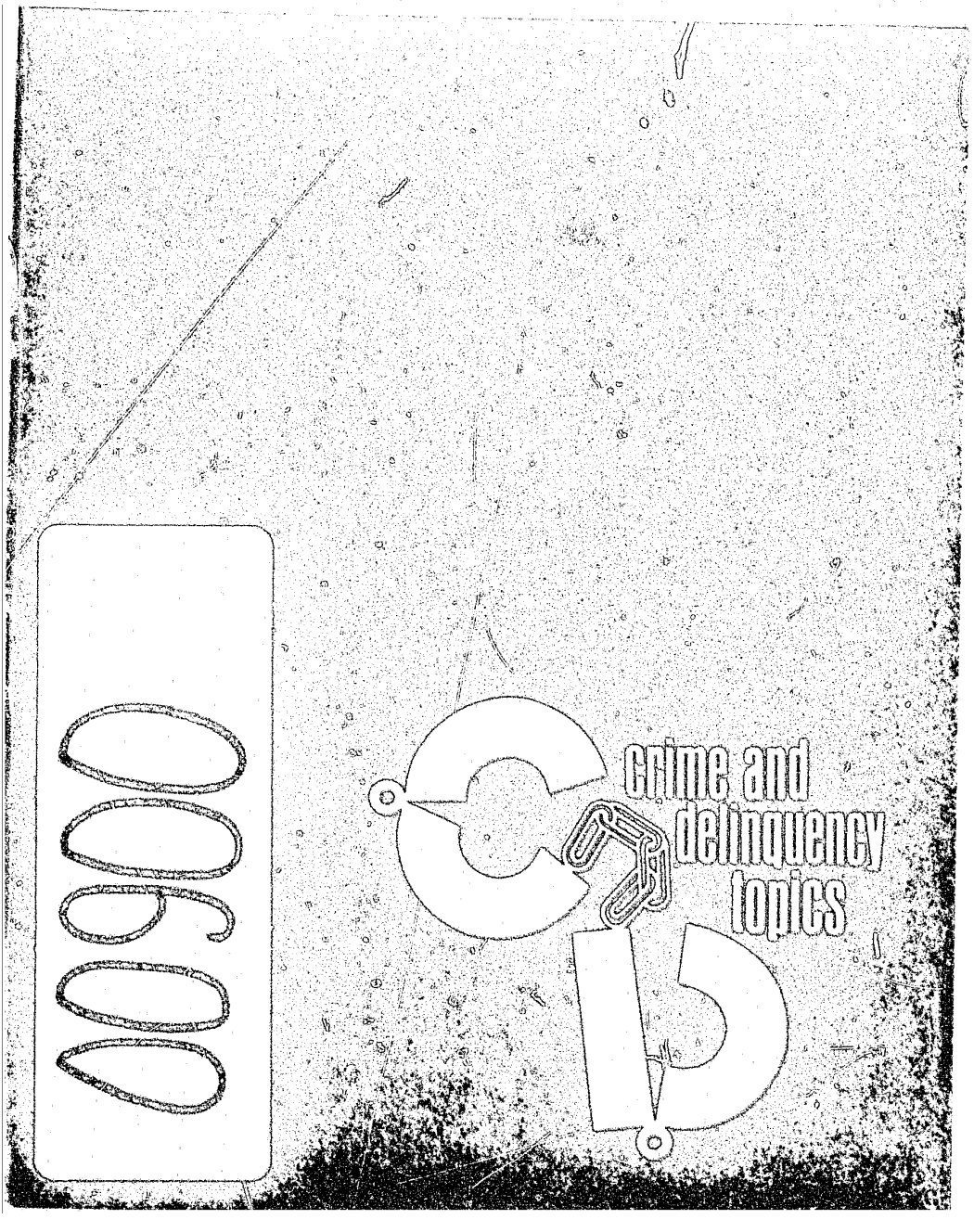

CRIME AND DELINQUENCY TOPICS:

A Monograph Series

Diversion From the Criminal Justice System

National Institute of Mental Health
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Foreword

This monograph is one of a series of literature reviews and evaluative discussions on current topics of significance in the area of crime and delinquency. These monographs are designed to inform program administrators, policy makers, and other interested persons about significant findings to date which may be useful in the development and improvement of programs in the crime and delinquency area, and about research gaps and needs.

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The *diversion* of persons from the criminal justice system has long been practiced in the United States, largely because the system allows—in fact, requires—considerable discretion on the part of the police, with regard to decisions to arrest or dismiss and court referral or informal disposition, and on the part of the prosecutor or intake worker, with regard to official or unofficial processing. Diversion from the justice system may occur, of course, at any stage of judicial processing; but concern over the tremendous burden placed on courts and the injustices associated with the inability of the courts to handle the volume of cases, compounded by evidence that criminal processing often does more harm than good, has resulted in a focus on diversion of certain groups of offenders before court processing.

Informal preadjudication disposition occurs in both the juvenile and the adult justice systems, for many of the same reasons. First, even with the best legislative formulation, definitions of criminal conduct are not likely to be completely unambiguous.[1] The decision to divert an individual from judicial proceedings is affected by many factors, including the nature of the offense, the circumstances of its commission, the attitude of the victim, and the character of the accused.[2] The use of discretion is affected also by the consideration that the stigma of official processing might seriously limit the accused's social and economic opportunities or impose on him a deviant role, leading to further antisocial acts. Further, the huge volume of cases would seem to require some screening of those less serious, to allow concentration of law enforcement resources on what are considered to be major crimes.

The issue of screening out less serious cases is germane to the two areas in which diversion as a conscious policy currently is given most attention: minor noncriminal "delinquent" behavior, and adult conduct which is socially disapproved but which might be more appropriately handled by social agencies or public health authorities. While it is clear that considerable numbers of persons are diverted from the criminal justice system as a result of official discretion, the assumption that less serious offenders are screened out is questionable. Arrest data and court statistics indicate that "most of the cases in the criminal courts consist of what are essentially violations of moral norms or instances of annoying

[1] President's Commission on Law Enforcement and Administration of Justice, *Task Force Report: Juvenile Delinquency and Youth Crime*, Washington, D.C., the Commission, 1967. p. 10.

[2] *Ibid.*

behavior, rather than of dangerous crime," [3] and that many juveniles contacted by police for truancy, waywardness, or "incorrigibility" end up in juvenile court with an adjudication of delinquency. It is difficult to see how these might be viewed as "major crimes." Diversion does occur; but its use is so informal, unstructured, and lacking in principle that it tends to depend on the personal inclination of the individual official.

Arguments against informal prejudicial processing are: (1) that broad powers of discretion may be abused; (2) that enlarged discretionary power results in inconsistent law enforcement and disrespect for law; (3) that discretionary power may be used to further staff convenience at the expense of other goals of crime prevention and control. These are valid criticisms of "diversion" as it might operate if informal discretionary powers were merely extended. The proponents of diversion, however, are advocating that prejudicial disposition be made a conscious and clearly defined policy, that the processes of diversion be given some procedural regularity, and that decisions be made on the basis of explicit and predetermined criteria. Assuming that alternate resources are made available and that nonjudicial procedures are defined, the extended use of unofficial or informal disposition need not necessarily result in an increase in "invisible" decisionmaking by individuals with great discretionary authority.

