



ALASKA JUSTICE FORUM

A PUBLICATION OF THE JUSTICE CENTER

Spring 2004

UNIVERSITY of ALASKA ANCHORAGE

Vol. 21, No. 1

Police Patrol and Public Alcohol Use in Anchorage

Brad Myrstol

One out of every three minutes Anchorage Police Department patrol officers spend with members of the public is in the context of an alcohol-related event—more than 45 minutes per shift. Fourteen percent of all patrol shift time is devoted to alcohol-related events. Overall, this officer time may comprise expenditures of over five million dollars annually.

In discussions of social problems within Alaska, the topic of alcohol use often takes center stage. Alcohol is viewed by many in the state—justice professionals and laypersons alike—as the root cause of a wide range of social ills, many of which necessitate the involvement of criminal justice agencies. And while questions remain concerning the causal role of alcohol use, there is evidence to suggest that alcohol is at least implicated in a wide variety of crimes and other undesirable conduct in Alaska. (Two other recent *Forum* articles have looked at this issue: “Alcohol Use Among Anchorage Arrestees” by Brad Myrstol [Winter 2003] and “Forcible Rapes and Sexual Assaults in Anchorage” by André Rosay [Winter 2004].)

Less clear than the degree of alcohol involvement in crime and delinquency is its impact on criminal justice agencies responsible for handling the problems associated with public alcohol use. The information criminal justice agencies collect generally does not provide sufficient detail to allow for accurate impact estimates. Paradoxically, because alcohol use is so intimately connected to behavior brought to the attention of public authorities (particularly criminal violence), the direct influence of alcohol use alone, excluding other factors, is nearly impossible to estimate—especially for the court and correctional systems, where alcohol involvement is so ubiquitous across cases as to be nearly constant.

For police agencies, the task of measuring organizational impact is made difficult by the broad scope of their institutional mandate, which goes far beyond mere law enforcement. In the United States, state and

local police respond to a wide range of problems, only a minority of which constitute actual violations of criminal law. Non-criminal situations (for example, an officer responding to a complaint about noise or an officer transporting a chronic inebriate to safe shelter) also often involve alcohol.

This article presents preliminary findings from the Police Alcohol-related Services Study (PASS) conducted by the Justice Center in January 2004. The objective of PASS was to bring the role of alcohol involvement in police work to the center of analysis by describing the nature (who, where, when and what), assessing the consequences (economic, organizational, institutional, and cultural) and investigating the causes of alcohol-related encounters and incidents experienced by the patrol division of the Anchorage Police Department (APD).

Methodology

PASS is a study of the impact alcohol consumption by the public has on one aspect of the Anchorage Police Department: *patrol work*. In order to make findings generalizable to all patrol in Anchorage, patrol shifts and patrol beats were selected according to a random sampling plan. Officers were not permitted to decline a PASS observer when they were selected for observation and PASS observers were randomly assigned to sampled day-shift-beat combinations to reduce the effects of any systematic bias they might introduce.

PASS Sample

PASS examined patrol work across three separate, but interconnected, levels

Table 1. Distribution of Sample Observations, by Shift
Designed versus realized sample.

Shift and time	Designed sample		Realized sample	
	N	Percent	N	Percent
"A" Shift 11:00 PM to 9:00 AM	21	27.6 %	19	29.2 %
"B" Shift 7:00 AM to 5:00 PM	32	42.1	25	38.5
"C" Shift 3:00 PM to 1:00 AM	23	30.3	21	32.3
Total	76		65	

of analysis: observation sessions (*rides*), events (*activities* and *encounters*) and individuals (officers and members of the public).

This discussion is a preliminary analysis of PASS data consisting of 65 rides, with more than 2,230 events. A *ride* is an observation session to which a PASS observer was assigned. An *event* is defined as any action undertaken or incident participated in by the officer observed, either self-initiated or at the direction of others. That is, *event* is a term used to describe what officers did while on duty during an observation session.

Table 1 and Table 2 provide a description of the temporal distribution, by time of day and day of week, of the PASS sample. Table 1 presents a comparison of the distribution across time of day for the PASS sample as designed with the sample that was actually carried out in the study—the *realized* sample.

Please see *Police patrol*, page 9

Table 2. Distribution of Sample Observations, by Day of Week
Designed versus realized sample.

Day of week	Designed sample		Realized sample	
	N	Percent	N	Percent
Sunday	10	13.2 %	8	12.3 %
Monday	10	13.2	7	10.8
Tuesday	12	15.8	11	16.9
Wednesday	11	14.5	8	12.3
Thursday	10	13.2	10	15.4
Friday	13	17.1	12	18.5
Saturday	10	13.2	9	13.8
Total	76		65	

A Review

Human Rights Watch: The Mentally Ill in U.S. Prisons

Antonia Moras

The enormous growth in the national prison population has intensified the problems presented by the needs of mentally ill inmates. A report released by Human Rights Watch late last year—"Ill-Equipped: U.S. Prisons and Offenders with Mental Illness"—examines in depth the situation of the adult mentally ill in state and federal prisons. The report is long and well-researched, blending material from legal documents, court records, academic studies, site visits, interviews and letters.

Originally established in the 1970s to monitor compliance with the human rights provisions of the Helsinki Accords, Human Rights Watch has developed into a more broadly focused international observer of government policies and practices affecting human rights throughout the world, with its reports, such as this one, based on intensive fact-finding research. Behind its examination of this aspect of U.S. prisons is the understanding that "because prisons operate in secret, for the most part, it is important for

the public to have access to as much material as possible."

The report is a tool for focusing attention on the situation. It offers recommendations for change, but its main value possibly lies in the depth and thoroughness of its research, which provides detached examination of the range of problems presented by mentally ill prisoners. The report provides a detailed look at the situation behind the numbers that have been compiled in numerous other reports.

Prisoners have rates of mental illness two to four times higher than those occurring in the general population, and according to this report, there are three times more mentally ill people in U.S. prisons than in mental health hospitals. Between two and three hundred thousand people incarcerated in federal and state prisons suffer from severe mental illnesses such as schizophrenia or bipolar disorder. On any given day, about 70,000 are psychotic. These numbers represent a severe crisis for prison systems throughout the country.

The report discusses two main reasons why the numbers have risen to a crisis level. First, as a result of the deinstitutionalization movement of the 1960s, many mental health hospitals were closed, but community mental health systems which were envisioned as taking the place of hospitals did not develop sufficiently. Many mentally ill—particularly the poor—are now without access to help. Over the same time, politically-generated "tough on crime" attitudes throughout the country have given rise to criminal codes under which more people are being incarcerated for a wider range of crimes for longer periods.

A term—*criminalization of the mentally ill*—has become current. It encompasses the ways in which the mentally ill who do not have access to adequate support and treatment can become caught in the justice system when their behavior deteriorates to the point where they commit a criminal offense—often low-level street disorder types of crime, but sometimes violent and more destructive acts. By default, correctional systems have become the greatest providers of treatment for the mentally ill in the country. But correctional systems are very poorly designed to be treatment providers.

The report only glances at how criminal codes handle the factor of mental illness, and only by implication does it look at sentencing practices. Its focus is the actual administration of prison systems in which, rightly or wrongly, there are many mentally ill pris-

oners. It provides an overview of the medical and administrative complexities presented by mentally ill inmates, with numerous examples and case studies garnered from prison, court and medical records, academic research, interviews, and letters. One aspect of the investigation encompassed review of litigation involving various state prison systems. Investigators also solicited letters from inmates. Some of these are appended to each chapter. The authors did not edit the letters, choosing instead to present the individual voices of these prisoners directly. The physical and mental desperation of the some of inmate voices as they describe their illnesses and prison experiences is searing.

As recently as two decades ago, there was little mental health care available in prisons, but there were also many fewer prisoners with mental illness. As the numbers have risen, prison systems have responded with policies for providing for this sub-population of the incarcerated but, as the report notes, "Many prison systems have good policies on paper, but implementation can lag far behind." Almost all systems now struggle to structure and fund care for these inmates.

