TOO POWERFUL TO OVERCOME NARCOTICS ADDICTION: CALIFORNIA’S CIVIL ADDICT PROGRAM, 1961-1971

Nathan A Wilson
B.A., Central College, 2006

THESIS

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF ARTS

in

HISTORY

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

SUMMER 2009
TOO POWERFUL TO OVERCOME NARCOTICS ADDICTION: CALIFORNIA’S CIVIL ADDICT PROGRAM, 1961-1971

A Thesis

by

Nathan A Wilson

Approved by:

Dr. Rebecca Kluchin, Committee Chair

Dr. Chloe Burke, Second Reader

Date

5/19/09

iii
Student: Nathan A Wilson

I certify that this student has met the requirements for format contained in the University format manual, and that this thesis is suitable for shelving in the Library and credit is to be awarded for the thesis.

Dr. Mona Siegel, Graduate Coordinator

Department of History

May 18, 2009
Abstract

of

TOO POWERFUL TO OVERCOME NARCOTICS ADDICTION: CALIFORNIA’S CIVIL ADDICT PROGRAM, 1961-1971

by

Nathan A Wilson

California’s Civil Addict Program, a statewide compulsory civil commitment treatment program for narcotics addicts headed by the Department of Corrections, emerged within the context of new applied therapeutic perspectives in dealing with narcotics addiction at the state and local levels. Program officials promoted the Civil Addict Program as one of both treatment and control through rehabilitation at the California Rehabilitation Center (CRC) facilities, combined with intensive outpatient supervision in the community. Prior to this new era of the medical management of narcotics addiction, the federal government’s strict narcotics violations policies had set the tone for the increasing penalization of the narcotics addict since the 1914 Harrison Act. This thesis examines the treatment measures and prison-like atmosphere of the Civil Addict Program from its inception in 1961 until 1971. Numerous Department of Corrections archival documents, California legal statutes, and primary and secondary source journals and books have been utilized. This thesis finds that contrary to the program’s public face of treatment, the control exerted by Civil Addict Program officials, combined with the program’s bureaucratic organization under the auspices of California’s Department of Corrections, amounted to a very prison-like experience for most of the 18,000 addicts who cycled through the program in its first decade. Furthermore, the subjective medical authority given to program officials enhanced the Civil Addict Program’s punitive atmosphere beyond the traditional limits of California’s state prison system.

Committee Chair

Rebecca Kluchin

Date

5/21/07
ACKNOWLEDGMENTS

Foremost, I would like to thank my advisor Dr. Rebecca Kluchin for her expertise, her time and patience in meticulously working through several drafts of this thesis, and her enthusiasm for this study. I would also like to thank my parents, Greg and Susie Wilson, and my brothers, Adam and Benjamin Wilson, for their encouragement and support, my colleague and friend Nathan Hallam for our insightful discussions and necessary midtown adventures, and the staff at the California State Archives for their time and willingness to assist my research efforts. Without all their help and guidance, this thesis in its current form would not have been possible.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgments</th>
<th>vi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>2. THE CRIMINALIZATION AND TREATMENT OF NARCOTICS ADDICTS IN THE TWENTIETH CENTURY UNITED STATES</td>
<td>5</td>
</tr>
<tr>
<td>3. CALIFORNIA’S CIVIL ADDICT PROGRAM</td>
<td>27</td>
</tr>
<tr>
<td>4. A PRISON-LIKE EXPERIENCE FOR NARCOTICS ADDICTS</td>
<td>51</td>
</tr>
<tr>
<td>5. CONCLUSION</td>
<td>73</td>
</tr>
<tr>
<td>Bibliography</td>
<td>79</td>
</tr>
</tbody>
</table>
Chapter 1

INTRODUCTION

Written records dating as far back as 4,000 to 5,000 B.C.E. reveal humankind’s use of
opium for a wide range of purposes, including, but not limited to, pain relief and
treatment of physical ailments, spiritual rituals and mystical experiences, and simple
enjoyment and relaxation.1 While today public perception provides sharp distinctions
between illegal narcotics and pharmaceuticals prescribed by medical authorities, this
awareness is conspicuously modern.2 As recently as the early twentieth century in the
United States, an unregulated narcotics marketplace distorted the tenuous divisions
between the criminal addict and the legitimate medical drug user and between illicit
narcotics and medicines prescribed by physicians.

By the 1930s, the development of new anesthetics and non-addictive pain killers, the
professionalization of organized medicine, and the introduction of federal narcotics
violations penalties created an entrenched class of criminalized narcotics addicts whom
physicians were wary of treating. Within this context, two Public Health Service (PHS)
federal narcotics hospitals comprised nearly the only viable sources of narcotics addiction
treatment and research in the United States until their demise in the early 1950s. After
two decades of treatment, the hospital staff, Bureau of Prisons (BOP) officials, and

---

1 Citizen’s Advisory Committee to the Attorney General on Crime Prevention, Narcotic Addiction: Report
Prohibition,” Southern Cultures (Fall 2006), 56.
federal lawmakers seemed to develop a general consensus of the incorrigibility of treating narcotics addicts due to poor treatment results.\(^3\)

By the mid-1950s, however, powerful groups such as the New York Academy of Medicine (NYAM), and the American Medical Association (AMA) and American Bar Association (ABA) Joint Committee on Narcotic Drugs challenged the legitimacy of federal control over narcotics addiction problems, and opened a new era of state and local community involvement in drug treatment. Medical physicians, psychotherapists, sociologists, and former addicts began contributing to narcotics addiction research and treatment. Clinics opened throughout the United States utilizing these therapeutic perspectives.

When Governor Edmund G. Brown took office in 1959, California faced severe narcotics addiction and illegal trafficking problems rivaled by no other state except New York. Its location next to the Pacific Ocean and its border with Mexico made it particularly susceptible to large-scale illegal narcotics trafficking. The extent of these problems had reached unprecedented levels, and garnered criticisms from federal and state politicians and law enforcement agencies.\(^4\) In 1961, in an effort to tackle these problems, the Brown administration instituted both stiff narcotics violation penalties and a statewide compulsory civil commitment treatment program for narcotics addicts called the Civil Addict Program.

---


California’s Civil Addict Program emerged within the context of new therapeutic perspectives in dealing with narcotics addicts, and was the first true statewide involuntary civil commitment program for narcotics addicts in the history of the United States. At the time, thirty-four states had legal statutes authorizing the involuntary commitment of narcotics addicts, though these were very rarely used. Many of these laws required relatives to report addicts, which most were reluctant to do. Furthermore, these states did not provide specialized treatment facilities, and so the few addicts committed under the law usually spent small amounts of time at mental hospitals before being discharged by the administrators.  

When Governor Brown signed the Civil Addict Program legislation into law in 1961, it placed the program under the authority of the Department of Corrections and provided funding for its treatment facility called the California Rehabilitation Center (CRC). The program accepted voluntary applicants and state inmates deemed narcotics addicts by a court of law in lieu of criminal sentencing. The Civil Addict Program served as a mechanism for the treatment and control of narcotics addicts by confining them from six months to ten years in CRC, with subsequent parole supervision and surprise chemical anti-narcotic testing upon release for a minimum period of three years.

Civil Addict Program visionaries presented it as a program of both treatment and control for narcotics addicts headed by the Department of Corrections. They envisioned a program where addicts received therapeutic treatment, obtained release into the

---


6 Ch. 11, Title 7 of Part 3, California Penal Code (1961).
community under supervision, and earned eventual discharge. This vision, however, proved false for the majority of program residents between 1961 and 1971, who instead encountered a very prison-like experience. Furthermore, the history of the Civil Addict Program in its first decade reveals the struggle and collaboration between medical and penal authorities in dealing with narcotics addiction, and the corresponding limits of control these authorities held over the narcotics addict.
Chapter 2

THE CRIMINALIZATION AND TREATMENT OF NARCOTICS ADDICTS IN THE TWENTIETH CENTURY UNITED STATES

On a chilly February night in 1960, Lawrence Robinson sat next to his girlfriend in the backseat of an automobile driving the streets of Los Angeles. Suddenly the red flicker of cherry lights penetrated through the dark night and into the car. Two police officers in a squad car followed close behind and pulled the vehicle to the side of the road for no apparent reason. During the proceeding four months, the officers changed their reasoning for this pullover multiple times. First, they said the vehicle had no rear license plate. Then they said the vehicle was driving too slowly. Finally, they claimed the occupants were driving through a notorious purse-snatching area. After making the driver get out of the car, the officers searched him for incriminating evidence, and found no illegal materials or drugs. Yet upon close inspection using a flashlight, the officers found a single scar tissue blemish on the driver’s exposed forearms. They placed him under arrest for being a narcotics addict.

Next, the officers forced the remaining passengers out of the car and into the street, and began searching the automobile’s interior. Finding nothing, they proceeded to search Robinson and the two women. Though Robinson had no narcotics or paraphernalia on his person, the persistent officers soon found the evidence necessary for his arrest: the marks on his own body. After making Robinson roll up his jacket sleeves, they discovered discolored, flaky patches of dead skin and needle scar tissue on his forearms. According to California law, this provided the grounds to arrest Robinson as a criminal for being a narcotics addict. The officers placed him inside the squad car and swiftly
took him to jail. The judge subsequently found Robinson guilty of narcotics addiction and sentenced him to a ninety day jail sentence and two years parole with anti-narcotic testing.

Robinson appealed the case, claiming violation of his Eighth and Fourteenth Constitutional Amendment rights. The Eight Amendment, ratified in 1791, prohibits the federal government from imposing excessive bail, fines, and cruel and unusual punishments for crimes. The Fourteenth Amendment, ratified in 1868, requires states to provide equal protection under the law for all citizens under its jurisdiction. Robinson claimed his punishment for having the status of being a narcotics addict consisted of cruel and unusual punishment, similar to penalizing an individual for contracting or carrying an illness. The case eventually made it to the United States Supreme Court in 1962 as Robinson v. California. The court ruled in Robinson’s favor, after finding the criminalization of narcotics addiction to be cruel and unusual punishment. In doing so, it framed this addiction as illness. Yet this verdict did not lead to freedom for Robinson and the over 18,000 individuals officially classified as narcotics addicts in California between 1961 and 1971. Instead, it transferred the jurisdiction over narcotics addicts to medical physicians and penal authorities under health and welfare laws, as opposed to criminal law, thereby ultimately strengthening California’s newly developed Civil Addict Program headed by the Department of Corrections.

8 Roland W. Wood, 18,000 Addicts Later- A Look at California's Civil Addict Program, December 1972, Department of Corrections Records, F3717:364, California State Archives.
California’s Civil Addict Program began in 1961 in a new era of medical management and therapeutic treatment for narcotics addiction at the state and local levels. Prior to this, the federal government exercised near total control over the use, sale, distribution, and trafficking of narcotics, along with the treatment of narcotics addiction, beginning with the 1914 Harrison Act and ending with the 1956 Narcotic Control Act. By the time the Civil Addict Program began, policymakers considered new approaches to dealing with narcotics problems. The Civil Addict Program appeared on the surface to be part of this new approach.

The Widespread Use and Availability of Narcotics at the Turn of the 20th Century in the United States

The widespread availability of narcotics in the United States at the turn of the twentieth century directly corresponded to an unregulated narcotics marketplace, in which opium dens and underground drug markets flourished, as well as overmedication stemming from medical practice. Opium, morphine, heroin, and cocaine were all available at low cost on the streets, through prescriptions, and over the counter. Physicians and druggists alike faced no restrictions in filling and prescribing narcotics to patients, and did so quite liberally. When physicians first began using cocaine in medical practice in 1884, many of them touted it as a wonder cure for alcoholism and morphine addiction, as well as for a number of other medical uses.9 Perhaps most well-known among these physicians is Sigmund Freud. In 1889, Dr. W.H. Bently of Valley Oak,

Kentucky, stated that he had prescribed over twenty-five pounds of cocaine in two years for medical purposes. After the synthesis of heroin in 1898, physicians began using it for medical purposes, including as treatment for morphine addiction.

Aside from easily available prescriptions, patients could also purchase elixirs over the counter with morphine contents as high as thirty to forty percent. These medicines contained no listing of ingredients on the labels, and were advertised as cure-alls for everything from general pain and anxiety to allergies. Powdered cocaine was packaged and advertised as a cure for hay fever. Mrs. Winslow’s Soothing Syrup, a popular medicine for teething infants, contained both alcohol and morphine. The labels contained no ingredients to reduce the chance of imitations, and many individuals suffered unintentional addiction from routine use of the powerful medications as a result.

Despite the large-scale abuse of narcotics at the turn of the twentieth century stemming from prescriptions and over the counter purchases, opiates did, in fact, have very credible uses. Civil War hospitals used opiates in treating injured soldiers, due to its incredible power in reducing pain and inducing calmness. However, many veterans suffered iatrogenic addiction—addiction originating from medical practice—as a result of its liberal use at the hospitals. Opiates also offered a cure for symptoms associated with

---

12 Ibid.
everything from cholera to anxiety. The alleviating power of opiates explains its place in the history of human medication dating back to 4,000 B.C.E. 15

The actions of physicians and druggists, the easy availability of powerful over the counter medications, the absence of regulations on narcotics, and the invention of the hypodermic syringe in 1853 contributed to an environment of widespread narcotics addiction in the United States by 1900. By this time, the United States imported 628,177 pounds of opiates, triple the amount from 1870.16 Surveys from 1878 to 1924 estimate between 250,000 to 500,000 Americans were addicts at the beginning of the twentieth century.17

These studies that generated this estimate reveal a narcotics addict demographic that was disproportionately white, middle class, and female, with addiction stemming predominately from medical practice.18 Females were particularly vulnerable to narcotics addiction stemming from medical purposes because physicians tended to over-prescribe morphine for a broad range of women’s health issues due to “little understanding of women’s health.”19

Race and class prejudices, however, played a large role in stigmatizing narcotics addiction, resulting in the myth of non-white urban lower class males comprising the major narcotics addict demographic. Authorities often used this assumption as a means

16 Bonnie, "The Forbidden Fruit," 984.
17 These numbers were arrived at through an average of multiple studies derived from State Boards of Health, physician and druggist surveys, the United States Public Health Service, and the Narcotic Division of the Prohibition Unit of the Internal Revenue Service. Ibid.
18 Ibid., 982-983.
to maintain existing hierarchical structure and privilege. In the early 1900s in the South, especially in Atlanta and New Orleans, police warned of the dangers of urban blacks high on cocaine, blaming them for everything from “rape to urban riots.” The prohibition of marijuana in the 1930s targeted Southwestern migrant workers from Mexico. As early as the 1870s, San Francisco enacted laws banning the smoking of opium in opium dens, though doing so in large part to prevent the mixing of white and Chinese races.