Diversion from the criminal justice system, whether in accordance with an explicit policy or in the form of case-by-case exceptions to the rule, occurs primarily because of official concern that application of the full criminal process is not always possible or appropriate. In the past, consideration of the need for diversion and special handling of some classes of deviants led to the establishment of the juvenile court and a noncriminal procedure to be used "in the interest of the child" as well as to the sanctioning of civil commitment "for treatment" of mentally ill offenders either adjudged incompetent to stand trial or after dismissal of criminal charges because of insanity. Experience with these measures has demonstrated that humanitarian intentions do not guarantee either more humane treatment of the individual or more successful rehabilitation. Juvenile court procedures have been found to infringe on the rights of the child and adjudication of a person as mentally ill proved to involve problems of stigma as harmful—some say even more—as a criminal record. Civil commitment procedures have been attacked for their failure to protect individual rights as well as on the grounds that adequate treatment is often not provided and the custody involved generally becomes

[3] President's Commission on Law Enforcement and Administration of Justice, *The Challenge of Crime in a Free Society*, Washington, D.C., the Commission, 1967. p. 14.

the equivalent of penal incarceration. Despite the criticisms of such noncriminal court measures, there has been considerable interest in broadening the use of civil commitment as an "enlightened" alternative for narcotic addicts and alcoholics, and since the early days of the juvenile court there has also been an increased use of the delinquency adjudication for relatively minor misbehavior or for such vaguely defined statutes as "incorrigibility."

In more recent years, there has been a noticeable shift in emphasis from lightening the impact of either civil or criminal court processing on certain groups of social deviants[4] to removing such persons entirely from the judicial process. The American system has a general tendency to rely too heavily on the law and legal process for the solution of pressing social problems. In particular, the arbitrary assignment to the criminal law and its processes of a variety of human conduct and conditions has come to be regarded as a problem of "overcriminalization." The problems associated with "overcriminalization" and the growing concern for the consequences associated with the expansion of the "sick" role have resulted in a body of literature and some experimentation with direct referral to community agencies, transfer of responsibility for certain groups to public health authorities, and legal reform to *remove* some kinds of minor misconduct of victimless "crimes" from the criminal statutes. Recent attempts to find alternatives outside of the legal process have been most evident in the cases of juveniles brought to court for noncriminal misconduct—drug users and drunkenness offenders; "status" offenders such as addicts, alcoholics, and vagrants; and mentally ill offenders.

These two opposing trends—the expanded use of civil and criminal procedures for an increasing variety of behavior and the countering attempt to eliminate the option of reliance on official coercion and thus transfer responsibility for some less socially injurious conduct to other authorities—currently are both evident and the issues are still being debated. Three types of social response to deviant, but not clearly criminal, behavior can be distinguished according to degree of involvement of law enforcement, courts, and correction: (1) penal sanction and criminal processing; (2) legal reform and transfer to public health authorities or social welfare agencies (the "sick" role); and (3) the compromise solution—civil processing and compulsory commitment.

[4] Throughout this monograph, the term "deviant" is used to suggest nonconforming or socially disapproved behavior, whether illegal or not. No implication of mental or emotional disorder is intended.

From the very extensive literature on both present practices and proposed changes in these areas, several issues emerge as predominant: civil commitment or compulsory court-ordered treatment; the use of health resources and other nonpenal measures for purposes of social control and individual treatment (referral to clinics or Youth Service Bureaus and provision of outpatient or other voluntary treatment for addicts and alcoholics); and constitutional and statutory reform (to "legalize" abortion, homosexuality, vagrancy, or drunkenness not accompanied by other illegal activity).

Civil commitment generally is described as a noncriminal process by which a sick or otherwise dependent person is involuntarily committed to a nonpenal institution for care, custody, or treatment.[5] As such, it is often represented as a useful and human means of diverting selected types of deviants from the criminal justice system. However, closer inspection reveals that the affirmative aspects of diversion exist only in theory.

The rationale for civil commitment, as it is generally phrased, is at first difficult to resist. The putative offender (juvenile, mentally ill, sexual psychopath, or addict) is "diverted" to a noncriminal proceeding and subsequently hospitalized for treatment rather than sentenced to prison or otherwise punished. At the same time, society is protected against whatever dangers such persons might present if left at liberty and, through rehabilitation, against the possibility of repetition of disapproved behavior upon release. Everyone seems to benefit and, since few people these days support the punishment of ill persons or children, such a plan of "treatment" appeals to contemporary notions of justice.

Why, then, is civil commitment the subject of such controversy? Much of the criticism—of the civil processing of offenders designated as ill and the so-called processing of juveniles—has been focused on the lack of adequate procedural safeguards, the absence of the treatment which is supposed to justify commitment, or the injustice of the longer confinement often imposed under civil as compared with criminal law. For example, one writer argues that most involuntary civil commitment laws do not adequately safeguard the rights of the individual because of almost insurmountable problems of definition;[6] another stresses the fact that the New York compulsory commitment statute fails to supply the alleged addict with the basic protections to which one in danger of losing his liberty is entitled and recommends that a task force be established to survey known treatment methods

[5] In practice, however, some commitments are to penal institutions and the proceedings often follow suspension of criminal proceedings.

[6] Kaplan, Leonard V., Civil commitment 'As you like it,' *Boston University Law Review*, 49(1):14–45, 1969.

and design a program to be used throughout New York institutions;[7] a third implies that the major issue in question is whether the method of treatment is capable of producing a lasting cure.[8] The President's Crime Commission accepted involuntary civil commitment as offering "sufficient promise to warrant a fair test" but restricted itself simply to warning that such programs "must not become the civil equivalent of imprisonment," that the best possible treatment should be provided, and that length of confinement should not exceed that which is "reasonably necessary."[9] In the field of juvenile justice, similar arguments are found: the principle of civil intervention leading to involuntary treatment for alleged conditions and behavior that are noncriminal generally is accepted, while criticism is focused on the need for the safeguards of procedural due process, the imprecision of definitions, inadequate theory, inadequate resources, lack of data, etc.

Although these may all be important areas of concern, the emphasis is unfortunate in that attention to specific problems of procedure and adequacy of treatment tends to mask or at least divert attention from the more basic issue of the validity of civil commitment itself.

Sol Rubin has pointed out that the concept of civil commitment in "quasi-criminal" cases (defendants acquitted of crime for insanity, sex offenders, addict violators of drug laws, or juvenile and youthful offenders) raises more than one question of legal and social soundness.[10] He distinguishes these civil commitments from others (quarantine of persons with contagious disease, commitment of mentally incompetent persons) which are well established and well based in law, explaining that "it is the concepts of these better-established civil commitments that serve as the rationale for the more recent forms."[11] The power of the State in both of these older forms of commitment is derived from two legal doctrines: the sovereign's power of guardianship over persons under disability *(parens patriae)*, and the police power to take steps necessary for the protection of the populace. These powers are not absolute. The statutes merely define the class of persons who are committable; the determination of whether a particular case meets the criteria must be made by means of a judicial or administrative proceeding. Rubin explains that, since the

[7] Due process for the narcotic addict? The New York compulsory commitment procedures, *New York University Law Review*, 43(6):1172–1193, 1968.

[8] Steinan, Leslie, Commitment of the narcotic addict convicted of crime, *Albany Law Review*, 32(2):360–387, 1968.

[9] *Op. cit., supra* note 3, p. 229.

[10] Rubin, Sol, *Psychiatry and Criminal Law: Illusions, Fictions, and Myths*, Dobbs Ferry: Oceana, 1965. See especially pp. 139–170.