Care for mentally ill prisoners is expensive, adding significantly to the generally high costs of prison systems. Because of the way costs associated for caring for the mentally ill are dispersed throughout correctional budgets, as well as the budgets of other state agencies, it is hard to calculate totals, but the authors of this study cite figures from the Pennsylvania correctional system. In Pennsylvania, the average cost to incarcerate one inmate per day is given as \$80. For a mentally ill inmate, the added cost of mental health services, medication and additional correctional staff raise this to a daily average cost of \$140.

The mentally ill have, by definition, limited skill in coping with daily reality. They are at an even greater disadvantage under the physical conditions and routines which characterize many prisons—the crowding, the noise, the lack of medical attention. They are vulnerable to exploitation and abuse. Because, due to their illnesses, they often can't internalize prison behavior rules, they are often in violation and they become subject to disciplinary measures, further undermining their stability.

Among the greatest problems involved in managing the mentally ill prisons is that correctional staffing is rarely at an adequate level to supervise and care for these prison-



Alaska Justice Forum

Editor: Antonia Moras
Editorial Board: Allan Barnes, Sharon Chamard, Ron Everett, Pamela Kelley, Robert Langworthy, Alan McKelvie, Brad Myrstell, Deborah Periman, John Riley, André Rosay, Lawrence Trostle, Darryl Wood
Typesetting and Layout: Melissa Green

Justice Center, Robert Langworthy, Director

Published quarterly by the

Justice Center
University of Alaska Anchorage
3211 Providence Drive
Anchorage, AK 99508
(907) 786-1810
(907) 786-7777 fax
ajjust@uaa.alaska.edu
<http://www.uaa.alaska.edu/just/>

© 2004 Justice Center,
University of Alaska Anchorage
ISSN 0893-8903

The opinions expressed are those of individual authors and may not be those of the Justice Center.

The University of Alaska provides equal education and employment opportunities for all, regardless of race, color, religion, national origin, sex, age, disability, or status as a Vietnam-era or disabled veteran.

ers. The report analyzes the complexities presented by this lack of human resources. Few systems have enough correctional guards and mental health care professionals available. In addition, correctional officers in many state prisons have never received training in working with the mentally ill. Correctional staff are actually present with prisoners more than medical or other mental health care personnel. They become more alert to the behavior patterns of individual prisoners but are often not trained to handle this behavior—which can be dangerous and frightening. The stress and fear can lead to abuses, including excessive use of force to control inmate behavior.

There are also usually too few mental health care professionals available to treat prisoners. Therapy sessions can sometimes be little more than a roll-call walk through a cell block by a counselor. Therapist positions may be filled by poorly qualified personnel, and prison systems easily fall into

depending on medication alone to control these inmates. In addition, turnover among correctional staff and mental health care staff can be destabilizing for the mentally ill and can also lead to problems with continuity of care.

The administration of mental health care in prisons is also hampered by the lack of specialized facilities to provide hospital care for the most seriously ill; poor screening; inadequate data management; and poor tracking—especially in larger systems. In the regular movement and transfer of prisoners which typify many larger systems, continuity of care becomes an immense problem. Moreover, because in general the prison population comprises primarily young adults in the age range in which chronic mental illness begins to appear, many prisoners begin to develop signs of sickness after they are already incarcerated—and are not readily diagnosed.

Prison administration—the structured

routines and discipline necessary for safety and security, particularly in larger prisons—often work against the stability of the mentally ill, causing a deterioration in behavior rather than more conforming behavior. For example, prison scheduling—necessary to manage the general inmate population—can impede timely access to medical attention for mentally ill inmates: “Some prisons require prisoners to take medication in the early evening that should be taken just before a patient goes to sleep [causing the patient] to become increasingly anxious before the medication takes effect.”

Medication is too often the only assistance available. The Human Rights Watch investigators found problems in this area too. Budget constraints sometimes force the use of older, less effective drugs, and in some systems the prescribing physicians may have had almost no contact with the inmate. In

Please see *Mentally ill*, page 4

Mentally Ill Inmates in Alaska Prisons

As with the U.S. prison system in general, the Alaska correctional system is the largest provider of mental health care services in the state. According to a 1997 one-day snapshot study done for the Alaska Department of Corrections (DOC) by Care Systems North, approximately 37 percent of the DOC population exhibit a mental disorder. Twenty-nine percent exhibit mental illness, with 12 percent showing major psychiatric disorders. Eight percent exhibit chronic alcoholism. In comparison to correctional systems in other states, Alaska prison administrators are dealing with fewer mentally ill inmates, but these *percentages* are higher than national prevalence rates, according to the snapshot study. A 2003 DOC grant proposal states that the mental health staff see over 2000 separate individuals each year.

As of June 2004, the Alaska Department of Corrections had 40 clinical positions, some unfilled, dedicated to mental health care services. Additional positions are occasionally filled under temporary contract. The system operates two in-patient acute care units—a men’s unit with approximately 24 beds at the Anchorage Correctional Complex and a women’s unit with approximately 18 beds at Hiland Mountain. These units provide 24-hour psychiatric care and are usually running at 75 to 80 percent capacity. In addition, there is a sub-acute-care unit at Spring Creek and supported-housing units at Palmer and Hiland Mountain.

The consensus among professionals working with the mentally ill inmate population is that in Alaska, as elsewhere, staffing and resources are inadequate to meet the needs of this population. There are not enough sub-acute-care units, and there is little counseling available. Moreover, screening at intake can be inadequate for identifying the mentally ill, leading to lags in providing treatment and medication. However, the state system follows the guidelines established by the National Commission on Correctional Health Care (including submitting to outside monitoring of its institutions) and is considered to be one of the better systems.

All Alaska correctional officers receive some training in working with the mentally ill, and those COs who are assigned to the specialized care units get additional training. Training for probation officers also includes a mental health component. Some probation officers carry solely mental health caseloads and coordinate the supervision of released inmates with DOC and community health clinicians.

The system does use inmate segregation—or isolation—as a tool for managing the prison population, including those who are mentally ill.

DOC retains the seriously ill in-state, sending only stabilized inmates to the private contract facility in Arizona.

In an effort to address the problems presented by mentally ill who fall under supervision of the correctional system, Alaska has put in place several small programs. Among these are the Institutional Discharge Program Plus (IDP Plus), which provides pre-release planning and case-coordination after release for mentally ill felons, and the Jail Alternative Services program (JAS), which works in conjunction with the Court Coordinated Resource Project (mental health court) to essentially divert eligible misdemeanants from serving time in jail. Both of these programs attempt to construct a net of services from different agencies and departments to provide access to treatment and medication, benefits such as Social Security and Medicaid, and housing. Both programs have shown some success in reducing recidivism, but their funding is not secure.

Another administrative problem for the correctional system with regard to the mentally ill is that DOC facilities admit over two thousand individuals each year under protective custody. These individuals have not been arrested and charged but rather are being held temporarily because they have become incapacitated by alcohol, drugs or mental illness and their behavior has led to police taking them into custody for their own safety.

Beyond the immediate problems for DOC in supervising the mentally ill who come under its jurisdiction lies the inadequacy of the statewide behavioral health system, which presents reentry problems for those leaving DOC’s supervision. A major stumbling block for many released prisoners is that access to federal benefits is often delayed—leading to gaps in treatment and periods without medication during which behavior can deteriorate quickly. In addition, adequate housing is in very short supply. Released prisoners vary in their need for structure in their living situations. There is an absence of sufficient low-cost housing along the entire continuum from low-income apartments, to single room occupancy units, to intensive assisted-living facilities. Many released prisoners resort to living in homeless shelters. Another gap in the overall community mental health care system is the absence of enough treatment programs that can handle individuals with a dual diagnosis—mental illness combined with a substance abuse problem. Without housing or medication or programs, a released inmate’s behavior can deteriorate to the point where another arrest for another offense occurs.

Mentally ill (continued from page 3)

some systems, non-medically trained guards are the ones to distribute the medication.