Two Images of the Narcotics Addict

Two conceptual images of the narcotics addict developed in the United States by 1900. First, the image of the unsuspecting addict hooked inadvertently through legitimate medical purposes. These addicts were often white, middle class, and female. Second, the image of the pleasure-seeking addict hooked though vice. These addicts were often lower class, non-white, urban, and male. Despite surveys at the time that revealed a narcotics addict population disproportionately leaning towards the former, the latter became the dominant image. This popular perception became dominant because it focused on the most visible forms of addiction in society and maintained race and class hierarchies.

These two conceptual images of the narcotics addict gave rise to divergent measures in dealing with them depending upon social status. The white middle class individual addicted to narcotics through medical means fit the medical community’s model of disease, and thus deserved and received medical treatment. The non-white lower class

20 Ibid., 57.
21 Ibid., 56-57.
individual addicted through vice fit the criminal justice system's model of criminality, and thus deserved and received punishment. Many factors, such as "employment, status, race, gender, and class," determined which response an addict would receive for their condition. The privilege of treatment varied according to these "vacillating cultural perceptions."

The recognition that a large percentage of narcotics addiction in the United States stemmed from medical practice and unlabeled medicines sold over the counter gave temperance and progressive reformers the initiative to get involved with efforts to solve the problem of narcotics addiction through federal regulations and increased treatment efforts. Thus, narcotics addiction became associated with a myriad of social reforms targeting urban vice in the Progressive Era. In this sense, it also became increasingly framed as a moral-legal issue.

Two developments in the early 1900s led to increased stigmatization of narcotics addicts, and ultimately to criminalization. First, the development of new anesthetics and non-addictive pain killers reduced the possibility of patient iatrogenic addiction. Second, the 1906 Pure Food and Drug Act required the labeling of narcotic content in medicines, thus alerting the consumer to addictive substances contained therein. This latter development marked the initial move by the federal government to reduce narcotics addiction caused by medical practice and medicine. It also allowed reformers to

---

25 White, *Slaying the Dragon*, 111.
28 Ibid.
distinguish between those addicted through legitimate medical purposes or through personal vice.

For those addicted to narcotics through legitimate medical purposes, private treatment options existed, though typically they were only affordable to the affluent. The course of treatment frequently took place in inebriate asylums, and focused primarily on physical symptoms of withdrawal, lacking emphasis upon the psychological aspects of addiction. Staff at the asylums facilitated withdrawal by either forcing the addict to go "cold turkey," gradually stepping down narcotic dosage quickly (usually within a week), or within a period of several weeks to months. 29 Physicians generally discouraged "cold turkey" withdrawal because of the risk of health complications, and possibly even death, of patients with high-level tolerances. The majority of individuals who achieved withdrawal quickly usually became re-addicted after release. In fact, physicians found the best odds for long-lasting treatment in extended withdrawal periods. During withdrawal, patients regularly received varying tonics and stimulants—including codeine, quinine, caffeine and whiskey, among others— to help revitalize their bodies. Oftentimes these mixtures were purely experimental, and either useless or potentially harmful. Those unable to afford such private treatments could purchase tonics and medicines from the druggist. However, these unregulated substances could often be more harmful than beneficial in curing narcotics addiction. 30

Federal Crackdown on Narcotics Addiction and the Struggle over Treatment

29 White, *Slaying the Dragon*, 111.
30 Ibid., 111-112.
Those addicted to narcotics through street use and illegitimate prescriptions, along with complicit physicians, faced punishment by federal authorities beginning with the 1914 Harrison Act. The Harrison Act implemented a federal tax and mandatory registration on the import, distribution, sale, possession, and manufacture of “opium or coca leaves, their salts, derivatives, or preparations.” In essence, this amounted to a regulatory, not a prohibitory, measure. It required physicians to register, pay a tax, and keep records of all dispensed narcotic drugs for access by the federal government. In theory, the Harrison Act appeared harmless to the physician’s role in treating addicts through maintaining them on regular medicinal doses or gradually helping them withdrawal. It directly stated that distribution of opium derivatives and cocaine did not apply “to the dispensing or distribution of any of the aforesaid drugs to a patient by a physician, dentist, or veterinary surgeon registered under this Act in the course of his professional practice.”

But in reality, the Harrison Act criminalized both narcotics addicts and the physicians complicit in supplying or treating them. This occurred because of the ambiguous language contained therein, specifically “in the course of his professional practice.” Federal authorities had the freedom to interpret the meaning of this phrase, which they ultimately agreed meant that supplying any amount of narcotics to a perceived addict was illegal, regardless of the circumstance. The first step towards criminalizing narcotics addiction came when Department of Treasury officials, in charge of enforcing the regulatory Harrison Act, decided that opiates prescribed to addicts must be given at

32 Ibid., sec. 2a.
33 Ibid.
“progressively decreasing doses” to achieve complete abstinence. These officials both disapproved of ambulatory treatment—providing narcotics at an outpatient level in the attempt to gradually reduce the addict’s narcotics dependence or safely maintain this dependence—for fear it would lead to sustained narcotic maintenance, and misunderstood the high relapse rate for opiate addicts undergoing treatment. Unfortunately, this misunderstanding occurred in large part because the treatment success rates by asylum physicians were greatly exaggerated, even as high as ninety-five percent. The final steps toward criminalizing addicts and treating physicians came through successive Supreme Court decisions upholding the Harrison Act between 1919 and 1922. In 1922, United States v. Behrman ruled that that any physician distributing narcotics to an addict patient violated the Harrison Act. As a result, the Harrison Act evolved from a regulatory to a prohibitory act. With this, ambulatory and narcotic maintenance treatment became criminalized for the first time in the United States. Though the history of drug laws in the United States dates prior to the nineteenth century, the Harrison Act is the first federal law criminalizing narcotics possession.

Once enforcement of the Harrison Act began, the fine line between an addict patient and non-addict made many physicians wary of supplying narcotics at all to patients, especially as part of an effort to either cure or maintain a patient’s addiction. This fear was justified. Department of Treasury officials routinely used addicts—often under threat of arrest or in exchange for narcotics—as informants to trap and expose physicians

35 White, Slaying the Dragon, 113-14.
in violation of the Harrison Act. By 1938, over 25,000 physicians had been indicted under the Act.37

The 1914 Harrison Act, followed by subsequent Supreme Court rulings that criminalized narcotic maintenance, marks the beginning of what historian David Courtwright calls an era of narcotics control lasting until 1964, when a surge of methadone maintenance clinics opened throughout the country and offered a new treatment model.38 During this era, federal lawmakers passed legislation that increasingly stiffened penalties for narcotics violators and greatly reduced the medical physician’s role in treating narcotics addicts.

The enforcement of the Harrison Act immediately severed countless addicts’ sources to narcotics. Just after the Act’s passage, many addicts believed they could apply for Department of Treasury “registration permits,” or at least continue receiving prescriptions from their physician, but to no avail.39 Instead, addicts undergoing serious withdrawal either attempted to find physicians and druggists willing to risk supplying and treating them, or learned to purchase narcotics through illegal channels, which caused drug prices to soar. The outcome of criminalization resulted in large numbers of narcotics addicts throughout the United States who faced grueling or even life-threatening withdrawal, or found narcotics any way possible. This was especially true in

37 White, Slaying the Dragon, 113-14.
38 Methadone is a synthetic long-lasting narcotic used to suppress heroin withdrawal. When properly regulated, it is supposed to eliminate the high produced by heroin, while enabling the addict to maintain functional control. Allied troops discovered the substance, originally called Dolophine, in 1946 in a German laboratory after VE Day. David T. Courtwright, “Introduction: The Classic Era of Narcotic Control,” in Addicts Who Survived: An Oral History of Narcotic Use in America, 1923-1965, ed. id., Herman Joseph and Don Des Jarlais (Knoxville: University of Tennessee Press, 1989), 1-44.
39 White, Slaying the Dragon, 112-113.
urban areas due to the large populations, the high numbers of physicians, and the illegal drug markets.

In the aftermath of the Harrison Act, local physicians and city officials in urban areas opened up narcotic clinics in an effort to deal with the large numbers of narcotics addicts facing withdrawal. Not only did these clinics provide treatment, but they also helped to relieve fear amongst communities of impending addiction-related crime. The majority of these morphine clinics operated in metropolitan areas in the Northeastern and Southern states. Some of these clinics provided gradually decreasing doses, while others maintained addicts at regular levels. By 1921, however, Treasury Department officials threatened to arrest those operating narcotics clinics, and most shut down immediately. In 1925, the last of over forty clinics nationwide shut down in Knoxville, Tennessee. 40

The arrest of narcotics addicts under the Harrison Act resulted in a dramatic increase in addict inmates in federal prison by 1929, arousing concern among prison officials about a need for specialized treatment. Statistics show that while only sixty-three perceived addicts entered federal prison in 1915, that number rose to 1,889 by 1929. Prison officials complained they often had trouble with these addict inmates. Even the superintendent of the federal prison system advocated separate specialized treatment for incarcerated addicts. 41

**The Public Health Service Federal Narcotics Hospitals**

In 1929, federal lawmakers responded to the call for specialized narcotics addiction treatment by passing the Porter Act, which mandated the creation of two federal narcotics

---

40 Ibid., 114-15.
41 Ibid., 122-23.
treatment hospitals headed jointly by the Public Health Service (PHS) and the Bureau of Prisons (BOP). Staffed by medical physicians and psychotherapists, these hospitals accepted both federal inmates and voluntary applicants. These remained nearly the only viable sources of narcotics addiction research and treatment in the United States until the implementation of state and community drug treatment programs beginning in the early 1950s. The first such hospital opened in Lexington, Kentucky in 1935, and the second in Fort Worth, Texas in 1938. Lexington received patients from east of the Mississippi River, while Fort Worth accepted patients west of the river. Both institutions sat on 1,000+ acres of land containing dairy and agricultural farms and various labor shops and recreational facilities, and could easily hold over 1,000 patients.42 The highly visible security gates and barred windows of the Lexington facility closely resembled a prison in appearance. Both hospitals continued treatment and research efforts until ultimately they were transformed into federal prisons by the mid-1970s.

Treatment carried out at the PHS federal narcotics hospitals consisted of withdrawal, followed by rehabilitation using psychotherapeutic techniques. Patients transferred from federal prisons had to complete one year in the program, though the majority usually served longer. Voluntary patients could sign out at any time, and nearly seventy percent did so against staff advice.43 Withdrawal, the most difficult stage for addicts, usually lasted up to a week. In 1948, hospital staff implemented the use of methadone in this stage for those addicted to heroin and morphine. During withdrawal, the addict’s body

42 White, Slaying the Dragon, 123.
became sick from the absence of narcotics in its system, and the patient experienced cold
sweats, tingling flesh, chills, fever, trembling, and severe physical and mental agitation.
These symptoms varied according to the amount of the addict’s drug use habit. To help
ease the pain of withdrawal and promote quicker recovery, staff often gave patients hot
baths during the day and sleeping aids at night. Once the addict’s body readjusted to the
absence of narcotics in its system, rehabilitation took place in the hospital. Rehabilitation
entailed labor on the hospital grounds, recreational and group activities, and some
therapy.44 Patients spent a large part of their day working in the farms, woodworking
shop, garment shop, print shop, or the laundry.

Research comprised a large part of the Lexington program, and contributed
simultaneously to new scientific developments in the field of narcotics addiction studies,
as well as to the notion of narcotics addiction as ultimately incurable. In 1948, the
Addiction Research Center (ARC) officially opened at Lexington under the auspices of
the National Institute of Mental Health (NIMH), with its main objective to study “why
individuals varied in the propensity to addiction and relapse.”45 Its staff included
chemists, biophysicists, medical officers, psychologists and psychiatrists. They
performed various independent experiments on addicted patients using narcotics—both
street drugs and pharmaceuticals—ranging from the objective effects of different types of
drugs to the addictive qualities of new pharmaceutical medicines. In order to find
suitable subjects for experimentation, ARC staff intensely scrutinized patients to discover
the frequency and types of drugs used, along with their personality characteristics. Those

---

45 Campbell, *Discovering Addiction*, 57.
fitting the profile of an authentic narcotics addict remained eligible for testing. However, this process also facilitated the image of “incurable junkies” by the deliberate selection of certain individuals over others to study why addicts are so prone to relapse.\textsuperscript{46} Hence, those qualified as suitable for testing appeared to have reached a level of addiction others had not. This ultimately became viewed as a mark of distinction among patients in the hospital, and contributed to the idea of the incorrigibility of narcotics addicts.\textsuperscript{47}

The ideology behind the PHS federal narcotics hospitals, in fact, seemed to be that addicts—even former addicts—were “considered always already ill.”\textsuperscript{48} Even treatment and rehabilitation could not remove this notion and label of sickness. Lexington’s first medical director, Dr. Lawrence Kolb, exemplified this ideology by creating a five-tiered classification system for narcotics addicts entering the hospital. Classes I through V included the following, respectively: mentally healthy persons addicted through legitimate physician prescriptions, hedonistic persons seeking pleasure, psychoneurotics, habitual psychopathic criminals, and those with addictive tendencies who were unable to regulate use.\textsuperscript{49} This system of classification starkly differentiated every category of sick addict from the healthy physicians and research staff at the hospitals. Social class also further delineated this distinction, in that staff comprised mostly white, educated middle-class individuals treating mostly the poor and working classes.\textsuperscript{50} Dismal treatment results reinforced this distinction.