[11] *Id.*, p. 141.

protective functions must be related to the real needs of the individual or the community, the element of dangerousness or helplessness must be found. In those civil commitments which Rubin calls quasi-criminal (and which are commonly considered a *diversion* from the criminal justice system by reason of the "civil" label), the criterion for commitment usually is not the test of dangerousness or helplessness, but the criminal act.[12] While these commitments are sustained, usually by reference to *parens patriae* or the police power, they are not civil commitments in the sense of quarantine [13] or the commitment of mental incompetents. It becomes obvious that, as Rubin so clearly demonstrates, "the 'civil' character of the quasi-criminal commitments is, in brief, a legal fiction." [14]

The essential problem with this fiction is not that it allows the incarceration of ill persons and children in what is essentially penal custody, or that it permits circumvention of due process requirements of the criminal law, or even that it disguises the fact that civil "treatment" is often more punitive than criminal "punishment." Although all of these charges are serious enough, to stress these points implies that were these defects removed (through provision of better treatment, less prison-like facilities, greater attention to procedural regularity and individual rights), then civil commitment of, say, the addict offender would be the admirable innovation it was intended to be. The essential point is rather that existing commitment statutes, in permitting the "civil" incarceration of classes of persons for treatment of illness without a finding that the individual is *also* clearly dangerous or helpless, are unjustifiable. In fact, such statutes are penal in nature. A statute which prescribes the consequences (whether these are called treatment or punishment) that will attend certain behaviors or conditions, has been described as a *penal* statute even if it is specifically classified as nonpenal.[15] Where a proceeding is truly nonpenal then the question of whether a defendant is subject to control should depend on whether his condition is serious enough (dangerous, helpless) to require intervention by the State.

The courts usually have been willing to support the legislatively determined distinction between civil and criminal commitment—and to do so without careful scrutiny. The Supreme Court of the United States, in *Robinson* v. *California* (1962), decided

[12] *Id.*, p. 142.

[13] The rationale for civil commitment of addicts, however, frequently draws on this analogy, maintaining that drug addiction is "contagious" and spreads from social contact with the addicts. For example, see: Kuh, Richard H., Civil commitment for narcotic addicts, *Federal Probation*, 27 (2) :21–23, 1963.

[14] *Op. cit., supra* note 10, p. 142.

[15] *Id.*, p. 149.

that drug addiction is a disease and that an addict cannot constitutionally be dealt with as a criminal on the basis of his addiction. While it found penal imprisonment for addiction to be cruel and unusual punishment, the decision did not rule on the civil commitment (imprisonment?) of these same individuals. Rubin stresses that the decision only implies that civil commitment of a sick person would be proper, but that its language on this point is dicta and no precedents are cited.[16] While this dictum states that "a State might establish a program of compulsory treatment for those addicted to narcotics . . . [which] might require periods of involuntary confinement . . . [and] penal sanctions might be imposed for failure to comply with established compulsory procedures," the Supreme Court still has not handed down a decision on the civil commitment of ill offenders, and the substance of civil commitment statutes has not been examined to establish its "civil" nature. Meanwhile, the persistence of the label "civil" attached to procedures to commit ill persons for compulsory treatment, even though they have not been proven to be dangerous or incompetent, allows us to believe that these persons are being properly diverted from the criminal justice system.

The case for civil commitment of ill persons in lieu of criminal processing is seriously challenged by the Supreme Court decision in *Powell* v. *Texas* (1968). The Court upheld the criminal conviction of Powell, an alcoholic, on the grounds that he had committed an illegal act—being drunk in public—whereas in *Robinson* the issue had been that of a condition—being an addict—which could not in itself be viewed as criminal. Most interesting was the cautionary attitude of the Court toward civil commitment as opposed to penal incarceration.[17] The Court in *Powell* claims that "one virtue of the criminal process is, at least, that the duration of penal incarceration typically has some outside limit . . . . 'Therapeutic civil commitment' lacks this feature; one is typically committed until one is 'cured'." It is also objected that there is as yet no known generally effective method of treating alcoholics and that facilities for their treatment are "woefully lacking." Thus, in the space of a few years the Court has moved from a position of invitation to one of deep suspicion.

As Rubin points out, each of the Court's objections to civil commitment of alcoholics holds true for the drug addict.[18] The case for civil commitment, both in terms of legality and of social value, obviously is still unsettled.

[16] Rubin, Sol, Civil commitment of addicts and alcoholics, Paper presented to the Governors' Conference on Drug and Alcohol Abuse, January 12–13, 1970, Miami Beach, Florida: New York, NCCD 1970.

[17] *Ibid.*

[18] *Ibid.*

Compulsory Treatment as a "Nonpenal" Alternative

Civil commitment is not the only sticky problem in the diversion of individuals from the criminal justice system. Several contemporary beliefs have converged around compulsory treatment: (1) that offenders should be treated instead of punished; (2) that some conditions—alcoholism, addiction—are not criminal but manifestations of illness; (3) that some persons, because of their condition—youth, mental illness—should be given special consideration or dealt with less severely; and (4) the belief that the State has a right and obligation to intervene where the individual or society is endangered. The quasi-criminal "civil" measures (civil commitment, juvenile court procedure, or compulsory treatment of the noncrime enforced by the prospect of penal processing for a crime) come into operation to satisfy the requirements of these beliefs. The supposed diversion of persons to civil processing whose condition or behavior is held noncriminal appears to be an attempt to have it both ways: the individual, not being criminal, is not subject to penal sanction *but*, for the protection of all concerned, he may be subjected to similar measures classified as nonpenal.

The point on which this whole structure should rest is the power of the State to intervene in cases where no penal sanction exists, a power which is, or should be limited by the requirements that there be sufficient danger either to other individuals or to the populace and sufficient helplessness[19] of the individual. To achieve analytical clarity, then, it is necessary that dangerousness and helplessness be clearly distinguished from the existence of a condition such as addiction or mental illness.[20] Lady Wooten notes, "The concept of illness expands continually at the expense of the concept of moral failure." [21] That the State's power to intervene in civil cases is clearly limited must be recognized, not merely because ignoring this fact leads to abuse, but because without constant attention to the weaknesses in such thinking, any behavior might be convincingly described as "harmful to self or others," given a particular value system. An extreme example, but one which differs only in degree from official disapproval of the "incorrigible" child who persists in disobeying parents, teachers, and police, is that of the adult individual whose "wrong thinking" is considered a danger to himself and others and whose incarceration for "reeducation" is thus justified.

[19] As Rubin has suggested, "helplessness" rather than mere disability should be the criterion. *Op. cit., supra* note 10. It might even be argued that a completely disabled person is not helpless as long as he has someone to take care of him. Thus, the question may become: under what circumstances should the State be permitted to deprive a person of the power to make decisions about himself?

[20] This point has been argued by a number of authors with reference to mental illness, addiction, and other conditions. A finding of addiction, for example, would be considered a necessary but not sufficient condition for commitment. See: Civil commitment of narcotic addicts, *Yale Law Journal*, 76(6):1160-1189, 1967.

[21] Wooten, Barbara. Sickness or sin. *Twentieth Century*, 159:433-434, 1957.

Society cannot have it both ways. If a deviant behavior or condition is to be defined as not criminal then it would seem that an individual should not be compelled to accept treatment for that condition or behavior unless the condition is ruled inherently dangerous, and he should not be committed for other reasons except on a determination that he himself is dangerous or helpless.

If society decides that certain nondangerous offenders should be diverted from the criminal justice system, then it should not be satisfied with the substitution of measures which differ only in their description as "nonpenal" or "treatment."

There are other alternatives for handling the noncriminal juvenile, the narcotic addict, the alcoholic, and other nondangerous deviants. These might be discussed together because the principle is essentially the same: in the case of a noncriminal deviance, where the individual is not otherwise committable under State power (i.e., neither dangerous nor helpless), he may be released to the community; where a crime has been committed and the defendant is also a noncriminal deviant, he may be dealt with by the penal process for his offense. In either case, society may be more adequately protected by laws relating specifically to dangerous offenders.[22] Despite the similarities, the different offender groups will be discussed separately here because they usually are dealt with as such in the literature.