The report focuses in particular on the widespread use of segregation— isolation as a disciplinary measure used to control inmates who have violated prison rules. Isolating prisoners who have become disruptive or have otherwise broken prison regulations in some form of solitary confinement is a common practice. The report criticizes it as being overused in general in U.S. prisons and particularly overused with mentally ill inmates.

Because the mentally ill often act out, they are difficult to manage and are likely to incur this type of disciplinary measure, but solitary confinement inevitably worsens mental illness. Segregation or isolation cells are often used because there is no alternative: prisons lack sub-acute care facilities. When held in isolation under particularly restrictive conditions, these inmates are also more prone to self-destructive acts—self-mutilation and suicide.

The lack of proper care begins a cycle—disruptive behavior, management by isolation, worsening behavior, hospital confinement until stabilized and then a return to inadequate care. As the report comments, “The penal network is thus not only serving as a warehouse for the mentally ill, but by relying on extremely restrictive housing for mentally ill prisoners, it is acting as

an incubator for worse illness and psychiatric breakdowns.”

Some of the most troubling incidents described in the Human Rights Watch report involve the placement of mentally ill prisoners in segregation. It is in this area that the investigators found the most abuses—prisoners in some systems being held for long periods in isolation cells, sometimes naked, sometimes surrounded by their own waste.

This is the area in which the report is most strongly critical of the U.S. prison system as a whole. The evidence is clear that some prisons are in violation of international covenants on prisoners to which the U.S. is a signatory.

Mentally ill prisoners can also be caught in a cycle of recidivism, in which they return again and again to prison. The Human Rights Watch report touches briefly on the general lack of pre-release planning for these inmates and the absence of support beyond the prison for the mentally ill. Newly released prisoners often lack money, housing, employment and access to medical care. This makes reentry difficult for all prisoners, but for the mentally ill the situation can be disastrous. Gaps in treatment and suspension of medication can result in a resurgence of the illness—and behavior that leads to another arrest.

The report concludes with a review of the pertinent legal standards, both under U.S. law and international covenants, noting that advances and improvements in prison conditions have often been the result of

litigation.

The report presents extensive, specific lists of recommendations for action by different entities, including the U.S. Congress, other public officials and community leaders, and correctional administrators. Among these is passage of an already-drafted piece of legislation, “The Mentally Ill Offender Treatment and Crime Reduction Act,” which could serve as a catalyst for reform throughout the country. Many of the recommendations would involve commitment of more resources, and they would entail deep structural changes within prison systems.

What emerges again and again in the Human Rights Watch report is that with the mentally ill, prison systems are being constrained to handle problems beyond the scope of their resources—problems that by their very nature will become worse, not better, under the conditions of mass imprisonment. The report is not an unrealistic plea for the release of mentally ill prisoners who have been convicted of crimes, but it does advocate for some specific reforms. Perhaps more importantly, it provides a clear, deep focus on the daily realities of operating large prison systems, particularly with regard to this most vulnerable type of inmate.

Antonia Moras is editor of the Alaska Justice Forum. The report discussed in this article, “Ill-Equipped: U.S. Prisons and Offenders with Mental Illness,” can be found on the Human Rights Watch web site at www.hrw.org.

Corrections and State Mental Health Funding

Since FY 2002, there has been a large decrease in the amount of money allocated for mental health programs throughout the state, including many programs that affect the situation of offenders with mental illness. Between FY 2002 and FY 2004 the total operating budget for state mental health programs across all agencies decreased by 8 percent, or close to \$12 million, according to a study of the state FY02-FY04 mental health budget base released this March. The FY 2005 budget passed by the legislature reflects a further 5 percent decrease below FY04 levels. The study notes that the numbers themselves do not fully describe the funding changes. Many costs previously borne by the state have been shifted to federal funding sources, including Medicaid. Information Insights, Inc., in Fairbanks, conducted the study for the Mental Health Trust Authority.

With only a 1.4 percent decrease overall between FY02 and FY05, the mental health component of the DOC operating budget has not been as severely cut as that of other agencies, but there has been a reduction in funds for programs available to inmates with mental illness. In addition, substance abuse programs have been eliminated in 13 facilities throughout the state, with only residential programs for the most severely addicted still funded—at Hiland Mountain and Meadow Creek. Federal funds have formed the basis for these remaining residential programs, with the state providing match. In addition, some of the programs directly aimed at assisting mentally ill offenders, such as the Jail Alternative Services (JAS) project, are still being funded on a pilot basis.

Although the DOC mental health budget has remained relatively

stable, the situation of many of the mentally ill under the jurisdiction of DOC is ultimately affected by cuts to other agencies—those which may be funding treatment programs in the community or low cost housing programs. The budget of the Department of Health and Social Services, which administers many of these programs or channels grant monies for them, decreased 9 percent between FY02 and FY04, with a further 5 percent cut in the FY05 budget. Moreover, the shift to Medicaid funding in some program areas has resulted in eligibility and administrative gaps affecting some discharged inmates.

In contrast to many other state units, the court system’s mental health component—for mental health court and the other therapeutic courts—has increased steadily since FY02, with a significant increase in FY05 funding.

The mental health component of state agency budgets is covered by a separate legislative bill—the Mental Health Appropriations Bill. The Mental Health Trust Authority, a public corporation established by statute, makes annual program-specific budget recommendations to the governor for all state agencies with mental health-related programs. The Trust is charged with responsibility for the needs of four populations: those who experience mental illness, mental retardation or similar disabilities, chronic alcoholism with psychosis, or Alzheimer’s or related dementia. Trust budget recommendations thus cover a broad array of programs and services across many state agencies. The governor’s office submits its revisions of the Trust’s recommendations to the legislature, which works out the final mental health budget concurrently with the general state budget.

Measures of Outcomes Associated with Alcohol Abuse in Alaska

Darryl S. Wood

Since the topic of alcohol abuse and its attendant social harms are a continuing part of the public conversation in Alaska, this article will look at the various secondary data sources that can be used in examining effectiveness of alcohol control policies. A number of agencies retain data relevant to the impact of public policies involving alcohol, but not all the data collections are solid—reliable and valid—for research purposes. Considered below are the data collections assembled by the police, public health agencies, and other entities such as the state child protection and transportation departments. In addition to describing each data source, this article discusses each in terms of whether it provides statewide coverage, the extent to which it is complete, and the level of geographic and temporal specificity it provides.

Data collections for examining alcohol control efforts would ideally have the following characteristics: they would be complete; they would measure associated harms at the community level; they would be available for many years; and they would allow for measurement of those harms on a weekly or monthly basis in order to capture the time series effects of changes in policy. In Alaska, four different sources meet these requirements to a useful extent: the Alaska Trauma Registry, death certificate records from the Bureau of Vital Statistics, reports of harm from the Office of Children's Services, and traffic accident records from the Department of Transportation. Data maintained by law enforcement agencies are, in general, less useful when considered as a means for understanding the impact of public alcohol policies.

Before examining the useful data sources, this article will first consider the flaws in available police statistics.

Police Data Sources

There are two possible sources of police statistics relevant to understanding the harm that results from the use of alcohol in Alaska—the Uniform Crime Reports (UCR) and calls-for-service records kept by individual police agencies. These sources share one major shortcoming: although each is useful for understanding the harms that occur in some jurisdictions in Alaska, neither is particularly useful for making inter-community comparison measurements on a

statewide basis.

Uniform Crime Reports

The Uniform Crime Reports are a standardized record of offenses known to the police. For agencies in Alaska, these records are available from the Inter-university Consortium for Political and Social Research (ICPSR) for the years 1975 through 2001. The UCR provided by the ICPSR are available on a month-by-month basis in 27 annual data sets. The UCR includes measures of the so-called Part I offenses—the serious criminal offenses of murder (and non-negligent manslaughter), aggravated assault, forcible rape, robbery, burglary, motor vehicle theft, and larceny theft. Also included are records of the number of simple assaults recorded per police agency per month. For all of these Part I offenses and simple assaults, the UCR record the number of offenses that have come to the attention of the police and are considered to have actually occurred—that is, the reports are not “unfounded.” The Part I offenses are recorded whether or not an arrest is made for the offense.