\textsuperscript{46} Ibid., 68-69. 
\textsuperscript{47} Ibid; Acker, \textit{Creating the American Junkie}, 182. 
\textsuperscript{48} Campbell, \textit{Discovering Addiction}, 71. 
\textsuperscript{49} White, \textit{Slaying the Dragon}, 124. 
\textsuperscript{50} Campbell, \textit{Discovering Addiction}, 68-69.
Despite any genuine treatment efforts at the PHS federal narcotics hospitals, studies showed its results to be largely ineffective, leading to consensus among hospital staff and prison authorities of the intractability of treating narcotics addicts. Multiple studies found ninety to ninety-six percent of discharged addicts became re-addicted, the majority within six months of leaving the facilities. A former Fort Worth Chief Medical Officer declared, “In widespread professional and public opinion, the hospitals came to be considered failures; measured by a criterion of enduring cure of most patients, they failed.” As a result, a general consensus seemed to develop among the PHS medical community, the BOP, and lawmakers of the incorrigibility of treating narcotics addicts. By the early 1950s, this contributed to the demise of the PHS federal narcotics hospitals and a resurgence in stiff narcotics violations penalties.

**Increased Narcotics Violations Penalties and Backlash from Medical and Legal Authorities**

By the 1950s, federal authorities expressed troubling concern over a dramatic increase in narcotics arrests, coupled with a rising demographic of younger narcotics users in the United States. A 1951 study by the Special Senate Committee to Investigate Organized Crime in Interstate Commerce, otherwise known as the Kefauver Committee, revealed a sharp increase in addiction patterns and narcotics arrests in the United States between 1947 and 1951. Most importantly, these statistics involved a large number of individuals under twenty-one years old. Major newspapers also publicized this alarming

---

51 White, *Slaying the Dragon*, 125.
52 Ibid.
trend. For example, in June 1951, the *New York Times* released an article quoting Federal Bureau of Narcotics commissioner Henry Anslinger stating “the present wave of juvenile addiction struck us with hurricane force in 1948 and 1949.”\(^{55}\) Two weeks later, the *Washington Evening Star* reported that that 1 out every 87 to 174 New York City residents were using illicit narcotics. This hysteria demanded a call for action, and one the overpopulated PHS federal narcotic hospitals could not meet.\(^{56}\)

Louisiana Representative Hale Boggs, armed with prison and arrests statistical data and media savvy, emerged as a major proponent of greatly increased narcotic penalties and mandatory minimum sentencing. Testifying before the Kefauver Committee Hearings in 1951, he reported narcotics violation arrests had risen twenty-four percent between 1949 and 1950, and seventy-seven percent between 1948 and 1950. Furthermore, he noted a trend in younger narcotic addicts committed to the PHS federal narcotics hospitals. In the first half of 1956, the average age of committed resident to Lexington was thirty-seven and a half year old, whereas by the first half of 1950 it decreased to just under twenty-seven years old.\(^{57}\) These hospitals also faced severe overcrowding. Rather than examine the contribution increased narcotics penalties may have had in the problem, Boggs believed that stiffer penalties were the solution. He was convinced that enforcement of stiff narcotics violations penalties had reduced crime in many communities, and believed that communities still plagued by crime were the result of a lack of federal penalty enforcement.\(^{58}\)

\(^{55}\) Ibid, 1064-1065.  
\(^{56}\) Ibid.  
\(^{57}\) Ibid.  
\(^{58}\) Ibid., 1066.
Not only did Boggs make his objectives known to fellow politicians, but he also broadcasted directly to the citizens. In mid-1951, he organized a far-reaching media campaign through major news outlets. Between May and June, he released nearly a dozen articles in both national and prominent publications, including *Time* magazine and the *Washington Evening Star*. These articles contained inflated statistics of narcotics addiction in the United States, statements on the ease with which children could obtain narcotics, interviews with concerned school and political officials, and horrifying testimony by drug addicts on withdrawal, prostitution, and lost opportunities.\(^5^9\)

In late 1951, Boggs and a majority of Congress members passed the Boggs Act, which implemented the strictest punishment to date for buying, selling, receiving, and concealing illegal narcotics in federal drug trafficking cases, and was also the first minimum mandatory drug sentencing law in the United States.\(^6^0\) Prior to the Act, narcotics violations carried no minimum penalty, and a maximum penalty of five year sentences.\(^6^1\) With the Boggs Act, any of the aforementioned activities carried a maximum $2,000 fine and two to five years prison time for first offense, five to ten years for second offense, and ten to twenty years for third offense. The Act also introduced mandatory minimum sentencing upon second and ensuing offenses, thereby eliminating judicial discretion in suspending sentences and giving early parole, decisions that Boggs considered part of the narcotics problem.\(^6^2\) The relatively small fine in comparison to

---

\(^5^9\) Ibid., 1065-1066.
\(^6^2\) Bonnie, "The Forbidden Fruit," 1068.
prison time indicated legislators' priority in solving this problem primarily through incarceration.\textsuperscript{63}

The precedent set by lawmakers in increasing penalties to root out what they perceived to be a narcotics menace, especially in the aftermath of disappointing treatment results at the PHS federal narcotics hospitals, inevitably led to even stiffer measures enacted to law. In 1956, Congress passed the Narcotic Control Act, which, though retaining the same penalties for narcotics users as under the Boggs Act, greatly increased prison time and fines for narcotics dealers.\textsuperscript{64} As a result, those convicted for the first time selling narcotics to an adult received a minimum five years in prison and maximum twenty years. Subsequent offenders received a minimum of ten years and maximum of forty years in prison. An adult convicted of selling narcotics to anyone under eighteen years old faced ten years to life in prison and the possibility of the death penalty. Fines also increased to a maximum of $20,000 for all convicted sellers, and judges could not suspend prison sentences or give probation.\textsuperscript{65} In addition, the Act enabled drug agents to arrest suspected drug violators without warrants.

Congressional motivation behind the 1956 Narcotic Control Act resided in the belief that stiff punishment under the Boggs Act worked, and that United States' borders faced an onslaught of illegal narcotics trafficking that could only be remedied through increased penalties against dealers. The House Committee report stated that narcotics violations arrests had decreased from 1952 (in which no statistics were given), to 19,489

\textsuperscript{63} Ibid., 1067.
\textsuperscript{64} Rowe, \textit{Federal Narcotics Laws}, 34.
\textsuperscript{65} Ibid.
in 1954, while arrests in 1953 numbered 23,627. The Senate reported “increased flow of drugs into the United States” through its borders. However, actual narcotics smuggling statistics revealed fluctuating patterns just as easily attributable to changes in enforcement personnel and search and seizure policies as to changes in narcotics supply and demand. Ultimately, though, both arguments pushed for increased penalties: one to improve success of existing narcotics laws, the other to reduce danger of illegal trafficking and associated crime.

A New Era of Narcotics Addiction Treatment

The precedents set by the 1951 Boggs Act and the 1956 Narcotic Control Act created mounting frustration within a growing consensus of the medical community. Powerful groups, such as the New York Academy of Medicine (NYAM) and the American Medical Association (AMA), began to release public statements criticizing law enforcement’s handling of narcotics addicts and the inability of physicians to intervene without risking legal consequences. The NYAM’s 1955 “Report on Drug Addiction” stated the present “punitive approach” to handling narcotics addicts might not be the most effective measure in reducing addiction and related problems. It also blamed current federal regulations in making the physician a “potential criminal” when attempting to treat narcotics addicts. These sentiments echoed throughout the country. Physicians demanded more independence in the research and treatment of drug addiction at the expense of an all-too-powerful criminal justice system.

66 Ibid., 35.
67 Ibid., 35-36.
68 Ibid., 35.
In 1955, the AMA and the American Bar Association (ABA) established the Joint Committee on Narcotic Drugs as a collaborative effort to offer new solutions to an apparently escalating narcotics addiction problem in the United States. Its final report, published in 1959, arrived at many of the conclusions medical authorities and public health groups had proposed in the past few years. The report pointed to an increase in illegal narcotics usage in the United States after World War II, just as Congressional figures had done in promoting the Boggs Act. However, it claimed the resulting authority these laws gave to law enforcement not only failed to present a comprehensive solution to the narcotics problem, but also occurred at the expense of medical and public health officials. This imbalance of power created a situation where penalties remained the only solution. Penalties, however, neither addressed the addicts' physical and psychological dependence upon narcotics, nor worked towards a cure or rehabilitation. Furthermore, the report acknowledged the high relapse rates among those treated at the PHS federal narcotics hospitals, and recommended that the medical community en masse receive much greater freedom in the research and treatment of narcotics addiction. Up to this point, any physician outside of the overburdened PHS federal narcotics hospitals attempting to treat narcotics addicts faced ever-present criminal sanctions.\textsuperscript{70} As a solution, the Joint Committee recommended the authority over handling narcotics addicts be transferred from the criminal justice system to the medical community.

The recommendations of the Joint Committee, combined with increasing narcotics problems in the U.S. despite a history of tough federal narcotics violations policies, signaled the demise of the era of intense federal control over narcotics, and indicated a new era of state and local community involvement in drug treatment programs. Medical physicians, psychotherapists, sociologists, and former addicts began contributing to narcotics addiction research and treatment. Clinics opened throughout the United States utilizing both medical and therapeutic perspectives.

California's Civil Addict Program emerged within this context of new treatment efforts. It was the first compulsory narcotics addict civil commitment program of its size in the United States. Program visionaries presented their program as one of both treatment and control for narcotics addicts under the auspices of the Department of Corrections. They foresaw a program providing medical and therapeutic treatment to narcotics addicts, release back into the community under supervision, and eventual discharge. The majority of residents who remained incarcerated in the program between the years 1961 and 1971, however, experienced something quite different. In the case of Robinson, arrested in 1961 in Los Angeles under suspicion of being a narcotics addict, his Supreme Court trial would ultimately reveal both the Civil Addict Program's prison-like qualities, and empower the program through medical rationale, despite any real subsequent change in this direction.

---

CALIFORNIA’S CIVIL ADDICT PROGRAM

The history of criminalization and treatment surrounding narcotics addiction in California beginning in the late nineteenth century reads like an escalated version of what occurred throughout the rest of the country. In particular, opium from China filtered through the San Francisco port at unprecedented rates from the Gold Rush era until 1909, when importation of non-medical opium in the United States became prohibited through the Opium Exclusion Act.

Even before then, California was among the first states to enact opium restrictions. In 1875, San Francisco introduced the first municipal law in the nation banning the smoking of the drug in opium dens. This law, however, derived equally from citizens’ prejudicial concern over the mixing of white and Chinese races—and in particular, young “innocent” white women—and from concerns about the harmful effects of opium upon individuals and society.\(^1\) In 1881, a California statute criminalized “operating and patronizing of public dens,” and violators faced a six month jail sentence and up to $500 in fines.\(^2\) In 1931, California law criminalized narcotics addiction.\(^3\) Despite these early regulations, California’s borders proved prime targets for narcotics trafficking.

A 1954 study released to Edmund G. Brown, then California’s Attorney General, outlined serious narcotics trafficking and addiction problems within the state. It


estimated that approximately 20,000 illegal narcotics users and 32,000 medical or legal users resided in California, and predominately in large urban areas. Police departments in Los Angeles, San Francisco, San Diego, Oakland, Sacramento and Fresno accounted for 75% of all narcotics arrests. The study also reported an increase in narcotics violators under the age of twenty-one, contrary to a noted decrease in all other cities in the United States.4

The study explained California’s narcotics problems as stemming largely from international trafficking, in which California proved particularly vulnerable. It stated that heroin most likely came principally from three areas of the world: Eastern Asia, Europe and the Near East, and Mexico. Heroin arriving in Los Angeles came primarily from the Near East by way of New York, whereas heroin in San Francisco came primarily from Eastern Asia in a direct route. These findings exposed a lack of border security stopping international drug trafficking by air, sea, and roads. For instance, only approximately thirty border agents patrolled southern California’s border with Mexico, where five million pedestrians and two-and-a-half million vehicles, each containing approximately three passengers, passed through annually. The number of airports in California further compounded the narcotics trafficking problem by allowing smugglers multiple points of entry by plane. Additionally, the Los Angeles and San Francisco seaports, among the largest in the United States, received an annual 8,500 ships, and woefully lacked Customs Bureau agents. San Francisco’s seaport regularly deployed only ten agents to search ships. Ultimately, the Federal Bureau of Narcotics (FBN) and the Customs Bureau

4 Ibid., 18.
estimated over 50% of illegal narcotics entering California arrived by ship or plane, with less than 5% detected by federal authorities, though in reality as little as 1% detected by authorities.  

**Governor Brown’s Special Study Commission on Narcotics**

In 1958, the citizens of California voted Brown into the governorship. As Governor and central visionary behind the Civil Addict Program, he sought to confront California’s narcotics problems through a multitude of measures consisting of education efforts, increased penalties against narcotics violators, increased border protection, treatment efforts, and close interaction between federal, state, and local authorities. His prior history as a District Attorney (D.A.) in San Francisco from 1943 until 1950 and California Attorney General (A.G.) from 1951 to 1958 familiarized him with the extent of narcotics problems facing California. However, most of his efforts before he became Governor consisted of enforcing narcotics violations penalties, as opposed to offering treatment measures. Brown viewed himself as a tough D.A. who enforced the law “rather strenuously.” As a D.A., he waited until an issue became widely publicized, usually precipitated by some trigger event, and then took the opportunity to embark on a legal prosecution campaign. For instance, he says “I waited for an arrest, for example, of a big gambler to start enforcing the bookmaking statutes as a felony.” By the time

---

5 Ibid., 20-21.
7 Ibid.
Brown became Governor in 1959, California’s narcotics problems had risen to full view among both state and federal authorities.