Narcotics Addicts

There has been relatively little experimentation in the United States with the diversion of addicts from the criminal justice system. While the ruling that an addict cannot constitutionally be labeled a criminal for his addiction would suggest a step in this direction, in practice this has not been a large concession. Civil commitment statutes have functioned to retain the State's ability to incarcerate or otherwise intervene in the lives of both the addict offender and the addict nonoffender. Rather than reducing the number of persons subject to State intervention, civil commitment ironically has greatly increased this number by bringing into the system that population of otherwise noncriminal persons whose only "offense" is their illness.

Both California and New York, the states with the largest ad-

[22] The Model Sentencing Act, adopted by NCCD's Advisory Council of Judges, establishes criteria for identifying dangerous offenders and provides for the sentencing of an offender upon a finding of dangerousness, where such an offender has been convicted of a felony. Advisory Council of Judges, *Model Sentencing Act*, New York: National Council on Crime and Delinquency, 1963. p. 16.

dict populations, have enacted civil commitment statutes and both have developed extensive rehabilitative programs based on civil incarceration.[23] While both the California Rehabilitation Center Program and the program of New York State's Narcotic Addiction Control Commission (NACC) are described in terms of rehabilitation, treatment, and hospitalization of "patients," neither is based on the medical model. Both programs depend for their identification as "nonpenal" and "medical" on the distinction between treatment and punishment, with no apparent recognition of the fact that treatment can be provided as well in a penal institution. There is nothing inherently nonpenal about a treatment facility.

An Alternative: The Medical Model

What has come to be called "the British system" [24] of narcotics control and treatment of addiction—in which the addict is viewed as an ill person to be treated, if he feels the need, by the medical profession—is statutorily, though not in practice, the American system as well. The legislative enactments of both countries appear the same: narcotic drugs may be prescribed by physicians, in the course of professional practice only, for the treatment of addiction. The essential difference is that in Britain the determination of proper treatment of addiction rests with the medical profession, while in the United States the definition of professional practice has been rigidly established by nonmedical authorities.

An account of the intimidation of the medical profession by the Narcotics Division of the Treasury Department following its merger with the Prohibition Unit in 1920 may be found in several sources.[25] Narcotics Bureau regulations still provide for the penal sanction of physicians who administer drugs to addicts,[26] although this regulation is in clear violation of both the Harrison Act [27] and the Supreme Court ruling in *Linder* v. *United States* (1925).[28] The *Linder* decision set forth what is still the Supreme Court's interpretation of the Harrison Act, ruling that physicians

[23] For a brief description of the establishment of the New York program, see: Kuh, *op. cit., supra* note 13. On the California program, see: Wood, Roland W., New program offers hope for addicts, *Federal Probation*, 28(4):41-45, 1964.

[24] E.g., Lindesmith, Alfred R., The British system of narcotics control, *Law and Contemporary Problems*, 22(1):138-154, 1957.

[25] For example, see: Rubin, *op. cit., supra* note 10; Advisory Council of Judges, *Narcotics Law Violations*, New York: National Council on Crime and Delinquency, the Council 1964; U.S. Department of Health, Education, and Welfare, Juvenile Delinquency and Youth Development Office, *A Community Mental Health Approach to Drug Addiction*, by Richard Brotman and Alfred Freeman, Washington, D.C.: U.S. Government Printing Office, 1968.

[26] *Code of Federal Regulations*, Title 26, Sec. 151; 392, 1961 Supp. 1963.

[27] Act of December 17, 1914, ch. 1, 38 Stat. 785, as amended, 26 U.S.C. Sec. 4701-36 (Int. Rev. Code).

[28] *Lindner* v. *United States*, 268 U.S. 5 (1925), at 22.

may, in the course of proper professional practice, prescribe drugs to addicts for the treatment of their addiction. The Court states that the Harrison Act "says nothing of 'addicts' and does not undertake to prescribe methods for their medical treatment." It also states that "if the Act had such scope [to prohibit administration of drugs by physicians to treat addiction] it would certainly encounter grave constitutional difficulties."

The medical model, in which the medical profession has the authority to determine and to administer proper treatment to ill persons, is clearly prescribed, in regard to narcotics addiction, by the present law. It is only the nature of administrative enforcement by the Narcotics Bureau and the collaboration of the A.M.A. which deters physicians from administering drugs to treat (not necessarily maintain) addiction. The Supreme Court in *Robinson* stated that "the narcotic drug addict is a sick person, physically and psychologically, and as such is entitled to qualified medical attention just as are other sick people. [29] This decision has been viewed as a significant advancement in its prohibition of penal imprisonment for addiction, yet it has done nothing to enhance the treatment of addicts as "sick people." Addicts will not receive the treatment to which they are "entitled" until the Bureau of Narcotics and Dangerous Drugs, U.S. Department of Justice regulations are amended to conform with the law, and physicians feel free to provide qualified medical attention to addicts just as they do to other sick people.

The Advisory Council of Judges of the National Council on Crime and Delinquency has issued a policy statement on narcotics law violations in which this recommendation is made.[30] The Council advises that the necessary action be taken, either by statute or by the appropriate bureaus and departments to have the interpretation of the Harrison Act as set forth in *Lindner* carried out administratively and the Bureau of Narcotics regulations amended. The ACJ also states that sick persons do not need criminal or civil process for medical care to be available to them (although some are subject to civil commitment) and that a drug addict "should have access to medical care, in or out of a hospital, without so-called civil commitment, unless he is, in fact, unable to take care of himself despite medication." [31] While recognizing that narcotics traffic is properly controlled by legislation and penal sanction, the Council states that the addict should be directed to medical help and should not be criminally prosecuted.[32] The fact that many addicts currently are subject to criminal prosecution

[29] *Robinson* v. *California*, 370 U.S. 660 (1962).

[30] Advisory Council of Judges, *op. cit., supra* note 25, p. 14.

[31] *Id.*, p. 13.

[32] *Id.* p. 14.

for illegal possession arises from the unavailability of "legal" drugs by prescription from physicians. The tragedy of the enforcement policy of the U.S. Department of Justice is that it creates criminals out of sick persons by denying them legal access to treatment.

If the medical model in its voluntary aspect is put into effect in this country, most communities would not be prepared to deal with addiction as a social problem. Private physicians obviously would be unable to handle the large numbers of addicts needing legal access to drugs, yet hospital and clinic facilities for the treatment of addiction are at present generally lacking. The New York State Planning Committee on Mental Disorders, in their report of the Task Force on Addictions (alcohol and drugs), observes that in New York State, at least, little progress had been made in the treatment of addicts within the structure of the general hospital, even as emergencies in the dangerous state of acute intoxication; that within the community mental health board structure the problem has remained as the lowest priority; and that the police, the courts, and correction have continued to handle the problem by default.[33] The Committee suggests that the new approach of the community mental health center will have little impact on the problems of drug dependence unless the medical share of the responsibility is accepted and programs commensurate with the magnitude of the problem are instituted.

There have been a number of other references to the community mental health center as an appropriate structure for the treatment of the addictions. The Office of Juvenile Delinquency and Youth Development has issued a publication entitled *A Community Mental Health Approach to Drug Addiction*, authored by two professionals in the fields of psychiatry and community health.[34] The community mental health approach is described in detail and its application to the field of addiction, including treatment, research, and training, is outlined. The goals of treatment are expressed in terms of the individual's diagnosed level of dysfunction in different areas. Improved adaptation or functioning becomes the central goal, with particular phased subgoals assigned on the basis of individual characteristics. Addiction is viewed as a chronic condition and "success" in treatment is defined individually, as is the case with other chronic conditions. This approach is in stark contrast to the present requirements of compulsory treatment programs in which one relapse is taken to denote failure.

[33] New York (State), Planning Committee on Mental Disorders, Report of the Task Force on Addictions, Albany, 1965, 56 pp.