For less serious offenses—generally referred to as the Part II crimes—the UCR only provide records of police arrests. These Part II crimes include many offenses often associated with the use and abuse of alcoholic beverages: driving under the influence, violations of liquor laws, public drunkenness, disorderly conduct, and vagrancy. The ICPSR has available month-by-month UCR arrest records for police agencies in Alaska only for the years 1998 through 2001. For earlier indicators of arrests for Part II offenses by Alaskan police agencies it is necessary to refer to the annual *Crime in Alaska* reports issued by the Alaska Criminal Justice Planning Agency for the years 1976 through 1987 or to the annual *Crime Reported in Alaska* reports issued by the Alaska Department of Public Safety for the years 1988 through 2002. The arrest statistics presented in these two reports are given by

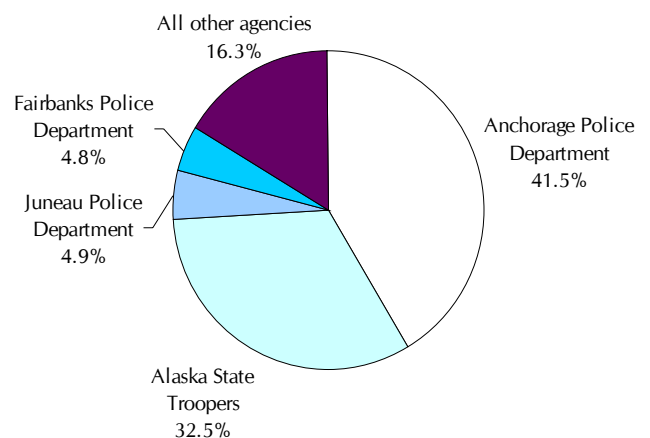
individual agency. Available in hard copy through 2001 and online for 2002, the volumes can be obtained at University of Alaska libraries in Anchorage or Fairbanks.

While many of the Part I offenses reported in the UCR may be associated with alcohol use, in general the information recorded does not permit a determination of the extent to which alcohol use is actually involved in crimes occurring in a given jurisdiction. The one exception to this rule is the Supplementary Homicide Reports (SHR) assembled by the FBI. Also available through the ICPSR for the years 1975 through 2001, the SHR provide incident-based information on all criminal homicides known to the police. Included in the SHR are the date of the offense, victim and offender demographics, information on the victim-offender relationship, weapons used, and, for the purposes of understanding the role of alcohol in criminal violence, information on whether the circumstances of the homicide involved a brawl due to the influence of alcohol.

Other than for homicide, most criminologists are reluctant to use UCR data as a measure of how much crime there is. They see the UCR data as lacking measurement validity (because the statistics only measure a fraction of the crime that occurs in society) as well as reliability (because the amount of crime that actually occurs that is eventually measured by the UCR varies from jurisdic-

Please see *Measures*, page 6

Figure 1. Proportion of Alaska State Population Served by Different Police Agencies, 2001



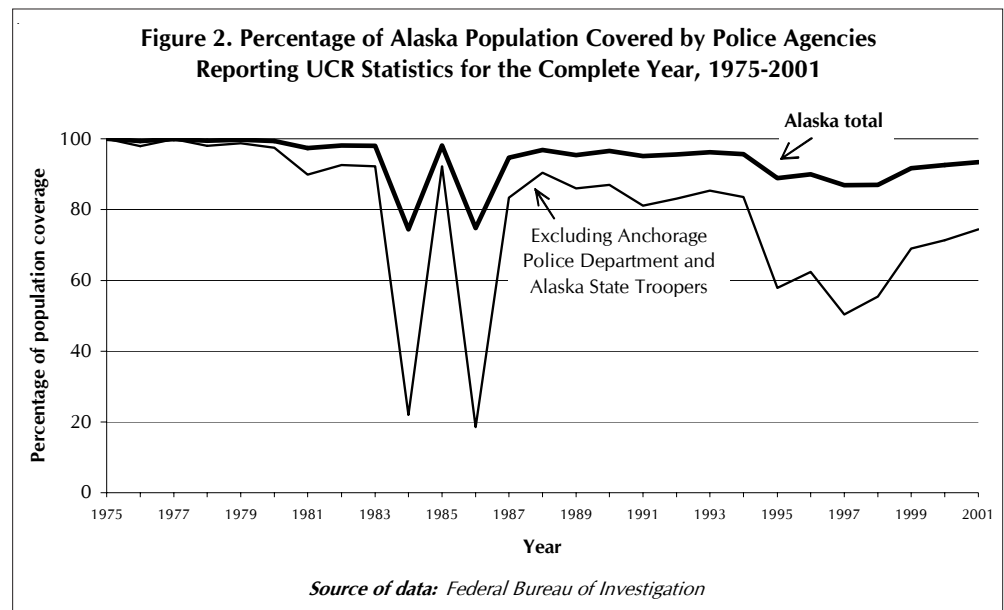
Source of data: Federal Bureau of Investigation

Measures (continued from page 5)

tion to jurisdiction). In addition to these usual misgivings, there are other reasons why the UCR statistics lack utility when attempting to understand inter-community variations in behaviors often associated with alcohol in Alaska. First of all, the UCR are limited by a lack of geographic specificity in Alaska. Secondly, the Alaska UCR data are somewhat incomplete because many police agencies, especially those from the less urbanized areas of the state, provide information to the FBI on a sporadic basis.

The lack of geographic specificity results from the fact that the reports are made at the level of the individual police agency rather than for specific geopolitical areas. For instance, the UCR contains those crimes known to the North Slope Borough Police Department—a broad level of aggregation. It is impossible to determine which offenses occurred in Barrow, the borough seat, and which offenses occurred in the seven other communities scattered across the approximately 90,000 square mile jurisdiction. This problem is even more conspicuous for those communities policed by the Alaska State Troopers (AST)—about a third (32%) of the state's population, as shown in Figure 1. Although these crimes are recorded in the UCR as offenses known to the Troopers, most have been reported to the Troopers from one of roughly 90 second-class cities or a similar number of unincorporated villages. Aggregation of these police statistics at a level above that of individual cities and villages masks theoretically important inter-community differences in the amount of harm associated with alcohol.

The other problem with the use of Alaska UCR data is that the data are incomplete on a time series basis. Many agencies, particularly those serving jurisdictions with smaller numbers of residents, report to the FBI only on a sporadic basis. The proportion of the Alaska population covered by police agencies that reported UCR statistics for a complete 12-month-year for the years 1975 through 2001 is shown in Figure 2. Overall, UCR crime statistics were reported to the FBI for a complete 12 months for most of the Alaska population (annual mean = 94%) during that time period. However, when the proportion of the population for which UCR offenses were reported to the FBI is considered for all police agencies except for the state's two largest departments (i.e., the AST and the Anchorage Police Department), the extent to which the data are incomplete on a time series basis becomes apparent.



Excluding the population served by the Troopers or the Anchorage Police Department, between 1975 and 2001, UCR crime statistics were reported to the FBI on a complete 12-month basis by agencies serving roughly four-fifths (annual mean = 78.5%) of the population. Particularly after 1994, these police agencies were even less likely to report.

Illustrating the problem of incomplete UCR data in the ICPSR holdings, the North Slope Borough Police Department (NSBPD) did not report for any months during the three years 1996 through 1998. This gap is particularly unfortunate for those wishing to understand the effects of local alcohol control policies. Residents of the North Slope Borough hub community of Barrow voted to allow alcohol possession in October 1995, then voted to ban possession in February 1996, only to allow possession again in November 1997. A valid examination of the effect these changes had upon alcohol-related violence across the North Slope Borough would have provided compelling evidence regarding the effectiveness (or ineffectiveness) of local prohibition.

Other police agencies serving hub communities in northern and western Alaska are also infrequent in reporting UCR records to the FBI. For example, the Unalaska Department of Public Safety, an agency serving a primary fishing port and the hub for the Aleutian Islands, went 17 years without reporting. The Nome and Kotzebue Police Departments also have not reported UCR statistics for many years. For understanding the effects of alcohol control policies, it is unfortunate that the police agencies in these two communities have not reported recently because they otherwise present potentially interesting comparisons. With simi-

lar population sizes and traditional indigenous heritages, one primary difference between the two communities is that Nome allows the local sale of alcohol and has a number of bars while Kotzebue forbids the sale of alcohol within city limits. Without complete UCR data, it is less possible to determine if the differences in alcohol control policies in the two communities translate into differences in rates of violent crimes associated with alcohol use.