When Brown took office in 1959, he “ran into heavy criticism about the narcotics problem” from federal and state politicians and law enforcement agencies. Federal Bureau of Narcotics (FBN) statistics showed 59.9% of known narcotics addicts in the United States resided in California and New York, while Illinois and Michigan contained 18.8%, and the other forty-six states contained 21.3% combined. For some years, hardliner FBN Commissioner Henry Anslinger singled out California for its “definite and serious” narcotics problem. Many authorities attributed this problem to unsatisfactory narcotics laws in the state. In announcing tentative plans for the Civil Addict Program in 1961, Brown estimated that 10,000-20,000 narcotics addicts resided in California at the time.

The high profile nature of narcotics problems in California in the late 1950s and early 1960s led to polarizing arguments between concerned citizens searching for a solution. On the one hand, a conservative-leaning faction comprising nearly “every D.A. and police chief in California,” along with several newspapers such as the Los Angeles Times, promoted the increase of penalties for narcotics violators. On the other hand, a liberal-leaning faction comprised largely of human rights groups, university academics, and

---

9 Craig Hosmer, Congressman, personal letter to Governor Edmund Brown, March 25, 1960, 1-2, Department of Corrections Records, F3717:165, California State Archives.
10 Citizen’s Advisory Committee, Narcotic Addiction: Report, 16.
11 Ibid.
sociologists, promoted ambulatory narcotics clinics and reduced criminalization of narcotics. As Governor, Brown needed to find a solution to satisfy the middle ground.

As soon as Brown took office in 1959, he instituted the Narcotic Treatment Control Project (NTCP). Administrators aimed the experimental NTCP at the narcotics addict criminal offender in an effort to “develop better methods of control and treatment of narcotics users after serving prison terms for criminal offenses.” The project officially started on October 1, 1959, and remained in operation well after the Civil Addict Program began. The NTCP worked by assigning smaller addict-offender caseloads of thirty individuals to parole officers, who subsequently closely supervised their parolees living in special halfway houses. The parolees faced scheduled and random anti-narcotic testing, and returned back to brief periods of incarceration if drug-use was detected.

Parole officers in the conventional prison system, on the other hand, normally supervised upwards of seventy-five parolees. Through such close supervision in the NTCP, administrators hoped to achieve fewer incidents of narcotics relapse, and swifter return to incarceration and treatment should relapse occur.

The apparent success of the group-living experiment and anti-narcotic testing within the NTCP led Governor Brown to push for a program with more expansive power. NTCP statistics showed that 52% of its addict offenders successfully passed anti-narcotic

---

13 Arthur L. Alarcon, Oral History Interview, 119-120.
14 Roland Wood, United States Senate Permanent Investigating Committee, Committee of Government Operations, United States Senate, 4, Department of Corrections Records, F3717:318, California State Archives.
15 Remarks of Richard A. McGee, Director of Corrections, to the Governor's Council at San Diego, September 30, 1960 (For release at 10 AM, Sept. 30), 3, Department of Corrections Records, F3717:900, California State Archives.
16 Dedication Program, CRC, Corona, California, Tuesday May 7, 1963, Department of Corrections Records, F3717:318, California State Archives.
testing within six months of leaving prison. Of those who initially failed testing and were briefly re-incarcerated, 20% were not detected using narcotics within one year of release. However, despite the NTCP’s favorable outcome, it was a limited program. First, it dealt with paroled criminal offenders who served time in correctional facilities as opposed to treatment facilities. This lack of specialized treatment facilities hampered efforts to cure narcotics addiction. Second, the program only involved prisoners, while yet a large narcotics addict population lived outside the prison’s walls. Third, it did not have the resources necessary to treat and control large groups of narcotics addicts in isolation from the general prison population. Both medical physicians and penal authorities believed that isolation was crucial in order to focus on the specific problems relating solely to narcotics addiction, and to prevent the spread of narcotics addiction to other inmates. The director of the Department of Corrections estimated nearly one-sixth of California’s adult prison population suffered narcotics addiction, though only approximately one-half of this group was imprisoned on narcotics charges.

In an effort to tackle California’s narcotics addict problem on a more expansive scale, Brown created the Special Study Commission on Narcotics in March 1960 by Executive Order. The Commission was to “investigate, evaluate, and make recommendations concerning the adequacy of the present laws relating to the illegal traffic in narcotics, including...adequacies of the present penalties to protect the people of the state, the application of the indeterminate-sentence law to narcotic violations, and the probation

---


and parole of persons who violate narcotic laws..."\textsuperscript{19} He instructed the unpaid six-person Commission to complete an interim report with recommendations by December for legislative action in mid-1961 and a final report in June 1961.

The six men making up the Special Commission came primarily from criminal justice system backgrounds. Project Director Arthur Alarcon, appointed by the Director of the Department of Corrections upon Governor Brown’s recommendation, played the most prominent role in the Commission. Alarcon served as a deputy D.A. in Los Angeles, prosecuting “hundreds of major felony cases” from 1952 to 1962, and taking leave to lead the Special Commission.\textsuperscript{20} He came to Brown’s (then serving as A.G.) attention after having written a book on California’s new Exclusionary Rule. This rule stated that evidence obtained without a search warrant could be excluded by judges.\textsuperscript{21} Alarcon’s legal expertise and familiarity with narcotics laws made him Brown’s choice candidate. The other five Commission members held similar backgrounds: A. Lamont Smith was Executive Director to the Board of Corrections, John Storer the Chief of the Bureau of Narcotic Enforcement, Director Harry M. Kimball a former FBI agent in charge of the San Francisco bureau, Walter Binns a municipal judge, and Robert Neeb a practicing Beverly Hills attorney.

The Special Commission first met on May 4, 1960 in Los Angeles with Governor Brown and Clemency and Extradition Secretary Cecil Poole to outline the scope of its work. It adopted a policy statement from a concurrent New York study called the Project

\textsuperscript{19} Stats. 1947, ch. 1181.
\textsuperscript{20} Arthur L. Alarcon, Oral History Interview, iii.
\textsuperscript{21} Ibid., 28.
Committee on the Use of Narcotics of the Community Council of Greater New York, which read: "To study problems in all age groups; to review and make recommendations regarding relevant laws, proposed legislation and needs; promote the evaluation of existing treatment facilities and recommend adequate treatment programs; continue to develop preventative measures and to foster community-wide education for prevention." The Commission augmented this policy with "preventative measures, medical treatment followed by a long period of supervision and control, and nation-wide education should be strongly stressed as a part of our study program." The sixteen points of study that followed contained various topics relating to narcotics, including the adequacy of current narcotics legislation, the proper use of search warrants in narcotics arrests, the role of education in drug prevention, the acquisition of funds for continuous narcotics treatment research, and the feasibility of a large-scale treatment and control program for addicts.

The Commission met again in June and created a list of agencies to meet with in preparation for its upcoming interim and final reports. This list contained the California Medical Association, California State Bar Association, California Peace Officer's Association, California District Attorney's Office, California Department of Corrections, and the California Conference of Judges. Rather than allow each agency to select representatives to attend meetings, the Commission members selected the individuals they thought best represented the agencies.

22 Minutes of the Meeting of the Special Commission on Narcotics, State Building, Los Angeles, California, May 4, 1960, 2, Department of Corrections Records, F3717:167, California State Archives.
23 Ibid.
24 Minutes of the Meeting of the Special Commission on Narcotics, San Diego, California, June 7, 1960, 2 Department of Corrections Records, F3717:167, California State Archives.
Over the course of Commission meetings during the next six months, members laid the groundwork for a statewide narcotics addiction treatment program that was similar in many ways to the PHS federal narcotics hospitals, though augmented by compulsory commitment measures and mandatory parole-like supervision upon release. The medical, correctional, and law enforcement authorities involved in the meetings agreed to this prospect in unison. Such a program necessitated an independent institution with full power to commit, release, and return individuals to the program. The lack of such power, on the other hand, characterized the inadequacies plaguing the PHS federal narcotics hospitals. Commission members believed these insufficiencies led directly to the demise of these hospitals. Furthermore, they believed that many patients sought admittance to these federal hospitals as a way to avoid prison, and not as a cure for their addictions.

The advantage of the soon-to-be Civil Addict Program, asserted a Los Angeles county Superior Court judge, was that administrators and judges could determine “on a selective basis” individuals fit for treatment or prison.25 Once selected, administrators could then exercise strong measures of control over the addict because of the isolationist features built into the program. This feature of isolation would simultaneously allow the staff to closely monitor and treat addicts free from distraction, and would prevent the spread of addiction and creation of new addicts among regular prison inmates.26

This idea of narcotics addiction as a contagion circulated widely amongst medical, judicial, and law enforcement agencies at the time, and led directly to the increased

---

25 Ibid., 11-12.
26 Minutes of the Meeting of the Special Commission on Narcotics, Los Angeles, California, July 20, 1960, 8, Department of Corrections Records, F3717:167, California State Archives.
measures of control eventually exerted by the Civil Addict Program. For example, in June 1960, a FBN district supervisor warned of the inherent danger of “the addict himself, whom I would call the catalyst, who is the carrier of this contagion.” FBN commissioner Anslinger prescribed that one addict would make four addicts, four would make sixteen, and so forth. Los Angeles Superior Court judge Lewis Drucker said in a July Commission meeting that sending narcotics addicts to state prison only spread the disease. Even Dr. Stuart Knox, in representing the California Medical Association (CMA) during Commission meetings, stated that “the public must be informed that isolation or quarantine is necessary in order to control the spread of narcotics addiction.” These fears created the need for a narcotics addition treatment program that utilized techniques of isolation, control, and strict follow-up supervision. Knox believed that nothing could replace the isolation of the addict as far as treatment was concerned, and that post-treatment supervision and parole should be extended to five years minimum. Furthermore, he asserted that mental health laws had more potential in underpinning such a program.

The Special Study Commission on Narcotics released an interim report in December 1960 and a final report in June 1961, outlining a comprehensive program meant to deal with narcotics addiction in the state of California through educational measures.

29 Minutes of the Meeting of the Special Commission, July 20, 1960, 8.
30 Ibid., 2.
31 Ibid., 2, 4.
32 Ibid., 3.
increased penalties, broader use of police powers, and a program of mandatory treatment for narcotics addicts. Governor Brown wanted the interim report released in December in order to prepare the recommendations for passage into law in 1961. This report featured proposals to increase narcotics violations penalties and to create the Civil Addict Program. Specifically, its proposals suggested the necessity of broader use of police search warrant powers, increased penalties, including prison over jail time with no early parole for narcotics violators, and “that steps should be taken leading toward making adequate facilities available so that every known addict may be eventually removed from the community under a voluntary or involuntary civil court commitment to a state hospital for quarantine, withdrawal from the physiological use of narcotics, and rehabilitative treatment.” The final report dealt primarily with increased educational drug prevention measures and research efforts. Specifically, it pushed for better coordination of services between agencies dealing with narcotics addicts, and for a state university to begin a specialized study on narcotics addiction and the effects of dangerous drugs.

**The Civil Addict Program Signed into Law**

Many of the recommendations of Governor Brown’s Special Study Commission on Narcotics were drafted into law in 1961, and shaped California’s narcotics policies and programs for the next decade. Brown’s new narcotics program contained both increased penalties against narcotics violators and the creation of a compulsory civil commitment

---

program for narcotics addicts. Never before had such a comprehensive program dealing with narcotics addicts and violators been instituted in California or any other state.

On May 5, 1961, Governor Brown signed into law the Dills-Regan Bill, making it the “toughest narcotics program in the history” of California by effectively tripling the existing minimum penalties for narcotics violations. Effective September 16, 1961, the law increased prison time for narcotics peddler violators with no prior record to five years to life with no chance of parole before three years. A peddler with one prior conviction received ten years to life with no chance of parole before ten years. A peddler with two prior convictions received fifteen years to life with no chance of parole before fifteen years.

That same year, Governor Brown also signed into law Senate Bill 81, creating California’s Civil Addict Program under the authority of the Department of Corrections and providing funding for its treatment facility called the California Rehabilitation Center (CRC). The Civil Addict Program served as a mechanism for the treatment and control of narcotics addicts by confining them for periods from six months to ten years in CRC, with subsequent parole supervision and surprise chemical anti-narcotic testing upon release for a minimum period of three years. The superintendent of CRC explained the ideology behind the Civil Addict Program consisted of five parts. First, removing the narcotics addict from society benefited both society and the addict by reducing the spread of addiction. Second, addicts deserved and needed appropriate treatment. Third, parole

34 Governor Brown’s 1961 Narcotics Program, 1, Department of Corrections Records, F3717:180, California State Archives.
35 Ch. 850 §§ 2, 3 [1961] CAL. STAT.
36 Ch. 11, Title 7 of Part 3, California Penal Code (1961).
supervision and anti-narcotic testing were crucial measures in "controlling the addict."

Fourth, if addicts failed to readjust to civil society during parole, they must be returned to confinement. Fifth, society must be protected from the antisocial acts of the narcotics addict.\textsuperscript{37}

The narcotics addict’s experience in the Civil Addict Program began by entrance into the program in one of three ways. First, an addict could voluntary commit to the program of his or her own accord by reporting to the local D.A. Second, "relatives or other responsible persons" could report who they believed to be a narcotics addict to a D.A.\textsuperscript{38}

In these first two scenarios, the D.A. then petitioned the Superior Court for addict commitment and the proceeding commitment trial and procedures began. Third, an addict charged with a crime could be diverted to the program as an alternative to prison, providing he or she did not have an excessively violent criminal history or large-scale peddling offenses.