[34] Department of Health, Education, and Welfare, *op. cit., supra* note 25.

Other types of treatment facilities, with which there has been some experimentation, are residence facilities (Daytop Lodge, Synanon); hospital programs; and outpatient treatment in clinics. Daytop and Synanon are similar in that both are administered by exaddicts and both utilize reality therapy and the communal unit in rehabilitation. Synanon appears to have been successful with many addicts. However, one writer argues that Synanon's success is only partial since it functions to support a dependent individual indefinitely in a protective community; it does not rehabilitate in the sense of improved ability to function in the outside community.[35]

An increasing number of State and municipal hospitals are adding local hospitalization facilities specifically for addicted persons admitted voluntarily. In the community program of New York City's Metropolitan Hospital, addicts are detoxified by the methadone-substitution method and placed in a rehabilitation ward for a period of four weeks, although they may sign themselves out at any time.[36] Major emphasis is placed on aftercare, including financial, family, and housing services, legal advice, recreation, and vocational counseling. The hospital program is associated with two local neighborhood agencies which work with addicts and ex-addicts.

Experience with outpatient care of addicts is more recent but the results obtained so far with the methadone-maintenance method appear encouraging. At New York's Bernstein Institute of Beth Israel Medical Center, addicts are given daily dosages of liquid methadone which eliminate the craving for drugs while blocking the effects of any opiates if they are taken. It is reported that individuals in the program have been able to adjust satisfactorily in terms of work, school, and normal community life and that the need for criminal activity to obtain drugs has been eliminated.[37] A new methadone program was recently established in Brooklyn, scheduled to treat 5,000 hard-core addicts over a five-year period. The clinic is operated by a private organization, the Addiction Research and Treatment Corporation, with grants from Federal and city governments. Many patients are referred from courts and prisons, but adult addicts may come in off the street. To obtain the methadone, an addict must cooperate with staff, come to the center daily, and refrain from any criminal activity. The research program will test whether methadone is more

[35] Sternberg, David, Synanon House: a consideration of its implications for American correction, *Journal of Criminal Law, Criminology and Police Science*, 53(4):447–455, 1963.

[36] Freedman, Alfred H.; Sager, Clifford J.; and Rabiner, Edwin L., A voluntary program for the treatment of narcotic addicts in a general hospital, New York, Metropolitan Hospital Center, 1962, 14 pp.

[37] Dole, Vincent P., and Nyswander, Marie, A medical treatment for diacetylmorphine (heroin) addiction, *Journal of American Medical Association*, 193(8):646–650, 1965.

effective alone, or in combination with counseling, job assistance, vocational training, and group therapy.[38]

The Community Service Society of New York recently has issued a publication describing four voluntary agency programs for addicts in New York, including three clinics and a therapeutic community residence which offers an outpatient program as well.[39] All focus their efforts on the individual addict with emphasis on improved health and decreased antisocial behavior. The treatment goal of the programs examined is abstinence, as opposed to the maintenance approach of other clinic programs. The relative value of maintenance vs. abstinence as a means or a goal of successful rehabilitation is a fundamental issue which will be settled only by further research and experimentation.

There has been a growing tendency to classify drugs and alcohol together, both for purposes of analysis and in the design of programs of public health treatment of dependency and addiction. The New York State Planning Committee on Mental Disorders included alcohol and drug dependence under a single heading for consideration in planning in mental health. A Special Commission to study the use of harmful and illegal drugs in Massachusetts described alcoholism as a "type of drug abuse the social consequences of which are virtually incalculable" and advised that both be handled within a total program of mental health for both individuals and society on a community basis.[40] A World Health Organization report on services for the prevention and treatment of dependence on "alcohol and other drugs" acknowledged the important differences between types of drug dependence but recommended that the two be considered together because of similarities of causation, interchangeability of agent, and thus similarity in measures required for treatment and prevention.[41] Combined services for persons dependent on alcohol and other drugs are provided in Toronto, Canada, by the Alcoholism and Drug Addiction Research Foundation. The comprehensive program developed for alcoholic dependence, including research, public education, training, and rehabilitation services, was extended to other drugs in 1963.[42]

The above are only some of the ways in which addiction might

[38] *New York Times*, Sunday, October 12, 1969.

[39] Community Service Society of New York, A study of four voluntary treatment and rehabilitation programs for New York City's narcotic addicts, by Judith Calof, New York, 1967, 52 pp.

[40] Massachusetts, Special Commission to Make a Study Relative to the Extent of the Use of Harmful, Injurious, and Illegal Drugs within the Commonwealth, *Report*, Boston, the Commission, 1968, 127 pp.

[41] World Health Organization, Expert Committee on Mental Health, Services for the prevention and treatment of dependence on alcohol and other drugs, (Technical Report Series No. 3631, Geneva, 1967, 45 pp.

[42] *Id.*, p. 28.

be handled as a public health problem by medical authorities without the use of civil commitment or other compulsory or penal measures. It is important to stress that drugs need not be "legalized" for the treatment of addiction to be carried out in the community. The legal basis for the administration of narcotics to addicts under a physician's care already exists; it is necessary only to make enforcement conform to law.

Chronic Drunkenness Offenders

While alcoholism and drug addiction may be considered together for the purposes of designing a public health approach to prevention and treatment, alcoholism presents a slightly different problem for the diversion of offenders from the criminal justice system. This difference was demonstrated in the Supreme Court ruling in *Powell* v. *Texas*. Alcoholism itself is not an offense, and rarely is possession of alcohol by an adult, but being drunk in public almost always is, and it is the public drunkenness charge which provides the basis for intervention to control alcohol. While removal of drug addicts from the justice system requires primarily a change in enforcement practices and the development of community facilities for treatment, in the case of the chronic drunkenness offender—the "visible" alcoholic—diversion requires a change in law. Civil commitment is not as popular a solution for the public drunk. The drunkenness offender usually is put in jail—as was deemed the lesser of two evils, by the Court in *Powell*.

Legal reform to make public drunkenness no longer an offense is now a respectable and widely voiced recommendation. The President's Crime Commission recommended that public drunkenness, unaccompanied by other illegal behavior, not be considered a crime.[43] The Pennsylvania Crime Commission's Task Force on alcohol and the criminal justice system reports that handling public drunkenness through criminal processes amounts to the "misguided criminalizing of a social problem." [44] It is fairly commonly agreed that while commission of a criminal act by an intoxicated person requires criminal handling, the problem of drunkennesss requires effective treatment rather than an adjudication of guilt.

It is at this point that the problems of addiction and alcoholism become similar, at least with respect to the goal of diversion of persons for whom State intervention for control is unnecessary or undesirable. If it is stated that these persons *require*

[43] President's Commission on Law Enforcement and Administration of Justice, *Task Force Report: Drunkenness* (Annotations, consultants' papers and related materials), Washington D.C., 1967, 131 pp.

[44] Pennsylvania, Crime Commission, Task Force report: alcohol and the criminal justice system, Harrisburg, Pennsylvania, 1969, 48 pp.

treatment rather punishment, the tendency is to suggest that they must be treated even if it is necessary to incarcerate or otherwise compel acceptance of these services. The labeling of such a disposition as "treatment" only hinders recognition of the similarity between treatment and punishment under conditions of compulsion.

Also, some few voices now are being heard to argue that it may be more sensible to take a protective shelter-maintenance approach to the problem. That is, it is suggested that the costs involved and minimal success possible in attempting to cure the alcoholic require a different approach. It may be that neither the "sick" role nor the "bad" role is appropriate and the State should rethink its function along the lines of providing temporary shelter for those who are rendered temporarily helpless and—the more controversial aspect—actually supply alcoholic beverages of good quality to the skid row alcoholic. Obviously, this approach is novel and controversial and needs a great deal of additional thought and research.