Calls-for-Service Records / Incident Reports

Calls-for-service records and incident reports generated in the day-to-day operations of individual departments provide a potential alternative to using the Uniform Crime Reports statistics. As might be expected, the availability of these records varies considerably along the lines of agency size and departmental resources. There are also substantial differences in the validity and reliability of these calls-for-service records.

The availability of calls-for-service records from the agencies (not including police departments responsible for airports and universities) recognized by the Alaska Police Standards Council (APSC) in the latter part of 2003 is mixed. Although no systematic assessment of these agencies' record-keeping and dissemination capabilities has been performed, it is probably safe to assume that, given the broad range of population sizes they serve, some departments are more able than others to be able to provide data for the purposes of studying violence and other offenses associated with alcohol use. The larger departments in the state, particularly those in Anchorage and Fairbanks, employ computer-assisted dis-

patch technologies that allow for the production of geographically and temporally specific data records amenable to a broad range of analytical techniques. Use of these records in research is limited mostly by the willingness of the agencies to share the information and by the ability of record-keepers to manipulate proprietary software programs to produce case-based data sets.

The incident reports produced by the Alaska State Troopers are one good example of the records that could be useful in alcohol research. Their records are available for the time period since 1990 from their headquarters in Anchorage, with each record listing the location, date, and offense (if any) for every call for service received by the Troopers. One important benefit of the Troopers' incident reports is that they allow for an examination of violent behavior and liquor law violations in all areas of the state not covered by municipal police departments. This coverage would include most, but not all, of the Alaska Native villages located in the more isolated areas of the state.

The availability of case-based calls-for-service records from smaller police departments is probably much more limited. An analysis of information drawn from the Census of State and Local Law Enforcement Agencies (CSLLEA) conducted by the Bureau of Justice Statistics in 2000 shows that many small departments in Alaska probably lack the resources to provide calls-for-service information in a format that would be useful for research purposes. For instance, 6 of the 42 APSC member departments responding to the CSLLEA had no full or part-time civilian employees, while 7 departments had only 1 full or part-time civilian employee. Typically in the more isolated areas of the state that are thought to be especially troubled by the harms associated with alcohol use, these departments are rather small, with an average of four sworn officers per department responsible to a mean population of 1195 residents.

Even the calls-for-service records for the larger police agencies more likely to be available for use in alcohol research are potentially beset by problems of measurement validity and reliability. One problem is that these records, as with most police crime statistics, are social artifacts that are often more of an indication of factors such as police presence and variations in the public's willingness to report offenses than a realistic measure of an underlying amount of criminal behavior.

Public Health Data Sources

An alternative to Alaska police statistics in considering the effects of alcohol control

policies are the data available from the state's public health authorities. The two main data sources are the records of traumatic injuries recorded in the Alaska Trauma Registry and the death certificate records compiled by the Alaska Bureau of Vital Statistics. The primary advantage of the public health data sources is that their records are not subject to the biases of incomplete data and differential reporting associated with the statistics produced by the police.

Alaska Trauma Registry

Maintained within the Alaska Division of Public Health, the Alaska Trauma Registry is a standardized, statewide record of all injuries resulting in a hospital admission or declaration of death in an emergency room. The data in the Alaska Trauma Registry have been gathered since the beginning of 1991 for all 24 acute care hospitals in the state. Information from the Alaska Trauma Registry is currently available in electronic format at the level of the individual trauma case for the years 1991 through 2000. Aggregation of individual trauma cases information in the Alaska Trauma Registry provides for city/village level indicators of harms associated with alcohol use, such as assault, suicide, and unintentional injuries, which are available across multiple time frames. The cases in the Alaska Trauma Registry could be used to consider the effects of a broad range of alcohol control policies and efforts directed toward the reduction of alcohol-related harm. For instance, a city could examine the impact of its programs aimed at reducing underage drinking by following trends in injuries to residents under the age of 21 years.

A broad range of information concerning each individual trauma case is recorded in the Alaska Trauma Registry. This includes information on treatment provided at the injury scene, by those transporting the patient, and by emergency room physicians. It also includes data on case outcomes such as the extent of disability resulting from the injury and whether the case ended in death. For the purposes of studying the effects of efforts to deal with alcohol-related problems, the most important information in the Alaska Trauma Registry involves (1) patient demographics, (2) injury specifics, and (3) alcohol and other drug screening. The demographics in the Alaska Trauma Registry include specifics on each patient's age, sex, race/ethnicity, and home address. Injury details include the cause-of-injury E-code, measures of injury severity, and records on the date, time, city/village, and place (e.g., home, work, or public building) of injury. Records of the results of blood

alcohol content as measured by blood test or breathalyzer are also available for a selected sample of cases.

A great deal of care has been taken to insure that the Alaska Trauma Registry provides a valid representation of traumatic injury in the state. Validation studies have been conducted on three different occasions to determine the extent to which cases of traumatic injury actually were recorded in the registry. Ninety-one percent of potential cases in 11 hospitals in 1994, 87 percent of potential cases in 6 hospitals in 1998, and 90 percent of potential cases in 11 hospitals in 1999 were eventually recorded in the Alaska Trauma Registry database; hence, although there are some gaps, the information that is recorded in the database is generally complete.

Bureau of Vital Statistics Death Certificate Records

Death certificate records compiled by the state Bureau of Vital Statistics (BVS) form another public health data source that can be used to examine the effects of alcohol control policies in Alaska. These records have value as a single data set in examining the impact of control policies and also can be combined with the records of the Alaska Trauma Registry for a complete data set to capture all cases of injury, whether or not they resulted in emergency medical care. Included in the BVS death certificate records are indicators of the dates of death and injury, city/village of injury, city/village of residence, decedent's age, sex, and race, and the cause-of-injury E-code. They are available on a case-by-case basis with records going back as far as 1980.

These death certificate records have been used in a number of studies on the effectiveness of alcohol policies in Alaska. Matthew Berman, a professor with the UAA Institute of Social and Economic Research, used death certificate records to examine the effects of local alcohol prohibition in isolated Alaska Native villages. A similar study, using cases from both the death certificate records and the Alaska Trauma Registry, was conducted by the author of this article to consider the impact of police presence upon traumatic injury in Alaska Native villages where alcohol is prohibited.

There are, however, some limitations to the BVS death certificate records as measures of alcohol-related harms. First, unlike the Alaska Trauma Registry, the death certificate records do not include records for non-Alaska residents. Another problem is that, except for those cases with specific

Measures

(continued from page 7)

alcohol-related cause-of-death E-codes, the BVS death certificate records do not record whether the death was alcohol or drug-related. It is necessary to examine individual death certificates to obtain this information. The one other shortcoming of the BVS death certificate records is that they are incomplete on a number of measures. For deaths by traumatic injury, the death certificate records are missing the place of injury in a tenth (9.9%) of cases and the date of injury for roughly one of seven cases (14.1%). Otherwise, the records of violent deaths are very comprehensive.

Less Useful Public Health Data Sources

Apart from the Alaska Trauma Registry and the BVS death certificate records, the other statewide data sources that could possibly be used for the study of alcohol-related harmful behaviors are largely incomplete or limited to certain subsets of the population. Among these less useful sources are Emergency Medical Services (EMS) records and hospitalization records. The state only began to catalog EMS records in 2001, and these records are not yet available for analysis. Once available, however, they might be preferable over Alaska Trauma Registry records because they would record those injuries that result in medical care but do not require an overnight admission to the hospital (as is the case with the trauma registry data). There is no statewide set of records for hospitalizations for all Alaskans of all races/ethnicities. Such records would have to be obtained on a hospital-by-hospital basis. However, hospitalization and medical system records for Alaska Natives, roughly 18 percent of the state population, are recorded in a centralized data system—the Resource and Patient Management System (RPMS) kept by the Indian Health Service. The extent to which these records are available for research is unknown. Accessing them would require the approval of the IHS, the Alaska Native Tribal Health Consortium, and other entities.