At the commitment trial, the suspected addict stood before a judge and two medical examiners who determined the status of addiction and entrance into the Civil Addict Program. The suspected addict received legal counsel and had the right to bring personal witnesses. The time between arrest and examination usually consisted of several weeks, sometimes months. Statements by the accused, and old physical indications of drug use, such as needle scarring, became the chief evidence used by medical examiners to prove


\textsuperscript{38} Roland Wood, \textit{United States Senate Permanent Investigating Committee}, 11.
their case.\textsuperscript{39} If the judge found the accused guilty either of being a narcotics addict, or in
“imminent danger of becoming addicted,” he or she formally committed that person into
the program.\textsuperscript{40} Since 1931, the California law criminalizing narcotics addiction stated
“No person shall use, or be under the influence of, or be addicted to the use of narcotics,
excepting when administered by or under the direction of a person licensed by the State
to prescribe and administer narcotics.”\textsuperscript{41} California code specifically defined narcotics
addiction as “any person who habitually takes or otherwise uses to the extent of having
lost the power of self-control any opium, morphine, cocaine, or other narcotic drug.”\textsuperscript{42}

If individuals committed to the Civil Addict Program, regardless of initial
commitment type, disagreed with the finding of addiction, they could request a jury trial,
during which the jurors were required to answer the question, “Is the person addicted to
the use of narcotics or is he by reason of the repeated use of narcotics in imminent danger
of addiction?”\textsuperscript{43} Three-quarters of the jury had to affirm the status of addiction in order
for the commitment process to proceed.

All individuals entering the Civil Addict Program were required to spend at least six
months in a CRC facility, though the average length of stay was fourteen months by
1967.\textsuperscript{44} Initially, before a separate large facility solely for addicts could be acquired,
program administrators sent southern California male addicts to the Reception-Guidance

\textsuperscript{39} B. Wilson, \textit{An Assessment of California’s Civil Addict Program}, June 1976, 2, Department of Corrections
Records, F3717:1660, California State Archives.
\textsuperscript{40} Wood, \textit{The Civil Narcotics Program}, 22.
\textsuperscript{41} California Health and Safety Code Section 11721.
\textsuperscript{42} California Welfare and Institutions Code, s 5350.
\textsuperscript{43} Felons did not receive the right to request a jury trial upon initial conviction until 1965. State of
California, The Welfare and Institutions Code, Division 3. NARCOTIC ADDICTS Sections 3000 thru 3311,
January 1, 1972, Department of Corrections Records, F3717:365, California State Archives.
\textsuperscript{44} Wood, \textit{The Civil Narcotics Program}, 3.
Center in Chino, northern California male addicts to the Reception-Guidance Center in Vacaville, and women addicts to the California Institute for Women in Corona. In the meantime, administrators made preparations to acquire a former naval hospital in Corona for program operations. By late 1962, the CRC Corona facility was ready, and residents moved in on January 7, 1963. By late March, the Civil Addict Program contained over 1,509 addicts at Corona and other satellite facilities, with the vast majority residing at CRC Corona. Nearly 210 addicts also lived outside the facility in paroled outpatient status. The CRC Corona facility sat on ninety-one acres and comprised sixty-seven buildings. The facility separately housed both men and women until 1968, when the women moved to a separate facility in Patton. However, even the large CRC Corona facility could not accommodate the large numbers of addicts admitted into the program, and in 1968 the California Correctional Institution in Tehachapi and the California Men’s Colony in San Luis Obispo became used as CRC overflow facilities.

Life for residents at the Civil Addict Program’s CRC facilities revolved around a therapeutic milieu of regular small and large group counseling sessions, work, and recreation. At CRC Corona, administrators placed men into three separate groups, with each numbering approximately 600 residents. Within these large groups, the men were further divided into individual groups of sixty who resided within a single dormitory. Administrators intended for each dormitory of men to serve as a therapeutic community,

---

46 *Dedication Program, CRC*, May 7, 1963, 2, Department of Corrections Records, F3717:318, California State Archives.
whereby the men primarily interacted only with each other. Five days a week, each dormitory of residents, along with corresponding staff, held group counseling sessions during which the men talked about general everyday living issues, any problems needing sorted out within the group, and family life and life outside the facility’s walls. Staff helped moderate discussion, but purposely allowed the residents to work out their issues amongst the group. For example, staff expected residents to distribute their own towels, and so gave each dormitory a stack of sixty. On one particular occasion, a few residents without towels complained to staff that others had distributed them unfairly, though staff gave them no sympathy. These residents then raised the issue at the next group counseling session. After much initial arguing, the group pinned blame on those who took more than one towel, and worked to distribute towels equally thereafter. In this way, residents were expected to work out their issues amongst themselves, in order to create an environment of trust and reliance upon each other.48 After each meeting, the staff met to discuss progress and to develop new and different strategies. Two to three times a week, each dormitory broke into four groups of fifteen, with each group partaking in an intense group counseling session lasting one hour or more. These smaller groups facilitated more in-depth probing of issues and counseling. 49

When not in group counseling sessions, Civil Addict Program residents had a number of work responsibilities, combined with some recreational time. After daily counseling sessions during the week, residents spent a half-day partaking either in “work therapy” or schooling and/or vocational training. The program offered elementary through high

49 Roland Wood, United States Senate Permanent Investigating Committee, 11-12.
school education, and included vocational training in upholstery, building maintenance, landscape gardening, house painting, cooking, and dry-cleaning, among others.\textsuperscript{50}

Two special authoritative bodies governed the lives of the residents in the Civil Addict Program. The Narcotic Rehabilitation Advisory Council (NRAC), consisting of a group of nine non-paid advisory members to the administrative authorities, governed the inpatient phase. The Narcotic Addict Evaluation Authority (NAEA), consisting of a group of three members employed part-time, governed resident discharge from the program, and release to and return from outpatient status. Both of these groups were created in 1963 as special entities concerned solely with the Civil Addict Program.\textsuperscript{51}

Prior to this, the CRC Advisory Council governed the inpatient phase, and the Adult Authority, which oversaw all Department of Corrections' parole responsibilities, governed the outpatient phase.

Upon serving at least six months in CRC, residents became eligible for outpatient status. Residents had the opportunity to remain in outpatient status for the rest of their commitment time, provided they could successfully follow the program's strict requirements, which are addressed in chapter three. If re-incarcerated, the resident's commitment time began anew. This means he or she received a full two-and-a-half or seven-year sentence beginning at the time of re-incarceration. The program did have a ten-year maximum time limit before automatic discharge, but NAEA members did not hesitate to reinstate someone back into the program after discharge.\textsuperscript{52}

\textsuperscript{50} Ibid., 12.
\textsuperscript{51} Stats. 1963, ch. 1706.
\textsuperscript{52} "Civil Commitment of Narcotic Addicts," \textit{The Yale Law Journal}, 76, no. 6 (May 1967): 1161.
Civil Addict Program caseworkers strictly supervised outpatients, and made sure they participated in regular anti-narcotics testing. As in the NTCP, each caseworker supervised thirty outpatients. Caseworkers met with the entire group once weekly for large group sessions, and also once a week in separate individual meetings, either at the addict’s home or workplace. They also kept in contact with employers, family members, and law enforcement to keep updated on the addict’s behavior. Regulations required residents to maintain employment, write and submit monthly reports on their activities, and submit to regular anti-narcotic testing, among others.\(^{53}\) If caseworkers found an addict failing to abide by outpatient regulations, or detected a return to narcotics use, they reported him or her to the NAEA for re-admittance into CRC.

Physicians used the chemical agent Nalline as the primary means for Civil Addict Program anti-narcotic evaluation. Presumably, they could inject the anti-narcotic chemical into the patient intravenously and determine if they had been using narcotics through measuring the pupils. Each resident had one scheduled weekly test and one surprise test every month.\(^ {54}\) Although mandatory for all Civil Addict Program outpatients, the Department of Corrections had also been selectively implementing anti-narcotic testing as a means of control for parolees since 1954 on a regular basis, sending those who failed testing back to prison.\(^ {55}\)

When the Civil Addict Program began in 1961, it received widespread praise from political and legal authorities. The Ad Hoc Committee of the White House Conference

\(^{53}\) Narcotic Addict Evaluation Authority, *Conditions of Release to Outpatient Status*, State of California, 1-2, Department of Corrections Records, F3717:381, California State Archives.

\(^{54}\) Remarks of Richard A. McGee, September 30, 1960, 8.

\(^{55}\) Ibid., 7.
on Narcotics and Drug Abuse hailed it as the “most promising” program of treatment and control for narcotics addicts in the entire nation. New York’s D.A., understanding the extent of narcotics addiction problems in both California and New York, called the program a “great step forward” and hoped that New York would follow California’s example shortly thereafter. At the time, the Civil Addict Program appeared to have the same anticipation surrounding it as the PHS federal narcotics hospitals initially held, but with the added benefit of mandatory commitment procedures and intense outpatient supervision.

Yet despite the emphasis by Governor Brown and the Special Study Commission on Narcotics on the Civil Addict Program’s alternative approach of dealing humanely with narcotics addicts, California law still criminalized narcotics addiction, raising the issue of whether Department of Corrections’ staff could effectively administer treatment to individuals in a non-punitive manner. The new treatment perspectives emerging in this era considered narcotics addiction an illness, with which criminality was incompatible. This apparent paradox demonstrates the difficulty Governor Brown faced in finding a middle ground solution to the problem of narcotics addiction in his State. The criminality of narcotics addiction in California was soon to be challenged by Lawrence Robinson, mentioned in chapter one. His case against the state eventually reached the Supreme Court.

The Decriminalization of Narcotics Addiction in California

56 Dedication Program, CRC, May 7, 1963, 2.
57 Walter Dunbar and Richard McGee, Narcotic Addict Treatment and Control in California, Special Report Governor’s Council, September 1962, 2, Department of Corrections Records, F3717:381, California State Archives.
In 1962, the Supreme Court heard the case *Robinson v. California*, which challenged the criminalization of narcotics addiction in California. The case stemmed from an incident late one night in February 1960 when two police officers unassigned for traffic duty pulled over the automobile containing Robinson, who was not driving, and three other passengers in Los Angeles. The officers did not issue a traffic citation, and their reason for pulling over the defendant changed several times during the course of the trial. Immediately upon pulling the automobile over, the officers searched the car, though finding nothing incriminating. Proceeding to search the occupants, the officers found a single needle scar on the driver’s exposed arm and arrested him. Next, they made Robinson roll up his jacket sleeves and inspected his arms with a flashlight. Finding what appeared to be needle scar tissue on Robinson’s arms, they also placed him under arrest. Robinson had no heroin withdrawal symptoms upon or after arrest, but the officers alleged he admitted to using heroin only forty-eight hours prior.58

Robinson stood before a jury trial some four months later in the Municipal Court of Los Angeles. One of the arresting officers testified that on the night of arrest he observed “scar tissue and discoloration” on the defendant’s right arm and “what appeared to be numerous needle marks and a scab” on his left arm. He also claimed Robinson admitted to occasional narcotics use. Another officer, in the Los Angeles Police Department Narcotics Division, viewed Robinson’s arms the morning after the arrest and testified to the best of his knowledge the marks signified narcotics use injected from a hypodermic syringe. He presented pictures to the jury of Robinson’s arms taken shortly after arrest.

He also noted that Robinson’s scars were several days old at the time of his examination and that he could not have been under the influence at the time of arrest. The judge then expressly rejected the charge against Robinson for being under the influence of narcotics at the time of arrest and informed the jury that Robinson could be charged with either using narcotics or being addicted to narcotics.\(^{59}\)

During the trial, Robinson testified on his own behalf that he neither admitted to the arresting officers that he had used narcotics, nor had he ever been addicted to, or even used, narcotics in the past. He claimed, backed by two witnesses, that the markings on his arms stemmed from an adverse reaction to injections he received by the military when serving overseas. He also demonstrated no visible symptoms of narcotic high or withdrawal during his arrest and subsequent trial.\(^{60}\)

The municipal judge instructed the jury they could convict Robinson on the grounds of having the status of being “addicted to the use of narcotics,” even if they did not believe he had used narcotics at all in Los Angeles. According to California health codes, Robinson could be found guilty either on the grounds of having lost control under the influence, or by having the status of drug addiction.\(^{61}\) Jury members were told narcotics addiction as defined by Section 11721 “meant strongly disposed to a taste or practice or habit of its use, indicated by the use of narcotics often or daily.”\(^{62}\) The jury subsequently found Robinson guilty of having the status of narcotics addiction, and

\(^{59}\) Robinson v. California.  
\(^{60}\) Ibid.  
\(^{61}\) California Health and Safety Code Section 5355 states one that has completely “lost the power of self-control,” while California Health & Safety Code Section 11721 dealt with the status of narcotics addiction.  
\(^{62}\) Robinson v. California.
sentenced him to ninety days in jail, followed by two years of parole with periodic anti-narcotic Nalline testing.  

Robinson appealed the case, claiming the state of California violated his Eighth and Fourteenth Amendment rights protecting him from cruel and unusual punishment. The case eventually made it to the Supreme Court. The Court determined that criminalizing the status of drug addiction in California, even if the individual did not possess or use narcotics in the state or participate in antisocial behavior there, did consist of cruel and unusual punishment. Instead, the verdict declared the status of narcotics addiction to be a disease and not a crime. In this sense, even one day in jail for having a disease constituted cruel and unusual punishment. Citing the 1925 Supreme Court case *Linder v. United States*, the High Court determined narcotics addicts were “diseased and proper subjects for (medical) treatment.” Since it was unlikely that any State would criminalize a physical disease or mental illness, it overturned Robinson’s lower court conviction. In doing so, it recognized that narcotics addiction could develop voluntarily or involuntarily, or even at the moment of birth, and that a State could require that “victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration.”  