The arguments against compulsory civil measures for narcotics addicts also apply to the alcoholic. However, until civil commitment of the drunk becomes acceptable practice, the major problem is not civil incarceration but compulsory treatment for an illness condition manifested by the existence of a closely related behavior—public appearance and/or disorderly conduct—which are considered to be crimes. Compulsory treatment involves placement on probation under conditions of abstention and requires attendance for treatment or suspension of criminal charges in exchange for participation in treatment and its sucessful completion.[45] There is here, as with compulsory treatment for drug addiction, a hint of double-think. *Addiction (drugs or alcohol) is considered a "noncrime," albeit associated with offense behaviors under present law—yet intervention concerns itself less with the offense than with the illness held to be not punishable.*

Not only is involuntary treatment for alcoholism a questionable practice, [as alluded to earlier] there are indications that it also is ineffective. The San Diego Municipal Court has been studying the relative effectiveness of treatment and punishment of chronic drunkenness offenders for several years.[46] During this time there have been various reports of municipal court programs in the United States which utilize such approaches as probation with referral to clinic treatment, Alcoholics Anonymous, court-sponsored honor classes, halfway houses, and camps in lieu of jail sentences. However, the San Diego Court felt that generalizations could not be made from the results of these programs because of the absence of adequate control studies. Previous research by court staff had suggested that probation with suspended sentence would be effective in getting the chronic drunkenness offender into treatment and reducing the likelihood of rearrest. To test this proposition, a controlled study was undertaken to compare the effectiveness of three different treatments following suspended sentence: (1) referral to an alcoholic clinic; (2) required participation in Alcoholics Anonymous; and (3) no treatment. The results of this carefully controlled study revealed no statistically significant differences among the three in terms of recidivism rate, number of rearrests, or time elapsed before rearrest. In fact, no treatment obtained slightly, though not significantly, better results. It was concluded that enforced referral to treatment was no more effective than no treatment at all. One explanation offered for this result is that the conditions of court-imposed referral confronted the offender with an anxiety-producing situation which may have increased the likelihood that he would resume his previous drinking pattern. Whatever the explanation, the concluding advice of this study must be considered: "The present data offer no support for a general policy of forced referrals to brief treatment." [47]

What are the alternatives? The President's Commission Task Force on Drunkenness recommended that communities establish detoxification units, as part of comprehensive treatment programs, to which inebriates might be brought by police for short-term detention under the authority of civil legislation; [48] yet the Commission also recommended that drunkenness not be treated as a criminal offense, thus bringing up the problem of compulsory civil detention for a noncrime.

The Vera Institute of Justice in New York City proposed and instituted a voluntary alternative—the Manhattan Bowery Project.[49] Following staff research into existing alcoholism programs in various parts of the country and the needs of homeless alcoholics in New York City, the Vera Institute concluded that there was an urgent need for emergency street rescue and sobering-up services for homeless alcoholics, effectively related to existing long-term rehabilitative programs. It was also concluded that all efforts and services on behalf of these men should operate on a voluntary basis without the use of either arrest or invol-

[45] Even here there are sophisticated legal problems to be dealt with. In *Sweeney* vs. *United States*, F.2d 10, 11 (7th Cir. 1995) the Court decided that it was unreasonable and therefore unenforceable to impose the typical "no drinking" condition on a chronic alcoholic placed on probation.

[46] Ditman, Keith S., et al., A controlled experiment on the use of court probation for drunk arrests, *American Journal of Psychiatry*, 124(12):64-67, 1967.

[47] *Id.*, p. 67.

[48] *Op. cit.*, *supra* note 43, p. 4.

[49] The proposal for the Project is included in Appendix D of the President's Commission Task Force report on drunkenness, *op. cit.*, *supra* note 43, pp. 58-64.

untary commitment. In its first year of operation, the Project's primary goals were to test whether Bowery alcoholics would accept a voluntary program of alcohol detoxification; whether such a program would be workable in a nonhospital setting; and whether on completion of detoxification, these men would accept referral to other types of programs for ongoing care. The results so far indicate that the majority of debilitated alcoholic Bowery men approached by a medically-oriented street patrol voluntarily agree to detoxification.[50] The Project also has found that Bowery men undergoing detoxification are manageable, both medically and behaviorally, in a well-staffed nonhospital facility, and that at completion of detoxification the majority of the patients are willing to seek further treatment. It is stressed that a voluntary program is preferable to a compulsory program because patients are more cooperative and managerial problems created by a compulsory program are avoided.

Another program providing an alternative to the police-correctional handling of the homeless alcoholic is the Boston South End Center for Unattached Persons. Assistance is offered to skid row inebriates approached on the streets. An official of the program has estimated that 80 percent of the men approached in this manner respond willingly.[51] The Center acts as a referral unit for existing community agencies providing medical, job placement, housing, and welfare services.

These programs suggest that the belief that most chronic inebriates require compulsion to "motivate" them to accept treatment is not well founded; they also refute the argument that police arrest is necessary as a case-finding tool. Through the concerted efforts of public and private social agencies, a large number of alcoholics may be provided voluntary treatment and welfare services before an offense has been identified by police. If an essentially unavoidable situation (such as public drunkenness is for many homeless and destitute alcoholics) is no longer treated as an offense, an even greater number of these persons might be "diverted" from the criminal justice system.

In areas where help has been extended to the skid row alcoholic by such organizations as the Salvation Army, the need for arrest and detention in order to provide social services and "control" of the situation has been considerably reduced.[52] Were such services

[50] Manhattan Bowery Project, *First Annual Report*, New York, the Project, 1969. 68 pp.
[51] *Op. cit., supra* note 43, pp. 4-5.
[52] A survey of Wayne County (Michigan) detention needs and jail practices reported that "much of the credit for the absence of alcoholics in Wayne County Jail must go the Salvation Army, which makes shelter available for more than 600 persons daily, the majority of whom are indigent alcoholics." National Council on Crime and Delinquency, Adult detention needs in Wayne County, Michigan: a survey of the Wayne County Jail, New York, 1968.

and facilities supplemented by other public and private agency efforts, including "aggressive casework" types of casefinding, and treatment offered on a voluntary basis to this group, "prearrest" diversion might be sucessfully implemented on a large scale.

Postarrest diversion presents other problems, similar in principle to those involving the commitment for treatment of the addicted offender. The literature on the alcoholic offender reflects a growing support for the postarrest "diversion" of offenders, for purposes of treatment, to institutional or other compulsory treatment. Most widely recommended are brief, involuntary detention in civil detoxification centers following arrest,[53] involuntary commitment to an inpatient facility for treatment,[54] and enforced treatment of offenders on probation.[55] These measures may be found effective in getting the alcoholic offender to accept treatment—or even to cure him; and they may be an improvement over the usual jailing and punitive detention; but they cannot really be considered a diversion except in name and their compulsory nature may well be unjustified if a right to refuse treatment is established. Closer examination reveals that these measures involve the use of community resources in penal treatment, the adoption of a treatment orientation in correction, or the substitution of nonpenal hospital/patient terminology, rather than an actual removal of the offender from the justice system. The goal of providing more humane treatment should not be confused with diversion.

That the intent to retain control remains the same is revealed by the wording of a recommendation found in the report of the Michigan Crime, Delinquency, and Criminal Administration Commission. The Commission supports the provision of a "statutory alternative" (to replace criminal arrest when this authority no longer exists) which would authorize 48-hour protective civil custody in a medical facility for those drunks who endanger only themselves.[56] Those who endanger others, of course, could be arrested and held under criminal sanction. In other words, when a nondangerous inebriate can no longer be arrested for public drunkenness, he might be "diverted" to a facility classed as nonpenal, under identical conditions of intervention for control, except that this time such a disposition is for his own good. While on the surface such handling might be significantly more humane, it is easy to see that no substantive difference exists.