Other Data Sources

A couple of other data sources providing statewide coverage also allow for inter-community comparisons of problems associated with alcohol abuse. These include records of harm to children from the state Office of Children's Services (formerly Department of Family and Youth Services) and records of traffic accidents from the state Department of Transportation.

Reports of Harm to Children

The Alaska Office of Children's Services (OCS) records contain information on reported incidents of harm to children and of substantiated cases of harm to children. These reports and cases are recorded in a statewide, standardized, centralized data system in the OCS office in Juneau. It is possible to obtain village/city level records of reported incidents of harm and of substantiated cases of harm through the OCS data system.

The OCS database contains cases going back to 1990, but according to OCS's data manager, these reports are reliable only from 1994 forward. Records of cases of neglect, physical abuse, mental injury, abandonment, and sexual abuse are available. The temporal and geographic detail of the OCS reports available for research is limited mainly by concerns over confidentiality and the willingness of the state to make the data available. While it is possible for OCS to produce a case-based data set that would permit the examination of any preferred time at the village/city level, concerns over confidentiality make it more likely that aggregated village/city level reports on a monthly basis for each of the five different types of child mistreatment could be obtained.

Three possible outcome measures for each of the five types of harm to children can be obtained to examine the impact upon child welfare of efforts to deal with alcohol-related problems. The first of these, the reports of harm, include each report of an incident of harm, substantiated or not, that comes to the attention of the OCS. They are reports of incidents and, especially in the larger offices, may include duplicate reports of a single incident. For instance, if a school nurse and a neighbor both reported the same incident of physical abuse for the same child, staff in the larger local OCS offices might not recognize that the reports are based on a single incident, thus inflating the number of incidents. A second outcome measure available from OCS is the substantiated case—those reported incidents of child harm found to be true. The records of substantiated cases are less likely to have duplications and hence are a more valid indicator of actual cases of harm to children. However, as with the records of reports of harm, the records of substantiated cases can include multiple referrals on individual children. For example, there would be two substantiated cases for a child that was harmed in August and then in, say, October. Likewise, there would be two substantiated cases of harm for a child that was both neglected and physically abused. The third outcome measure available from the Alaska OCS—the number of children

harmed—gives us less of an idea of how much harm is occurring in a given jurisdiction but does help to avoid the problems of duplicate reports and multiple referrals.

A preliminary analysis of the OCS records of harm to children seems to indicate that the records are reasonably complete. For example, for the reports-of-harm measure the village/city-of-referral variable was missing in only 19 out of nearly 175,000 reports of harm in the 11 year period 1990-2001. During that same period the village/city of referral variable for the substantiated case measure was missing in about 2 percent (1.87%) of 53,586 substantiated cases. Given that the OCS records are systematically gathered by a single state agency, it is sensible to expect similarly high levels of completeness on other variables in the database.

Traffic Accident Records

The other statewide, standardized data source that would be amenable to an analysis of the effects of alcohol policies is the traffic accident records maintained by the Alaska Department of Transportation (DOT). This data source contains records of all reported motor vehicle traffic accidents occurring on any public road in the state. Traffic accident records from as far back as 1977 are recorded by the DOT. Included in the DOT's Highway Analysis System (HAS) are records on each accident for location (including city/village and mile marker for outside of inhabited areas), date, time, alcohol relatedness, severity (i.e., property damage only, minor injury, major injury, or fatality), pedestrian involvement, and vehicle type (i.e., auto, truck, ATV, snowmachine). The information recorded in the HAS database is provided to the DOT by the state Department of Motor Vehicles (DMV).

The DOT's traffic accident records would be useful for examining the effects of a number of alcohol policies. Obviously, they would be required for any consideration of policies aimed at reducing drunk driving. They could also be used, for instance, to examine the effects of local regulations of drinking establishment closing times.

The completeness and coverage of the HAS record of motor vehicle accidents is limited by a couple of factors. First, accidents that go unreported to the police and those for which the police fail to notify the DMV are not included in the data. Secondly, the accident database only includes incidents that happen on public roads, so many of the snowmachine and ATV accidents occurring in roadless areas of the state are not included.

Without data in hand to analyze, it is difficult to determine exactly how well the

more isolated areas of the state are covered in the accident data. There are, however, a few reasons to believe that motor vehicle accident records receive less than full statewide coverage in the HAS database. One problem is that while many Alaska Native villages have roads used by the general public, not all of these roads are recognized in the state's records. For instance, only two of the eight villages in the North Slope Borough (Barrow and Point Hope) are represented in the route lists generated by the HAS database. Another indication that there might be less than complete coverage of the isolated areas of the state is that very few traffic accidents are recorded in the HAS database as occurring in isolated places off the main road system or Alaska Marine Highway. According to the latest report on traffic accidents in Alaska, in 2001 only 240 out of 15,273 traffic accidents (1.6%) were reported as happening in non-connected, isolated census areas. It is possible, however, that these small numbers reflect the fact that residents

of isolated Alaska Native villages just use motor vehicles much less and therefore have fewer accidents.

Conclusion

To summarize—relatively few statewide, standardized data sources in the state of Alaska are solid and extensive enough to ground a fruitful and valid consideration of the effects of variations in local alcohol policies. Statistics generated by local and state police, where they do exist, are generally inadequate for this purpose. The four data sources that appear to offer potential for the study of the harmful effects of alcohol use in Alaska are the collection maintained by the Alaska Trauma Registry, the Bureau of Vital Statistics death certificate records, the client and incident database at the Office of Children's Services, and motor vehicle accident records from the Department of Transportation. Each of these databases is centralized, complete, geographically specific to the village/city level, and allows for

the measurement of alcohol-related harms in time frames as narrow as the single date. Use of any one of these data sets could facilitate obtaining a clearer understanding of what impact, if any, specific alcohol control policies have upon the harm that often results from alcohol use in Alaska.

The research conducted for this paper was made possible by a Graduate Research Training on Alcohol Problems Fellowship, sponsored by the National Institute on Alcohol Abuse and Alcoholism grant number T32AA0724026. This research was also supported by National Institute of Alcohol Abuse and Alcoholism Center grant number AA06282 to the Prevention Research Center, Pacific Institute for Research and Evaluation, Berkeley, California.

Darryl Wood is an associate professor with the Justice Center. He is currently on a sabbatical appointment as a research scientist at the Prevention Research Center, Pacific Institute for Research and Evaluation, Berkeley, California.

Police patrol

(continued from page 1)

Examination of the distribution of observed shifts shows little difference between the sample of rides initially selected and those actually observed by the PASS research team. Moreover, the sample of observations collected for PASS closely approximates the ideal of one-third representation within each shift. Because APD deploys patrol units equally across all shifts, without an increase or decrease in the volume of patrol units according to time of day, it was important that the final sample be as evenly distributed as possible.

Just as APD maintains a constant deployment of patrol units by shift, it also maintains a constant patrol presence each day of the week. Therefore, each day of the week should have equal proportional representation in an ideal sample of cases; that is, each day should have 14.3 percent of all observations. As with time of day, examination of the distribution of observations across day of week suggests that the sampling design was successful in producing a representative sample in terms of the day of week observations took place (Table 2). There is no evidence that observations were overly concentrated on any particular day in comparison to all the rest. What differences were detected in the distribution failed to meet the threshold for statistical significance.

Finally, Table 3 displays information on the geographic distribution of the PASS sample. Preliminary evidence suggests that

the sample attrition experienced during the study was not evenly distributed across patrol districts. In particular, the Central patrol district is somewhat over-represented in the sample, and the North and South districts are under-represented. The percentage of PASS observations

which occurred in the East and West districts was not appreciably different from their overall presence within APD patrol. The consequence of this outcome is that to the extent that alcohol-related events are more likely to occur in the North and South districts, the sample may underestimate the impact of public alcohol consumption on Anchorage police patrol work. Conversely, if the Central district is more likely to produce alcohol-related events, then these data may exaggerate the impact of alcohol on patrol work in Anchorage.

