem that we face in firmly maintaining that alcoholism, the skid row alcoholic, the chronic drunkenness offender, is to become truly a public health problem. That the high quality treatment, the high standards of services that we provide other alcoholic patients are made available to the chronic drunkenness offender - now this does not mean that the chronic offender necessarily can benefit from the same type of treatment that our other alcoholic patients are involved in; but it does mean that whatever services are provided for them, they are the highest possible quality of services to meet the needs of this important patient population.

I have been impressed as I have visited many alcoholism facilities throughout this nation with the fact that even though the Easter Decision is more than nine months old and that a similar decision in the case of Joe B. Driver in the Fourth Circuit Court of Appeals at Richmond, Virginia, have established a new legal precedent, and that these precedents have been set on both a constitutional and common-law basis and there is no doubt that the precedent will spread from state to state and circuit to circuit; yet in spite of all these things, many alcoholism programs do not seem to be planning to take care of this situation when it inevitably happens in their own state and community and I was, therefore, very pleased to see that in Atlanta there is planning being initiated and that the Community Council here in Atlanta is drafting a proposal which will be submitted as an answer to the problems that can arise here; that there are a number of people interested in the chronic alcoholic offender; and that services are being demonstrated now which can be extremely important in meeting the treatment, the rehabilitation, the residential, and other needs of this impoverished group. We feel quite strongly in the District of Columbia that we have been bogged down in our own problems for over a year and that it's now perhaps our responsibility to communicate our experiences and observations to others throughout the country and Canada in order that some of the problems, the mistakes, and the frustrations experienced in Washington can be minimized elsewhere and it has been with this thought in mind that I have shared these comments with the staff of the Georgian Clinic and others who might come into contact with this tape recording.

Richard J. Tatham, Chief
Office of Alcoholism & Drug Addiction
Program Development
Government of the District of Columbia
Department of Public Health
Washington, D.C.

RJT: 2-24-67