[53] *Op. cit., supra* note 43, p. 5.
[54] Tao, L. S., Legal problems of alcoholism, *Fordham Law Review*, 37(3):405-428, 1969.
[55] Mills, Robert B., and Hetrick, Emery S., Treating the unmotivated alcoholic. *Crime and Delinquency*, 9(1):46-59, 1963.
[56] Michigan: Crime, Delinquency, and Criminal Administration Commission, *Report and Recommendations of the Commission*, N.P., 1967.

Examination of current practices and proposals concerning alternatives to penal sanction of the alcoholic offender supports the conclusions suggested by the literature on the narcotic addict: civil incarceration is not a diversion or "alternative" and thus it is difficult to justify; commitment or other compulsion for purposes of treatment, rather than because of dangerousness, is questionable; and there are voluntary alternatives involving a considerable saving in police, court, and correctional resources which are more consistent with a policy of diversion.

Prerequisite to the removal of the drunk or alcoholic offender from the justice system will be the development and expansion of community resources, including medical, welfare, and other assistance. The nonoffender drunk (where public drunkenness is not an offense in itself) then may be referred directly to social agencies for voluntary treatment or other services. An alcoholic who has committed an offense may be handled by the penal system, in which treatment for his condition might be offered. If his offense is not considered serious (disorderly conduct, disturbance of the peace), he might be routinely handled in a special program for misdemeanants, involving police warning, rather than arrest, and referral to community agencies for voluntary treatment or other assistance. The difference is an invitation to virtue rather than coercion to virtue.[57]

Petty Misdemeanant Offenders

Evidence that the overload on the courts is caused largely by the huge volume of minor offenses, plus the fact that penal sanctions do not seem to deter such offenses, makes the petty misdemeanant offender the most obvious case for removal from the criminal system. Here we do not deal as directly with the conceptual problems inherent in the "sick" role—"bad" role dichotomy—but other problems abound. The President's Crime Commission states that such behavior (the almost half of all arrests which are "essentially violations of moral norms or instances of annoying behavior") generally is considered too serious to be ignored, but its inclusion in the criminal justice system raises questions deserving examination.[58]

It is widely accepted that new procedures for handling these offenders—procedures which would avoid prosecution, would not result in a more serious "civil" disposition, and would not contribute to a criminal record—could and should be devised. One such procedure, proposed by Hugh Price, is especially relevant to

[57] See J. S. Kolnick, Coercion to virtue: the enforcement of morals, *Southern California Law Review*, 41, 588 (1968).

[58] *Op. cit., supra* note 3.

the misdemeanor problem because of its recognition of the social class bias of many arrests for petty offenses. Price proposes the establishment of neighborhood police offices in ghetto areas, staffed by community affairs officers (not necessarily career policemen, but trained in police-community relations) and several neighborhood aides.[59] All persons arrested for petty offenses such as family disputes, nonserious disturbances of the peace, loitering or trespass, or public drunkenness, would be brought initially to a neighborhood office where the officer would check the police "blacklist" of multiple offenders who are not to be handled by the informal procedure. A person would be blacklisted if he has been detained and released by the police or prosecutor three or more times in the past year or if he has failed to appear for a prosecutor's or family relations hearing during the past year. A blacklisted offender would be formally booked and presented in court for prosecution. An offender who is not found to be blacklisted would be recorded in a police log book but not formally "booked" so no arrest would be entered on a criminal record card. The community affairs officer then would meet with the offender and attempt to determine the problems which led to the violation. Any statment on the part of the subject could not be used by the State in any proceeding and the police could not use these interviews for interrogation about other crimes. Once the community affairs officer has assessed the severity of the offense and the nature of its origin, he may recommend that the parties contact a mental health, employment, or legal aid agency, but such referrals would not be binding on the parties. The officer may choose among several dispositions: outright release; release with warning; or referral to the prosecutor or family relations officer for conference. The last disposition would be used in cases where the facts of the violation are more serious, where the causative factors appear deep-seated, or where the offender has committed the limit of violations prior to blacklisting. At these hearings, further possibilities for referral to social, legal, or other agencies would be explored and again the dispositions of release, release with warning, and referral (not binding) to other agencies are available. At this second stage, the hearings officers also would be authorized to issue an order for arrest. Up to this point, however, no arrest has been recorded.

The proposed misdemeanor procedure is offered as a means of minimizing the impact of petty crimes on the courts and on the offender without impairing the ability of the police and courts to maintain law and order. It is also proposed as a means of reform-

[59] Price, Hugh B., A proposal for handling of petty misdemeanor offenses, *Connecticut Bar Journal*, 42(3):55–74, 1968.

ing the unequal and discriminatory manner in which petty offenses now are processed at the police station. The new system would "interject guidelines and predictability into the existing practices and apply them to a broader range of offenses."[60] The necessary statutory revisions are described and solutions to possible procedural and administrative problems are discussed.

This proposed model is a true example of diversion of offenders from the criminal justice system. Every attempt is made to handle the minor offender in alternate ways before an arrest is made. Where offenses such as public drunkenness or vagrancy are not removed from the criminal statutes, and to the extent that case-finding and provision of services are not offered before police contact, such a procedure exists as a possible alternative. One runs the risk, however, that by implementing this sort of a program one also reduces the possibility of removing some of these questionable laws from the books.

Noncriminal Juveniles

Although the juvenile court was established, ostensibly, as a means of removing the juvenile offender from the criminal justice system, this "nonpenal" alternative has functioned (as has the civil commitment procedure) in such a way as to draw even more persons into the system of control by State intervention. That the juvenile justice system has not fulfilled the need for an alternative to the penal system is demonstrated by the current demand for new ways of handling the problem juvenile through diversion from juvenile court processing.

The concern of the juvenile court with disposition in the interest of the child, rather than with direct reference to the alleged offense, as well as the vagueness of statutory descriptions of behaviors requiring intervention, has necessitated the use of broad discretion by police and court officials and has resulted in the present informal system of preadjudication diversion of many potential subjects of formal court action. Police "station adjustment," referral to community resources, or other intradepartmental handling by police has been reported to occur nationally in 45 to 50 percent of all juvenile contacts.[61] However, the criteria for selection of disposition generally are not explicitly defined, ordered in priority, or systematically reviewed for administrative purposes.[62] A study of differential handling by police and selection of juvenile offenders for court appearance in four different Pennsylvania communities revealed wide variations in rates of arrest and court referral.[63] Disposition, including whether a juvenile was diverted from formal processing, was related not only to offense, but to age, race, sex, and residence. Differential handling was found to be related to attitudes of the policeman toward the juvenile, his family, the juvenile court, and his own role as a policeman, and his perception of community attitudes toward delinquency.

Some critics of the existing system of informal disposition have argued that the observed arbitrary and discriminatory factors in the selection process be eliminated through professionalization of the police, the setting of explicit standards by police departments, training of officers in juvenile behavior, police-community relations programs or police-juvenile liaison schemes, or other means of improving police discretionary judgments. Certainly such efforts are important, especially since the police are often the first to come in contact with juvenile misconduct.

However, the screening of serious offenses from simple misconduct or other nonserious behavior should not be primarily a police responsibility. The police, for the most part, attempt to do what they believe the community—or important segments of it—expect them to do.[64] If the public relegates to law enforcement and the courts responsibility for what are essentially child-rearing functions (discipline, guidance, moral instruction, protection), it is not the task of the police to decide that arrest and court processing are not meeting these needs.