To conclude, preliminary analysis of the temporal and spatial distribution of PASS observations suggests the sampling design was successful in producing a representative sample of patrol observations in Anchorage which was not unduly biased in terms of when or where they took place.

Table 3. Comparison of Distributions: APD Beat Districts versus PASS Designed Sample versus PASS Realized Sample

Patrol district	APD beat distribution		Designed sample distribution		Realized sample distribution	
	N	Percent	N	Percent	N	Percent
Central	4	18.2 %	16	21.1 %	17 *	26.2 %
North	3	13.6	10	13.2	4	6.2
East	5	22.7	18	23.7	17	26.2
South	5	22.7	15	19.7	11	16.9
West	5	22.7	17	22.4	16	24.6
Total	22		76		65	

* PASS observer was mistakenly assigned to ride with a Central District unit by a shift sergeant.

Basic Findings

Definitions

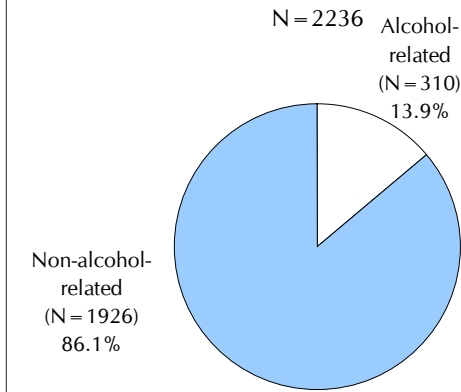
PASS observers coded alcohol involvement in *activities* any time an activity engaged in by the observed officer was linked to alcohol use by a member of the public in some way. Some examples of the most common alcohol-related activities observed during the study were:

- An officer completing paperwork for an alcohol-involved incident
- An officer en-route to an alcohol-involved incident
- An officer visiting a court or magistrate in connection with an alcohol-related incident

Please see Police patrol, page 10

Figure 1. Total Alcohol-Related Events Observed

Events include both activities and encounters.

**Police patrol***(continued from page 9)*

For *encounters*, PASS observers coded alcohol involvement if there was directly observable evidence that a person with whom the observed officer interacted in the encounter had been drinking:

- Member of public in possession of alcohol;
- Admission of alcohol use by member of public;
- Corroboration of alcohol use by third party;
- Detectable odor of alcohol emanated from member of the public (breath; clothing);
- Behavioral indicators (difficulty walking; slurred speech); and
- Objective measures of alcohol use (field sobriety test; breathalyzer).

If any of these indicators were present, PASS observers recorded the encounter as alcohol-related. (Observers did *not* record encounters in which alcohol may have been present but was incidental—such as in robbery from a cash register in a liquor store.)

Alcohol Involvement in Patrol Work: Percentage of Discrete Events

Roughly one of every seven events experienced by an APD patrol officer is connected to public alcohol consumption in some way. Figure 1 provides a visual depiction of the prevalence of alcohol involvement in police patrol in the Municipality of Anchorage. Of the 2,236 events observed for PASS, 310 (13.9%) were determined to be alcohol-related. How does this 13.9 percent break out across the two event dimensions of *activity* and *encounter*? Figures 2 and 3 answer this question.

When the totality of patrol *activities* was examined, those which were connected to

alcohol use by a member of the public in any way were found to comprise only a small minority. Of the 1,820 activities documented by PASS researchers, 11 percent ($n = 201$) were found to be alcohol-related. Alcohol involvement was more prevalent in police-citizen *encounters* than in *activities*, although alcohol-related encounters still represented a relatively small proportion of all *encounters*. Of the 416 police-citizen encounters observed over the course of the study, 26 percent ($n = 109$) were determined to be alcohol-related.

Alcohol Involvement in Patrol Work: Time Spent on Alcohol-related Events

In order to provide a more complete assessment of the impact of public alcohol use, PASS observers also documented officer time usage for every observation session. Observers were required to record the beginning and end time for every event (activities and encounters), for each shift. PASS researchers observed 65 10-hour shifts over the course of the study, for a total of approximately 650 hours (39,000 minutes). (This total is only a close approximation because some shifts ended early. At the time of writing a precise figure of time lost to early shift termination was not available.)

Preliminary time analyses were conducted across two dimensions. The first dimension examined was the total amount of time officers spent on alcohol-related activities as a percentage of *total observed shift time* (see Figures 4, 5 and 6). The second dimension examined was the amount of time APD patrol officers spent on alcohol-related activities as a percentage of *total event (activity v. encounter) time* (see Figures 7 and 8). PASS researchers observed more than 430 hours (25,996 minutes) of miscellaneous officer activity (all non-encounter events), and over 150 hours (9,119 minutes) of encounters between APD patrol officers and members of the public. (Because all of the

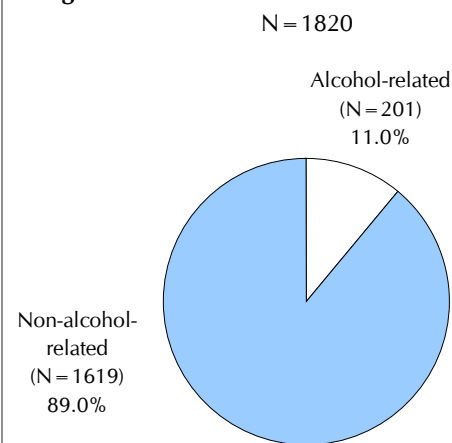
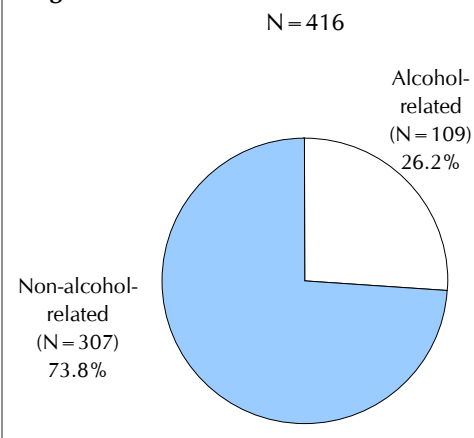
PASS data were not fully compiled at the time of this writing, the calculations presented in Figures 4, 5 and 6 are based on a denominator of 39,000 minutes, thereby making these alcohol-related percentages conservative estimates.)

There were a total of 310 alcohol-related events during the 28-day study period, constituting about 92 hours (5,547 minutes) of direct observation. These alcohol-related activities and encounters amounted to about one-seventh (14.2%) of the total time patrol officers were on shift.

Time Spent on Alcohol-related Activities

When only the amount of time officers dedicated to alcohol-related activities is viewed as a percentage of *total observed shift time*, the degree of alcohol involvement is significantly less than when both activities and encounters are combined. The percentage of alcohol-related involvement decreases from 14.2 percent (Figure 4) to 6.3 percent (Figure 5).

Even when alcohol-related activities are examined in the context of other activities, rather than all events, the total of time spent on them fails to reach 10 percent. Using only

Figure 2. Activities Observed: Alcohol-Related**Figure 3. Encounters Observed: Alcohol-Related**

total activity time as the percentage base, rather than total shift time, the percentage of alcohol involvement increases by about 3 points to 9.4 percent (see Figure 7).

Time Spent on Alcohol-related Encounters

APD patrol officers spent about 25 percent more time dealing with alcohol-related encounters (51.2 hours; 3,073 minutes) than they did attending to alcohol-related activi-

ties (40.8 hours; 2,448 minutes). Even so, this still represents less than 8 percent of all observed shift time during the study period (see Figure 6). But, when the focus is narrowed, the picture of alcohol involvement changes dramatically. Using only the *total time spent on encounters* as the percentage base, the amount of time spent on alcohol increases to just over 30 percent (see Figure 8). In concrete terms, this means that alco-

hol will be implicated in one of every three minutes patrol officers spend with the public.