In declaring the criminalization of narcotics addiction in California to be unconstitutional, *Robinson v. California* prompted Civil Addict Program administrators to delineate a clear line between the program and the state prison system. Officials allocated the Civil Addict Program’s authority from penal laws to health and welfare

---

63 Ibid.
64 Ibid.
laws. *Robinson v. California* never dealt with the constitutionality of involuntary civil commitment. Rather, it involved the constitutionality of criminalizing narcotics addiction. However, the Court did proceed to offer its opinion on involuntary civil commitment as dictum. Dictum is judicial opinion that is unnecessary to reach the legal decision in the specific case at hand. U.S. Supreme Court dictum, though not binding in lower courts, typically carries significant weight with these courts. In this case, the Court’s dictum said that states could use compulsory treatment measures as well as criminal law in the effort to regulate narcotics traffic. It is precisely this dictum that strengthened California’s Civil Addict Program. The constitutionality of such a program was not an issue in *Robinson v. California*. As a result, when the constitutionality of the Civil Addict Program appeared before the California Supreme Court in *In re De La O* in 1963, the Court utilized this dictum without fully analyzing the constitutionality of the program. Subsequent court cases faced similar denial based upon *In re De La O*. The placement of California’s Civil Addict Program under the authority of health and welfare laws gave it substantial authority over narcotics addicts, just as Dr. Knox had hoped for in the Special Study Commission on Narcotics meeting two years prior. By law, program residents were no longer considered criminals for having the status of narcotics addiction, but in turn, they faced a program of uncertain release. Instead of mandated by term length, Civil Addict Program residents obtained released from the

program according to program authorities’ subjective decision of when rehabilitation had occurred.
Chapter 4

A PRISON-LIKE EXPERIENCE FOR NARCOTICS ADDICTS

California's Civil Addict Program emerged in a new era of state and local narcotics addiction treatment programs throughout the United States. In California, the dialogue surrounding narcotics addicts—predominately those addicted to heroin—and their "harmful effects" upon society, reached epic proportions among legislators, law enforcement officials, physicians, and the media. Individuals leading these innovative programs endeavored to treat narcotics addiction through therapeutic methods, as opposed to criminal punishment.

The accruing frustration by physicians, sociologists, psychotherapists, and concerned former drug addicts over the handling of narcotics addiction for the last fifty years provided the impetus for these new treatment perspectives. Official policy in the United States since the 1914 Harrison Act consisted of increasing penalties against narcotics use, possession, and trafficking. These policies peaked with the 1951 Boggs Act and the 1956 Narcotic Control Act. During this time, narcotics addiction treatment measures diminished significantly. After Treasury Department officials forced city narcotic maintenance clinics to close in the early 1920s, virtually the only form of narcotics addiction treatment and research in the United States took place in two Public Health Service (PHS) federal narcotics hospitals. Multiple studies found that 90-96% of addicts discharged from these hospitals became re-addicted to narcotics, the majority within six
months of leaving the facilities. 68 Clearly this treatment, especially combined with stiff narcotics violations policies, proved ineffective.

When the Civil Addict Program began in 1961, Governor Edmund Brown presented it as a program of both treatment for and control of narcotics addicts, utilizing therapeutic efforts in conjunction with the penal system. He hoped this arrangement would save taxpayers the high cost of otherwise wasted prison sentences, whereby addicts would continue their habit upon release. 69 In this sense, the program’s structure contained aspects of therapeutic treatment coupled with confinement derived from the Department of Corrections. When the program legislation passed, Brown stated that addicts would be sent to a facility where “primary emphasis is on addict reform and rehabilitation.” 70

However, in reality, the prison-like atmosphere of the Civil Addict Program in its first decade greatly overshadowed, even undermined, its treatment qualities for most program residents. Ironically, this was a byproduct of both its association with the Department of Corrections, and the substantial medical power derived from health and welfare laws.

Governor Brown’s specific emphasis on the Civil Addict Program’s use of treatment and control appealed to a varied constituency in California. On the one hand, the treatment measures contained therein attracted physicians, psychotherapists, sociologists and former drug addicts who believed that rehabilitation, not criminal punishment, offered an effective solution to California’s narcotics addiction problems. These

69 Walter Dunbar and James P. Alexander, Press Release for Thurs. PM, Los Angeles, California, October 18, 1962, 2, Department of Corrections Records, F3717:1458, California State Archives.
treatment efforts utilized medical care, psychotherapy, behavioral therapy, work therapy, and the creation of a group support system for addicts to help combat and redirect addictive tendencies. On the other hand, the program’s exercise of control over addicts attracted a majority of law enforcement officials, District Attorneys (D.A.s), and media officials who supported increased narcotics violations penalties to solve California’s narcotics addiction problems. These control efforts utilized isolation and incarceration of addicts at California Rehabilitation Center (CRC) facilities, intense supervision, a strictly regimented schedule, and numerous regulations facing the addict upon release to outpatient status. The program’s excessive control over addicts resulted in a prison-like—hence, punishing—experience for the majority of program residents.

Comparatively, Civil Addict Program residents faced greater measures of control than inmates did in the state prison system, which translated into an experience much like prison. This is because inmates were punished for their crimes, but program residents were not considered criminals after Robinson v. California.

Michel Foucault articulates this meaning of control in Discipline and Punish, a historical study of the development of the prison systems and modes of punishment in Western Europe and the United States from the pre-Classical Age to the present. He documents the changing nature of punishment from brutal acts on the inmate’s body in view of the public to more humane measures of incarceration and rehabilitation managed by professionals in a private atmosphere. However, this evolving nature of punishment—or “economy of power”—did not loosen its grip upon the individual or the social body in instituting a more humanitarian mode of punishment, but rather it inserted “the power to
punish more deeply into the social body.\textsuperscript{71} When reformers removed punishment’s attachment to the individual’s physical body, they attached it firmly to the individual’s soul. As a result, those in authority gained greater control over their subjects.

The control Civil Addict Program authorities had over program residents was unprecedented in California’s correctional system. These officials could incarcerate anyone the courts determined to be a narcotics addict or in “imminent danger of becoming addicted.”\textsuperscript{72} By 1970, ten percent of the program’s population consisted of involuntary residents with no criminal charges.\textsuperscript{73} Once committed, addicts faced stiff measures of psychological control, as well as control through isolation, surveillance, a strictly regimented schedule, and numerous program rules. First, authorities removed and isolated addicts at a CRC facility, away from society and the general prison population. This allegedly prevented the spread of narcotics addiction and kept the public safe from criminal activity. Once incarcerated, addicts were further isolated into smaller groups within the facility to create an atmosphere of group dependence, and to preclude free association with the whole of program residents. These isolationist measures continued upon release from the institution, as outpatients were forbidden to associate with others in the program. Second, Civil Addict Program authorities kept addicts under careful surveillance at all times. At CRC, armed guards and the watchful eyes of staff kept close tabs on residents’ actions. Caseworkers carefully monitored addicts upon release from

\textsuperscript{71} Michel Foucault, \textit{Discipline and Punish: The Birth of the Prison} (New York: Vintage, 1995), 82.
the institution through personal contact and regular communication with law enforcement personnel and the addicts’ family members and employers. Third, institutionalized residents had to keep a strictly regimented schedule. Authorities structured the residents’ daily lives in this manner to replace destructive behaviors stemming from too much leisure time with productive activities that otherwise may not have been developed. Fourth, administrators governed the lives of addicts through multiple rules, with the promise of eventual discharge from the program if followed. Since the difficulties in controlling the addict increased upon release into society, these officials reserved the most stringent rules for those in outpatient status. These rules, addressed later in this chapter, were far more severe than prison parole regulations, and any infractions resulted in possible re-incarceration at CRC. Fifth, Civil Addict Program authorities held a certain amount of psychological control over residents. The fact that program administrators determined addicts’ release dates at will no doubt weighed on the minds of many residents. Furthermore, the use of psychotherapy in the Civil Addict Program, regardless of its efficacy or the staff’s intentions, presented a measure of psychological control over residents who understood that discharge from the program meant compliance with treatment efforts and the approval of program overseers. Even after discharge, addicts faced the ever-present lingering fear of involuntary reinstatement into the program by the Narcotic Addict Evaluation Authority (NAEA), thereby reinforcing and continuing the program’s control.

A Continuation of Punitive Policies Aimed at the Narcotics Addict and Offender
By all accounts, the CRC Corona facility looked and played the part of a prison. Newly-committed residents' first experience in the program entailed entrance through two separate security fences lined with barbed wire, where armed guards walked the premises day and night. Any resident who escaped or attempted to escape from the facility was charged with a felony, the same penalty prisoners received for attempting escape from prison.

In fact, the program contained mostly felons committed as an alternative to prison, and these persons had an advantage over residents with misdemeanors or no criminal charges at all. As early as 1963, the Civil Addict Program resident population comprised 67% with felony charges, 22% with misdemeanor charges, and only 11% with no criminal charges.74 By 1971, these numbers rose to 92% with felony suspensions, 6% with misdemeanors, and only 2% without criminal charges.75 Felons seemed to have the advantage in this arrangement, because they often spent considerably less time in the Civil Addict Program than they would have otherwise in state prison. Those with misdemeanors, on the other hand, often spent much longer periods of time in the program than they would have in state prison. Furthermore, those who volunteered to go into the treatment program could not be discharged until they had completed it in full, and were often unaware of the formidable amount of time they would serve.

The structure of the Civil Addict Program resembled that of a prison in several other ways. Once committed into the program, residents faced a strictly regimented schedule.

of duties, combined with incarceration, just as prisoners did. Moreover, before changes resulting from *Robinson v. California* took place in 1963, prison terminology, such as “incarceration” and “parole,” were officially built into the program’s language. In addition, the Adult Authority governed release to and from parole for both California’s prison system and the Civil Addict Program.

Residents on parole or outpatient status in the Civil Addict Program faced even stiffer regulations than those in the regular prison system. In addition to submitting to mandatory regular and surprise anti-narcotic testing, residents had to follow a list of thirteen stringent outpatient regulations. Among these regulations included not being allowed to drive a vehicle without written permission by the assigned caseworker, having no association with other program residents, and complete cooperation with the assigned caseworker. Caseworkers could even report outpatient residents for renewed incarceration at a CRC facility for “signs of deterioration in attitude or behavior.” No such rule existed for California’s prison parolees.

Yet the most telling description of the prison-like qualities of California’s Civil Addict Program from 1961 to 1971 came from the residents themselves. Regrettably, these voices are difficult to find outside of official program documentation due to the confidential nature of personal records within the Department of Corrections. Even published corrections material containing anonymous prisoners’ complaints and viewpoints must be examined critically. Often administrators used such material to

---

justify their programs, bringing to question whether the published material had been edited. However, even with such limitations, a few voices can be heard. As late as 1971, official program studies document residents' grievances on the formidable amount of time they had to spend in the program. Residents who volunteered to enroll in the Civil Addict Program specifically complained they were sent to a prison, not a hospital. A legal analyst performing on-site research in 1965 continually heard CRC referred to as "a jail in disguise." Documented complaints show many residents were convinced administrators gave everyone mandatory one-year inpatient sentences, as opposed to evaluating each resident individually, despite only a six-month inpatient requirement. Residents believed these officials did so based upon inpatients' criminal backgrounds, in spite of the program's treatment emphasis. Residents also complained that group counseling leaders were unqualified for the job because they were unable to solve small grievances between men in the dormitories and that the program's vocational training offered neither relevant nor beneficial skills for life on the outside.

Another inside source for gauging residents' reactions to the Civil Addict Program came from its Chief of Research from 1966-1969, John C. Kramer. Kramer frequently noted in published journal articles and statistical reports the bitterness many residents felt towards the program. He states, "Addicts who volunteered for commitment (four percent) frequently voice resentment and indicate that they thought they were coming to a

78 Kramer, "Civil Commitment for Addicts," 822.
80 Date August 16, 1971, 1, Department of Corrections Records, F3717:1542, California State Archives.
81 Ibid., 2.
hospital, not a prison." Kramer emerged as a major critic of the Civil Addict Program, and his concerns are detailed later in this chapter.

When the Supreme Court delivered the *Robinson v. California* verdict in 1962, Civil Addict Program administrators suddenly needed to distinguish the program as separate from the state prison system, which, prior to this, had been unnecessary. With narcotics addiction in California no longer a crime, officials began to remove the Civil Addict Program’s overtly punitive measures in 1963, and eventually reallocated its authority from penal laws to health and welfare laws in 1965. This removal of association with the state prison system signified the program’s early connection to it, and helped strengthen its existing commitment procedures. As part of these reforms, the legislature amended sections of existing law in 1963 to help eliminate the program’s “indicia of criminality” by removing prison terminology, establishing new advisory and parole-function boards created specifically for the Civil Addict Program, and making sure correct commitment procedures were followed. For example, the amended law gave those with felony convictions the right to a jury trial, if so requested, upon disagreement with original finding of addiction and commitment to the program. Even official program language took on a more therapeutic oriented ethos. For instance, this new amended language stated narcotics addicts and those “in imminent danger of becoming addicted, shall be treated for such condition and its underlying causes, and that such treatment shall be carried out for non-punitive purposes not only for the protection of the addict, or person

82 Kramer, “Civil Commitment for Addicts,” 822.
in imminent danger of addiction, against himself, but also for the prevention of contamination of others and the protection of the public."\footnote{CA penal code ch. I 1, Commitment and Corrective Treatment of Narcotic Addicts, Section 6399; Wood, United States Senate Permanent Investigating Committee, 21.}

After \textit{Robinson v. California}, Civil Addict Program officials implemented new terminology to distinguish the program from the state prison system. Previously known as inmates, individuals in the program became residents or inpatients, time spent in the program became inpatient status, parolees became outpatients, and time on parole became outpatient status. Through deliberate elimination of prison terminology, authorities hoped residents would view the program as treatment instead of prison.