Much of the literature on the removal of juveniles from the jurisdiction of police and the courts recognizes the extent of community responsibility in the area of social control. Many writers have urged that the definition of delinquency be narrowed to exclude a variety of behaviors which if committed by an adult would not constitute a violation of law (truancy, disobedience, school behavior problem, bad companions, etc.), implying not only that court processing for such conduct is unjust but that handling of noncriminal deviance by community agencies and individuals is more appropriate. It has been argued that juvenile court statutes which use terms such as "incorrigible" or "disobedient" might be nullified on the grounds of vagueness or "status" criminality.[65] It

[60] *Ibid.*

[61] *Op. cit.*, *supra* note 1, p. 12. However, one writer argues that national data on police disposition of juveniles suggest that the size of the police dismissal category is not half as large as has been alleged. Monahan, Thomas P., National data on police dispositions of juvenile offenders, *Police*, 14(1):36-45, 1969.

[62] *Op. cit.*, *supra* note 1, p. 14.

[63] Goldman, Nathan, *The Differential Selection of Juvenile Offenders for Court Appearance*, New York, National Council on Crime and Delinquency, 1963. 133 pp.

[64] *Ibid.* Goldman states that an important determinant of police discretion is perception of community attitudes toward delinquency. Also, Wilson describes police as acting according to perceived public expectations. Wilson, James Q., *Varieties of Police Behavior*, Cambridge, Massachusetts: Harvard University, 1968.

[65] McKay, Malcom V., Juvenile court jurisdiction over noncriminal children, unpublished paper, Cambridge, Massachusetts: Harvard Law School, 1969.

also has been suggested that judges simply stop accepting the dependent, neglected, or nondangerous child for detention, probation, or commitment, thus diverting such children to family and child-welfare agencies or social and mental health services [66] and forcing the public to accept responsibility for their problems. It is commonly acknowledged that many children in the United States who have not committed crimes and whose conduct does not present a threat to the community are being drawn into the correctional system, to the serious detriment of both the child and the system itself. If it is public apathy or tacit acceptance of this situation which allows it to continue, then a broad effort should be made to make it understood that existing practices are neither effective nor necessary.

The Youth Services Bureau has been offered as a major alternative to social control by the criminal justice system. The concept of the Youth Services Bureau was given official recognition by the President's Crime Commission, which recommended that such bureaus be established in the community to provide and coordinate programs and services for delinquents and nondelinquents.[67] The stated purpose of these bureaus is to facilitate the diversion of children and youth from judicial processing to social services. It is suggested that the nature of services provided and the specific operation of the bureaus will vary with the community because of local differences in the incidence and characteristics of delinquency and the resources available.[68] Presumably, local definitions of delinquency and interpretations of situations requiring intervention also will affect the nature and extent of service.

Although the concept of the Youth Services Bureau has only recently become popularized, the idea of employing the local community agency to develop and coordinate youth services is not entirely new. For example, ten years ago a local community action program was initiated in Oakland County, Michigan, to coordinate the efforts of individuals and social agencies in the development and delivery of services to youth.[69] From this developed the Oakland County Protective Services Program, involving the court, municipal government and school board, local agencies, and volunteer citizens in delinquency prevention activities, both for youth in general and on an individual basis. In Philadelphia, essentially

[66] Rector, Milton G., Statement before the U.S. Senate Subcommittee to Investigate Juvenile Delinquency, *Crime and Delinquency*, 16(1):93-99, 1970.

[67] *Op. cit.*, *supra* note 3, p. 83.

[68] California, Delinquency Prevention Commission, Youth Service Bureaus: standards and guidelines, Sacramento: Youth Authority Department, 1968, 30 pp.

[69] Moore, Eugene Arthur, Youth services bureaus: local community action program prevents delinquency, *Judicature*, 52(3):117-119, 1968.

the same function is fulfilled by the Youth Referral Program, in operation since 1944.[70] In this program, youths between the ages of seven and seventeen who have had minor contacts with police are identified and adult neighborhood volunteers work to achieve parental acceptance of responsibility for supervision of their children, cooperation among parents, educators, and community leaders in child guidance, and sponsorship of programs based on studies of environmental conditions affecting child behavior. While there are differences between these programs and the Youth Services Bureau, as it is currently described, the basic ideas are there: community responsibilty for handling minor misconduct and development of alternatives to court processing as a means of providing services to youth.

The experiences of the more recently established Youth Services Bureaus, such as those now in operation or underway in nine California communities,[71] have not yet been assessed by research. Reports of their establishment and operation are enthusiastic and expectations are high. It appears likely that whatever problems do arise, many juveniles nonetheless will be removed from the juvenile justice system and a variety of alternative dispositions will be demonstrated as feasible.

Two possible sources of problems in this type of organization and delivery of rehabilitative services are apparent: (1) that pressures to accept "treatment," even where it is unwanted, might develop; and (2) that the effort to provide services to those who are presumed to need them may prevent recognition of the fact that for much of what now is labeled as deviance, the problem is *not* how to treat it but how to absorb or tolerate it—or even encourage it. Not all deviant behavior requires treatment, whether in or out of the criminal justice system, yet the mere presence of a functioning mechanism of community services, with none of the more obvious drawbacks of the penal system, is likely to result in the "treatment" of many more individuals by official agencies. A rational policy of diversion, especially if the goal involves more than individual "cures," would seem to require that society broaden its definition of acceptable behavior rather than merely extend its control efforts to include treatment and provision of services. Some diversion should result in simple release from any system of intervention or control.

[70] Philadelphia, Division of Youth Conservation Services, A review of the Youth Referral Program, 1944-1969, Philadelphia, 1969, 13 pp.

[71] California, Youth Authority Department, Community Services Division, California's youths services bureaus: a study in community action and cooperation, by William A. Underwood, Sacramento, the Department, 1969. 9 pp.

Conclusion

From a study of factors related to differential rates of delinquency, Victor Eisner has concluded that our present delinquency problem stems from our cultural intolerance of diversity and variability and our overly restrictive boundaries on acceptable behavior.[72] His observations with regard to the repression and resultant alienation of adolescents in American society could be more generally applied, not only to youth and lower-class black communities, but to many groups on the fringe of and outside the mainstream of society.

> Our laws are made by only one segment of this culture, for whom many of the laws are unnecessarily restrictive. As a result we have alienated large groups of people, and we have applied a delinquency label to many of them . . .. Our high delinquency rates are evidence that our boundary-maintaining mechanism has excluded too many . . ..[73]

An understanding of this basic intolerance of diversity, increasingly apparent in the United States today, is prerequisite to the recognition of a major weakness in our efforts to prevent and control crime, and especially in the current emphasis on diverting offenders from the criminal justice system to agencies of civil and social control. Criminal statutes may be revised (to "legalize" public drunkenness, vagrancy, victimless sex offenses); control and surveillance of minor violations may be achieved without arrest (in special misdemeanant programs or youth guidance services); and health and welfare services may be made accessible to those who need them (clinics for treatment of addiction; employment services for youth and the poor; housing and other assistance for the skid-row alcoholic). All such measures are likely to result in fewer persons entering the criminal justice system. But as long as mainstream America continues to view all deviations from a narrowly defined acceptable norm as evidence of pathology requiring some kind of control response (whether punitive or rehabilitative), diversion is likely to remain largely a technique of enforcing conformity by alternate means. The "crisis of overcriminalization" might be more accurately understood as a crisis of *over-control*, because to construe it as merely a problem of the criminal law is to conceal the injustices inherent in a more general policy of social exclusion.

[72] Eisner, Victor, *The Delinquency Label: The Epidemiology of Juvenile Delinquency*, New York: Random House, 1969. 177 pp.
[73] *Id.*, pp. 132–133.

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