Estimating the Costs of Public Alcohol Use

It was thought that PASS's detailed accounting of the time patrol officers spent performing alcohol-related duties might facilitate an estimate of the financial impact of such incidents on the Anchorage Police Department. As an example, since 14.2 percent of all patrol officer time is dedicated to alcohol-related events (see Figure 4), the simplest cost estimate to produce is to calculate 14.2 percent of all patrol expenditures. Combining PASS time-use data with current budget estimates provided by the APD produces an estimate of annual alcohol-related budget expenditures of approximately \$5.2 million. This figure is based on recent budget estimates provided by the Anchorage Police Department showing costs of \$91 per hour each to maintain 202 line-level patrol officers (excluding sergeants and lieutenants) on the street, and it includes in-service training, supervision, retirement, and support staff costs, as well as all capital expenditures (patrol cars, communication equipment, weaponry, and so on) to place an officer in the field. The estimate assumes an annual work year of 2,000 hours per employee.

Several caveats are in order concerning this esti-

mate. It may be useful to place this estimate in context to assess its significance. While \$5.2 million is certainly a large sum of money, it is less than 10 percent of the 2004 budget proposed by the Anchorage Police Department (available on-line at <http://www.muni.org/iceimages/OMB/21-Police.pdf>). Second, the estimate represents the costs *associated* with alcohol-related events, not caused by them. To assert police activity in response to an incident was the *result* of alcohol use, it would also be necessary to show that the event would not have occurred but for the use of alcohol by an involved party. For events which were solely attributable to alcohol use (for example, transport of an inebriate to shelter or a liquor law violation) this may be possible, but for most alcohol-related events to which police are summoned, it is simply not possible to say with certainty that the incident would not have occurred without the influence of alcohol. Third, not only is it rare to be able to conclude that police activity is the result of public alcohol use, it is virtually impossible in both theory and practice to isolate the costs attributable to alcohol, even if other contributory factors can be identified. Take, for instance, a call involving violence between intimates where one person was drunk, and the other high on cocaine. What costs could be attributed to alcohol? What about cocaine? Are costs also attributed to anger? Fourth and finally, it must be realized that the time and effort expended by patrol officers to handle alcohol-related cases cannot be translated into cost savings even if they were never to handle another alcohol-related call. The money would still be spent because the field deployment of officers is not reduced, even when demand wanes. A full complement of patrol officers is maintained 24 hours a day, 7 days a week, 52 weeks a year.

A related but somewhat different point is recognition of costs incurred by police that cannot be reduced to a dollar figure. The first might be termed a "value-rational" cost and it relates to the reduced opportunities for police to do other tasks. Because time is a zero-sum entity, time spent policing public alcohol consumption is lost to other priority activities. A second set of costs difficult to put a dollar figure on is the subjective human impact associated with handling alcohol-related events. Like everyone else, patrol officers are influenced by the experiences they encounter while on the job. Patrol officers' attitudes, perceptions, beliefs and values are shaped by, among other things, their experiences and interactions working the street.

Please see Police patrol, page 12

Figure 4. Total Time Spent on Alcohol-Related Events, as a Function of Total Shift Minutes

Events include both activities and encounters.

Alcohol-related events = 310
Total shift minutes = 39,000

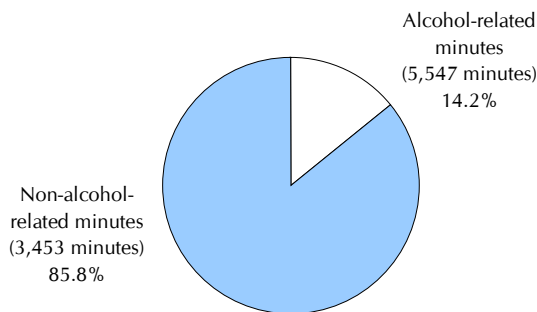


Figure 5. Total Time Spent on Alcohol-Related Activities, as a Function of Total Shift Minutes

Alcohol-related activities = 201
Total shift minutes = 39,000

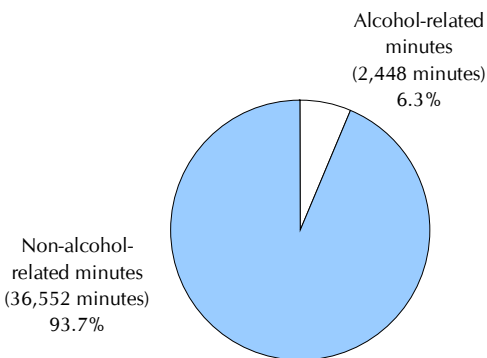


Figure 6. Total Time Spent on Alcohol-Related Encounters, as a Function of Total Shift Time

Alcohol-related encounters = 109
Total shift minutes = 39,000

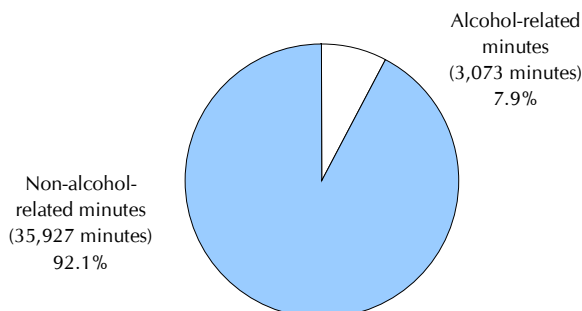


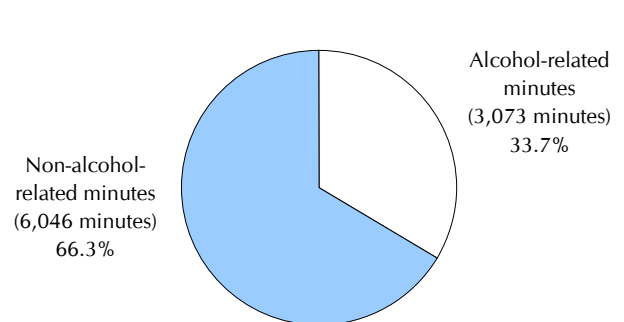
Figure 7. Total Time Spent on Alcohol-Related Activities, as a Function of Total Activity Time

Alcohol-related activities = 201
Total activity minutes = 25,996



Figure 8. Total Time Spent on Alcohol-Related Encounters, as a Function of Total Encounter Time

Alcohol-related encounters = 109
Total encounter minutes = 9,119



Police patrol

(continued from page 11)

Discussion

Data from the Police Alcohol-related Services Study (PASS) suggest that alcohol-related events constitute a relatively small proportion of what patrol officers do over the course of a typical shift. Alcohol was found to be involved in about 14 percent of all events, and approximately 14 percent of all shift time is dedicated to alcohol-related events.

Despite the low prevalence of alcohol involvement in patrol work within Anchorage, however, important time-allotment patterns emerge between police-citizen

encounters and other patrol officer activities. First, these data show that roughly one out of every four police-public encounters will be alcohol-related (see Figure 3). When applied to an average of 6 police-citizen encounters per officer per shift (416 encounters / 65 rides), an APD patrol officer will come into direct contact with a member of the public who has been drinking between one and two times *every shift*. Second, on average, one out of every three minutes officers spend with members of the public will be in the context of an alcohol-related incident (see Figure 8). PASS data show that patrol officers spend approximately 140 minutes per day in contact with members of the public (9,119 minutes / 65 rides), for a total of more than 45 minutes *per shift* in direct contact with

people who have been drinking. Thus, while the absolute prevalence of alcohol involvement in patrol work is quite low, it is certainly not inconsequential.

While they are difficult to estimate precisely, the costs—monetary, opportunity, social-psychological—in dealing with public alcohol consumption incurred by the Anchorage Police Department are substantial.

Future research by the author will examine the impact this degree of interaction with inebriated persons has on officers' attitudes, perceptions and behavior in contacts with members of the public.

Brad Myrstol is a research associate with the Justice Center.



Alaska Justice Forum
Justice Center
University of Alaska Anchorage
3211 Providence Drive
Anchorage, AK 99508

Return service requested

Non-Profit Organization
U.S. Postage
PAID
Anchorage, Alaska
Permit No. 107