The 1963 amended legislation also established two Civil Addict Program governing bodies independent of the state prison system. Previously, the Adult Authority managed all parole functions for California prisons and the Civil Addict Program. Now the newly created NAEA—an independent group of three members who earned part-time salaries—presided over residents' release and return to the program. The Narcotic Advisory Rehabilitation Council (NRAC)—an unpaid group of nine members—existed to give advice to administrative authorities and to help prevent the Civil Addict Program from unlawfully associating with the state prison system in the future.\footnote{Ibid., 21-24.}

A significant result of \textit{Robinson v. California} is that courts subsequently found Civil Addict Program commitment procedures had been implemented incorrectly and consistently violated due process of law. This occurred mostly because of delays in the medical examination of suspected addicts before trial, and the failure to properly advise
them of their legal rights. As a result, by mid-1964, 1,109 individuals filed writ of habeas corpus claiming illegal confinement. Of this group, judges released 761 residents from the program. Newly-incorporated changes, which mandated a shorter amount of time between arrest and trial and the proper notification of legal rights, prevented similar mishaps from occurring again on such a large scale.\textsuperscript{86}

Nevertheless, Civil Addict Program administrators found that such changes did not alter residents’ view of the program as prison, not rehabilitation. A 1965 review analyzing public and private approaches to narcotics addiction rehabilitation found that the “careful elimination of prison terminology and any other vestiges of penology do not seem to have made much of an impact within the institution itself.”\textsuperscript{87} Residents still faced mandatory detention at CRC for their addiction, just as inmates did in prison for their crimes, and outpatient status still mirrored parole because of the ever-present possibility of return to confinement at CRC.\textsuperscript{88}

The Civil Addict Program’s early association with California’s prison system through law, terminology, and methods overshadowed its rehabilitative efforts. Even after \textit{Robinson v. California} prompted regulatory changes, residents still felt the program to be a prison, as opposed to a treatment hospital. The fact that the program continued under the authority of the Department of Corrections certainly makes any distinction between the two rather ambiguous. Perhaps this explains why despite the program’s dual nature

\textsuperscript{86} Ibid., 24.  
\textsuperscript{87} Hirsch, \textit{A Study in Narcotic Addict Rehabilitation}, 16.  
\textsuperscript{88} Ibid.
of treatment and control, it appears that control greatly undermined and paralyzed treatment efforts from 1961 to 1971.

**A Program of Control Undermining Therapeutic Treatment**

Though *Robinson v. California* initially prompted the courts to recognize the Civil Addict Program's unconstitutional commitment procedures, resulting in the release of over 700 residents, it also strengthened the program by placing its power to commit individuals within the framework of health and welfare laws. In 1963, legislators amended existing laws to distinguish the Civil Addict Program as independent from state prison, and in 1965 reallocated its legal authority from penal laws to health and welfare laws. Under this arrangement, program administrators could deal with narcotics addicts as diseased individuals, instead of criminals, and therefore use "compulsory treatment, involving quarantine, confinement, or sequestration."89 In this sense, these officials gained legally binding subjective authority previously unattainable, all in the name of treatment.

In fact, careful examination of narcotics addiction treatment and efficacy in the Civil Addict Program discloses an organizational structure that actually undermined treatment efforts. Dr. Kramer brings this disparity to light. He determined the Civil Addict Program's placement within the Department of Corrections made it inflexible and unable to change. Despite any genuine intentions by actively involved staff, procedural provisions placed serious limitations on the staff's ability to make decisions. For instance, doctors only cared for residents' medical needs, while the NAEA (a board set

---

89 370 U.S. 660.
up by corrections officials) determined when rehabilitation had occurred among these residents. According to Kramer, legislators chose to place the program under the authority of the Department of Corrections because they believed corrections officials were better able to learn how to treat addicts than medical authorities were to prevent addicts from escaping. Subsequently, the program had a strong correctional setting, resulting in the feeling of betrayal from residents.90

Dr. Kramer’s inside observations specifically led him to criticize Department of Corrections administration for excluding “from active participation in the program psychiatrists, psychologists, and other mental health workers,” despite administrative espousal of its importance.91 Richard McGee, Director of Corrections, said the program must “offer the addict intensive, probing programs of counseling, psychotherapy and psychiatry.”92 These emerging techniques were fundamental to the new therapeutic perspectives for treating narcotics addiction in this era. Yet in 1968, Dr. Kramer and research colleagues pointed to a regular shortage of psychological staff at CRC. They claimed that Department of Corrections administration purposely orchestrated this, and it was “not merely the result of the unavailability of such professionals.”93 Even the daily duties of the few staff psychologists and psychiatrists, who oversaw over two-thousand residents, did not involve much individual assistance to program residents.94 By staffing even small numbers of psychotherapeutic personnel in limited roles, Kramer argued,

91 Ibid.
93 Kramer, “Civil Commitment for Addicts,” 134.
94 Kramer, “The Place of Civil Commitment,” 263.
Department of Corrections officials could give the program the public face of treatment, while also retaining the power to lock up narcotics addicts who could not be sent to prison on criminal charges.  

The scarcity of psychotherapeutic services in the Civil Addict Program raised concerns among the limited qualified psychological staff over proper resident treatment. In 1965, the program’s staff psychologist complained of heavy workloads due to staff shortage, which compromised their efforts. Since psychotherapists were supposed to evaluate each individual resident, Kramer questioned the accuracy of such rushed evaluations. Even required staffing positions remained unfilled. Prior to the program’s inception, official documentation listed a chief psychiatrist, staff psychiatrist, and research psychologist, among others, as minimum “basic full-time staff” for a CRC facility. Yet in 1967, the Civil Addict Program’s staff psychologist attended the Annual Conference of Chief Psychiatrists because the program currently had no psychiatrist on staff. He proceeded to state that “psychiatric personnel do not determine the treatment but function in an adjunctive role,” and that predominately social workers undertook treatment in the dormitories. Again, residents complained as late as 1971 that these

---

95 Ibid., 263-264.
96 California Department of Corrections, Minutes of Ninth Annual Workshop for Departmental Clinical Psychologist, Sacramento, California, December 1-2, 1965, 5, Department of Corrections Records, F3717:901, California State Archives.
98 California Department of Corrections, Minutes, Annual Conference of Clinical Psychiatrists, California Medical Facility, Vacaville, California, November 2-3, 1967, 4, Department of Corrections Records, F3717:901, California State Archives.
social workers were unqualified to solve the smallest grievances amongst individuals in the dormitories. 99

Residents themselves also complained about the deficiency in psychotherapeutic services. In 1972, officials asked twelve CRC inpatients for their outlook on the program and suggestions for change. They responded that the program was “completely inadequate so far as psychiatric and psychological therapy availability is concerned.” They also noted “that many of the counselors are lacking in skills essential for providing individual or group counseling.” 100

Ultimately, the group therapeutic structure created for inpatients was immediately pulled away upon outpatient status, yet the intensity of supervision, and thus control, remained. As stated earlier, CRC inpatients lived in groups of sixty in a therapeutic community type environment, in the attempt to create reliance, openness, and trust within the group. On a few occasions, administrators even required some outpatients to write to their dormitory on a daily basis upon release to outpatient status. 101 In fact, group identity in CRC became so prominent that individuals sent back to CRC joined their original dormitory groups. 102 Yet when released to outpatient status, the program pushed residents back into society without the safety net of the very community it worked to build. Except with special permission by Corrections officials, outpatients were forbidden to associate with anyone from the Civil Addict Program. In this way, the

99 Date August 16, 1971, 2, Department of Corrections Records, F3717:1542, California State Archives.
100 Report of Medical Services at California Rehabilitation Center, reviewed by James V. Lowry and Louis A. Gaul, September 28-29, 1972, 15-16, Department of Corrections Records, F3717:1871, California State Archives.
101 Hirsch, A Study in Narcotic Addict Rehabilitation, 10-11.
102 Ibid., 11.
program undermined its own therapeutic efforts by releasing residents into society under regulations more severe than those on prison parole, and yet with the expectation of positive results.

Criticism from California’s Drug Abuse Information Project

The strong measures of control built into the Civil Addict Program in its first decade came under fire by a major California drug abuse oversight committee mandated by law in 1967. The Drug Abuse Information Project (DAIP) fulfilled a 1967 Health and Safety code authorizing the Regents of University of California to “collect, and act as an information exchange for, information on research and service projects relating to drug abuse, and to provide advice with respect to the areas in which research is needed.”

Project directors performed this research by keeping in close contact with all of California’s drug abuse state agencies, hospitals, medical schools, county Departments of Public Health, and drug treatment programs funded by the National Institute of Mental Health (NIMH). The Regents of the University of California placed the DAIP at the San Francisco Medical Center under the leadership of Dr. David E. Smith, Clinical Professor of Toxicology, and founder of San Francisco’s Haight-Ashbury Free Clinic. The Haight-Ashbury Free Clinic provided free medical care and ambulatory treatment to the area’s extensive young drug-addicted population.

Early DAIP reports compared the Civil Addict Program to the punitive policies targeting the narcotics addict during the prior fifty years in the United States. Though it

---


had the public face of treatment, in reality it was a coercive program used to selectively incarcerate the young and unprivileged who otherwise faced no criminal charges, or would spend less time in prison. These reports specifically criticized the inherent disparity in the sons and daughters of middle class and influential citizens receiving probation for narcotics possession, and the poor and those residing in blighted neighborhoods receiving jail time or commitment to the Civil Addict Program. Ultimately, these inequalities reflected existing punitive narcotics policies targeting the narcotics user, and the resulting still present difficulties physicians faced in treating them. DAIP members believed that physicians, not law enforcement, should handle narcotics addicts. They stated that narcotics addiction was predominately a manifestation of other problems that law enforcement was incapable of dealing with. Unfortunately, the Civil Addict Program resided under the authority of Department of Corrections officials, and not physicians. As a result, DAIP deemed the Civil Addict Program as far more prison-like than treatment-like.\textsuperscript{105} When evaluating the effectiveness of CRC, they proposed reallocating its state funds to “more effective community based clinics.”\textsuperscript{106}

Like Dr. Kramer, DAIP members also believed the bureaucratic structure of the Civil Addict Program made it rigid and inflexible, and thus unable to provide proper rehabilitation for residents. Unlike Kramer, however, DAIP members made no mention of well-intentioned program staff restricted by limited roles. Instead, they focused on the


\textsuperscript{106} Narcotic Addict Evaluation Authority, \textit{State of California Memorandum, Subject: Comments on Second Annual Report to the Legislature, RE: Drug Abuse Information Project, by Dr. D. Smith}, to: Spencer Williams, California Rehabilitation Center, Corona, California, February 27, 1969, 3, Department of Corrections Records, F3717:1684, California State Archives.
way bureaucratic agencies dealt with subjects under their control. In this instance, the
Civil Addict Program as an institution was “not fond of nor sympathetic to drug users” in
providing treatment, in opposition to the care offered by concerned individuals operating
community clinics. By maintaining rules holding “higher priority than the people being
served,” DAIP concluded, the program could never offer effective treatment.\textsuperscript{107}

The Subjective Nature of Rehabilitation

Though Civil Addict Program administrators presented the program as one of
treatment and control, its control overshadowed and undermined treatment. Regardless
of rehabilitative efficacy, NAEA members retained the right to place outpatients back
into incarceration at a CRC facility or subject them to intense supervision for the
mandatory three or seven-year period. The ideology behind this stemmed from fear that
addicts must be removed from the social body—even from the regular prison
population—and isolated in order to prevent the spread of narcotics addiction to the
community. Therefore, addicts not responding to treatment remained under strong
supervision and control. Although the program had a fixed ten-year limit, administrators
“unblushingly” claimed the power to recommit individuals “irrespective of the periods of
time of any previous commitments” until they determined adequate rehabilitation had
been achieved.\textsuperscript{108} As a result, many suspected addicts remained under the program’s web
of control between 1961 and 1971, unless through means of illegal escape, filing
successful writ of habeas corpus, or death.

\textsuperscript{108} “Civil Commitment of Narcotic Addicts,” \textit{The Yale Law Journal}, 76, no. 6 (May 1967): 1161;
California Welfare & Institutions Code § 3201.
In fact, the Civil Addict Program had been predominately about control from the very beginning. In this sense, it aligned with the Brown administration’s increased narcotics violations penalties also introduced in 1961. Even after *Robinson v. California* prompted regulatory changes in the Civil Addict Program to clearly distinguish it from punishment and the prison system, Walter Dunbar, the director of California’s Department of Corrections, expressed concern that the program could circumvent this stiff narcotics legislation. In a review of the program in early 1962, Dunbar wrote, “Question: How long will addicts be kept in the center for treatment? Answer: The major emphasis in this program is on control. The answer is as long as necessary.”

The intensity of control used by the Civil Addict Program far exceeded that of state prison institutions in that it reached deep into personal areas of the addict’s life. While both the inpatient at CRC and the inmate in state prison faced incarceration and isolation from society, the outpatient in society faced far greater degrees of supervision and stiffer regulations than the parolee, coupled by more subjective measures leading to return to the program. For instance, though state prison parolees also faced regular anti-narcotic testing since 1954, they did so far less regularly. By 1960, only 600 out of an estimated 1,782 suspected narcotics addicts on parole from state prison faced regular testing, having much to do with the inmate’s profile and the availability of testing. By contrast, every

---

109 California Rehabilitation Center Advisory Committee, *Minutes of California Rehabilitation Center Advisory Committee on Commitment Procedures and Treatment Program*, California Rehabilitation Center, Corona, California, April 12, 1963, 4, F3717:258, California State Archives.


111 McGee, *The Narcotic Addict Control, 3; Remarks of Richard A. McGee, Director of Corrections, to the Governor’s Council at San Diego*, September 30, 1960 (For release at 10 AM, Sept. 30), 7, Department of Corrections Records, F3717:900, California State Archives.
Civil Addict Program outpatient faced a weekly scheduled anti-narcotic test, along with one surprise test monthly, for the duration of his or her three or seven-year sentence. Furthermore, the subjectivity of the anti-narcotic tests raises concerns over whether outpatients were treated fairly, aside from the other numerous strict and subjective terms governing outpatient status. DAIP reports criticized the testing for its subjective nature, the negative psychological impact associated with giving intravenous injections to former needle-using heroin addicts attempting to stay clean, and its “mild heroin-like experience.” 112 Corrections officials even acknowledged that some outpatients had “abnormal pupillary reactions” to the tests, thus making it difficult to ascertain when reuse of narcotics had actually occurred, and that the tests were not entirely foolproof or conclusive. 113

In the end, these strict regulations, legally enforced by the state’s right to a compulsory civil commitment and treatment program for perceived narcotics addicts by way of disease control and societal protection, predicated addicts’ freedom on the subjective judgment of Civil Addict Program authorities. These officials determined whether rehabilitation truly occurred in each resident, or at least occurred to the point of diminished threat to the community. The numerous inflexible outpatient regulations, which failure to comply with resulted in re-incarceration at CRC, further restricted the addict’s freedom. An outpatient’s return to CRC hinged largely upon the attitude of his

112 Regents of California, Second Annual Report to the Legislature, Drug Abuse Information Project, Dr. David E. Smith, San Francisco, California, December 1968, 3, Department of Corrections Records, F3717:1684, California State Archives.
or her assigned caseworker and the decision of the NAEA. Again, a caseworker could recommend return to CRC merely for "signs of deterioration in attitude or behavior."114

The subjective nature of interpreting narcotics treatment success rates is apparent in Civil Addict Program statistical studies from 1961 to 1971. Proponents of the program found statistics to back their enthusiasm, while critics underscored the dubious methods used to comprise those statistics, seeing instead an ineffective program with too much power. Statistics for treatment success rates can be widely manipulated. The program's own annual reports found that it achieved commendable success rate through increasing the number of drug-free years for program residents to reducing crime from known drug addicts.115 The 1966 NRAC annual report stated that 37.5% of addicts in the program remained drug-free in outpatient status for at least one year, and that 170 individuals had successfully completed the program and been discharged by that time. It predicted that over 300 residents would achieve successful discharge by 1967. In terms of the advantages the Civil Addict Program held for the community, the report stated that the 1,700 men currently in CRC could have been costing the community up to $136,000 daily through each stealing as much as $80 a day for narcotics.116 However, several in-depth studies of the Civil Addict Program tell a different story.

Evaluation articles written by CRC research analysts questioned the Civil Addict Program's accomplishments and reiterated the idea that assessing the achievements of drug treatment programs is a "perilous undertaking," depending largely upon

114 California Department of Corrections, General Information, March 10, 1972, 35, Department of Corrections Records, F3717:363, California State Archives.
115 Narcotics Rehabilitation Advisory Council, Third Annual Report of the Narcotics Rehabilitation Advisory Council, 1, Department of Corrections Records, F3717:259, California State Archives.
116 Ibid., 2-3.
interpretation. Kramer believed the program managed to rehabilitate but a “modest proportion” of all program residents. Although only approximately one out of three patients remained free from detected drug use after one year in outpatient status, that number decreased to only one out of six after three years in outpatient status. Furthermore, California state prison parolees, though an older demographic and faced with less stringent parole terms, maintained a nearly identical success ratio one year into parole as Civil Addict Program outpatients did. Kramer concluded that a treatment program should be evaluated not solely for the amount of success it may achieve, but also in terms of the consequences for the majority that fail. By 1970, over 18,000 individuals had cycled through the Civil Addict Program. Unfortunately, the majority spent many years in a vicious rotation of time spent at CRC and time spent under strict supervision in the community.

Chapter 5

CONCLUSION

The Civil Addict Program emerged in a new era of therapeutic treatment perspectives for narcotics addiction, marking a distinct change from the stiff federal narcotics violations policies governing both the addict and treating physician since the early twentieth century. However, the high profile nature of narcotics addiction problems in California continued to be a divisive issue. On the one hand, a conservative-leaning faction of District Attorneys (D.A.s), law enforcement officials, and major newspapers such as the Los Angeles Times endorsed increased penalties for narcotics violators. On the other hand, a liberal-leaning faction of human rights groups, academics, and sociologists, endorsed ambulatory narcotic clinics and reduced criminalization of narcotics.  

Governor Edmund G. Brown’s Civil Addict Program contained aspects that appealed to a varied constituency. First, it appeared on the surface to be an alternative to prison. The vast majority of program residents did, in fact, enter the program in lieu of prison charges. Second, the Civil Addict Program served as the public face of treatment. Enough so that many individuals volunteered entrance into CRC facilities to receive therapeutic treatment by medical physicians and psychological staff. Third, the program emphasized control over narcotics addicts. In this sense, program administrators could isolate and supervise addicts with no criminal charges, and who otherwise could not be

imprisoned. These measures of control “convinced... reluctant legislators” to pass the program bill into law.120

The Civil Addict Program is most significant, however, in terms of the experiences faced by the 18,000 individuals who cycled through the program by 1971, including their family members and friends who waited for them at home. Many residents, especially those who volunteered into the program, resented it for its prison-like atmosphere. Moreover, a large number of suspected addicts could never remove themselves from the program’s web of control between 1961 and 1971, unless through means of illegal escape, expiration of the maximum ten-year time limit, filing successful writ of habeas corpus, or death. Those with misdemeanors spent considerably longer time in the program than would have in prison. Many of these residents had been charged with minor narcotics offenses and may not have had serious addiction problems. In fact, officials expressed concern over the amount of mistaken evaluations. Ironically, the program seemed advantageous for felons, in that they typically served less time than would have in prison, and disadvantageous for everyone else. Provided the treatment worked, it offered new opportunities for felons, yet at the expense of volunteers and those with misdemeanors.

Over time, program administrators came to realize the punitive nature of the Civil Addict Program, prompted largely by the 1962 Supreme Court case Robinson v. California, which challenged the constitutionality of criminalizing narcotics addiction. In

turn, authorities removed official penal terminology from the program, ensured due process of law for suspected addicts, and reallocated the authority of the program from penal laws to health and welfare laws in order to remove its indicia of criminality and offer a more humane way of dealing with narcotics addicts. Somewhat ironically, these measures gave the Civil Addict Program power previously unattainable, most notably in strengthening compulsory commitment procedures and allowing program authorities the independent subjective decision of when rehabilitation had truly occurred for each resident.

Major criticisms by the Drug Abuse Information Project (DAIP), program staff, and residents themselves leveled against the Civil Addict Program also forced officials to take into account the prison-like nature of the program. The DAIP, a statewide drug abuse treatment oversight committee mandated by law in 1967, relentlessly condemned the Civil Addict Program as ineffective, as highly bureaucratic, and as an extension of the punitive policies targeting the narcotics addict over the last fifty years in the United States. Dr. John C. Kramer, Chief of Research at CRC from 1966-1969, released numerous publications pointing to these same issues. Program residents, when allowed the opportunity to share their point of view in interviews and questionnaires, voiced the same opinion.

By the mid-1960s, Civil Addict Program authorities began to realize the ineffectiveness and expense of applying too much control when attempting to treat narcotics addicts. Program studies from 1968 to 1971 concluded that no consistent relationship existed between the length of time spent in the program and overall
outcome. In 1972, the director of the Department of Corrections stated, “applying more control than is necessary reaches into the realm of punishment and makes the job of treatment more difficult.” It also made treatment more expensive. By 1969, administrators complained that if more treatment alternatives were not developed, new institutions would have to be built in order to accommodate the rising number of addicts entering the Civil Addict Program. They suggested partnership with local law enforcement and public and private agencies in developing new narcotics addiction treatment programs. Even Nalline anti-narcotic testing for outpatients had become troublesome by this time, due to rising costs and difficulties in supervising outpatients. Total annual testing center costs to the program, after all reimbursements, more than doubled from 1962 to 1964, from $93,172 to $190,583, due to the expanding number of outpatients with mandatory testing. Administrators expected the cost to soar to $254,370 by 1965. Moreover, the increasingly overcrowded testing sites posed considerable problems for staff and caseworkers monitoring addicts. Outpatients routinely brought drugs and alcohol into the facilities and used eye drops to cheat the tests. Caseworkers also had to spend large amounts of time in the centers at the expense of other duties, and

122 Roland Wood, 18,000 Addicts Later- A Look at California's Civil Addict Program, Dec. 1972, 15, Department of Corrections Records, F3717:364, California State Archives.
123 Department of Corrections, Issue Paper: What Alternatives Exist for Handling the Present and Future Population Within the Department of Corrections, Human Relations Agency, Revised 5-6-69, 1-2, Department of Corrections Records, F3717:1340, California State Archives.
124 California Department of Corrections, Nalline Test Operations, Parole and Community Services Division, 3, Department of Corrections Records, F3717:382, California State Archives.
had difficulties in keeping outpatients from associating with each other, which was an outpatient rule violation.125

Civil Addict Program administrators eventually instituted substantial program changes in the early 1970s, including methadone maintenance under limited circumstances and reduced mandatory time for all residents. Legislation in 1970 reduced commitment time for voluntary residents and those not charged with crimes to a maximum two and half year sentence and a minimum of no time served. It also reduced time for residents charged with crimes to a maximum seven year sentence and included the possibility of serving no time. However, authorities could impose an additional three year sentence on those charged with crimes if they deemed it appropriate for full rehabilitation. With this 1970 legislation, residents only needed to complete two years of anti-narcotic testing, as opposed to three, to be eligible for discharge. Also, residents over twenty-one years old who failed an attempted drug-free period in outpatient status became eligible for methadone maintenance under certain circumstances.126 These changes, while representing progress through experience, did not diminish the formidable amount of time taken for this to happen. Furthermore, this evolution neither eliminated the control Civil Addict Program authorities exerted over residents, nor reduced the medical authority given to these officials in making the subjective determination of when, and if, rehabilitation of the addict truly occurred.

125 Ibid., 4; California Department of Corrections, San Francisco District Office, *Inter-Office Communication*, 7-27-62, To: Cullen-Regional Administrator Reg. II, Division of Adult Paroles, 3, Department of Corrections Records, F3717:382, California State Archives.

Ultimately, the reallocation of Civil Addict Program authority from penal laws to health and welfare laws gave administrators extraordinary independent authorization to define the conditions of narcotics addiction and rehabilitation. From 1961 to 1971, in particular, they developed a program where control greatly overshadowed treatment, resulting in a prison-like experience for countless residents. Many of these perceived addicts lost their freedom for years of their lives through entrapment in an endless cycle of incarceration and intensely supervised time in the community. This should come as no surprise, however, owing to the experimental nature of the program and its placement under California's Department of Corrections, which specializes in dispensing criminal punishment through means of control. Similarly, the medical community and psychological professionals present potential restrictions on the addict's freedom when given the authority to define the conditions of narcotics addiction and rehabilitation. The labeling of narcotics addiction as a disease can easily strip the addict's freedom of personal responsibility, just as the Civil Addict Program stripped away countless addicts' personal liberties. Inherent danger lies in placing the authority to define the conditions of narcotics addiction and rehabilitation in a single institution or discipline, and thus abandoning moderation, balance, accountability, and cooperation with others. The new therapeutic perspectives for treating narcotics addiction that emerged in the 1950s offered an alternative to the extensive history in the United States of ever-stiffening penalties against the narcotics user. In its first decade, California's Civil Addict Program represents the intrinsic struggle between old and new ways of dealing with drug abuse, and the reallocation of authority over this issue from one institution to another.
BIBLIOGRAPHY


Minutes, Annual Conference of Chief Psychiatrists. Sacramento, California, December 5-6, 1968, Department of Corrections Records, F3717:901, California State Archives.


Nalline Test Operations. Parole and Community Services Division, Department of Corrections Records, F3717:382, California State Archives.

Narcotic Civil Commitment Program. Human Relations Agency, Sacramento, California, April 1, 1969, Department of Corrections Records, F3717:1340, California State Archives.

California Rehabilitation Center Advisory Committee, Minutes of California Rehabilitation Center Advisory Committee on Commitment Procedures and Treatment Program. California Rehabilitation Center, Corona, California, April 12, 1963, F3717:258, California State Archives.


Dedication Program, CRC, Corona, California. Tuesday, May 7, 1963, Department of Corrections Records, F3717:318, California State Archives.


Hosmer, Craig, Congressman. Personal Letter to Governor Edmund G. Brown, Sr. Dated
March 25, 1960, Department of Corrections Records, F3717:165, California State Archives.


---------. State of California Memorandum, Subject: Comments on Second Annual Report to the Legislature, RE: Drug Abuse Information Project, by Dr. D. Smith. California Rehabilitation Center, Corona, California, February 27, 1969, Department of Corrections Records, F3717:1684, California State Archives.


*Progress Report- Region VI*, January 5, 1972, Department of Corrections Records, F3717:1542, California State Archives.


*Region VI Program, Statement of the Need*. October 1969, Department of Corrections Records, F3717:1542, California State Archives.

*Remarks of Richard A. McGee, Director of Corrections, to the Governor's Council at San Diego*. September 30, 1960 (For release at 10 A.M., September 30), Department of Corrections Records, F3717:900, California State Archives.


---------. *Minutes of the Meeting of the Special Commission on Narcotics*. Los Angeles, California, July 20, 1960, Department of Corrections Records, F3717:167, California State Archives.

---------. *Minutes of the Meeting of the Special Commission on Narcotics*. Sacramento, California, November 15, 1960, Department of Corrections Records, F3717:167, California State Archives.

---------. *Minutes of the Meeting of the Special Commission on Narcotics*. San Diego, California, June 7, 1960, Department of Corrections Records, F3717:167, California State Archives.

---------. *Minutes of the Meeting of the Special Commission on Narcotics*. State Building, Los Angeles, California, May 4, 1960, Department of Corrections Records, F3717:167, California State Archives.


Wilson, B. *An Assessment of California's Civil Addict Program*. June 1976, Department of Corrections Records, F3717:1660, California State Archives.


Wood, Roland, W. *18,000 Addicts Later- A Look at California's Civil Addict Program*. December 1972, Department of Corrections Records, F3717:364, California State Archives.


United States Senate Permanent Investigating Committee, Committee of Government Operations, United States Senate. Department of Corrections Records, F3717:318, California State Archives.