

## Enforced Treatment—Is It Treatment?

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I feel a little like the lamb being led to slaughter in speaking of enforced treatment as a viable concept in the presence of such stalwart defenders of individual rights as Judge Bazelon, Bruce Ennis, Alan Dershowitz and Alan Stone. Of course, some of you may think that my very audacity in proposing such a position places me in the role of a wolf in sheep's clothing.

My thesis is that enforced treatment is nonetheless treatment and can, in fact, produce changes which are desirable from the standpoint of the individual and society. I shall present data which indicate not only that it is possible to treat patients successfully under coercion but also that without coercion treatment is often not possible. I shall attempt to show that enforced treatment has been conducted successfully for many years in various programs. I use the words "coerced" and "enforced" interchangeably, since both terms really apply whenever an individual becomes involved in a treatment program because of some external pressure. Finally, I shall focus upon the Patuxent Institution in Maryland, which, as many of you know, is a special post-sentence institution for "defective delinquents" who receive indeterminate sentences when committed by the courts following a full hearing.

Lest too many of you at this point believe that I am the wolf in sheep's clothing or a wide-eyed "therapeutic zealot," I offer one important caveat to my belief in enforced treatment. I believe that all reasonable due process requirements must be adequately met before the individual is forced to enter treatment. Of course, opinions differ as to when the requirements of due process have been fully met. Insurmountable problems may arise if we are to meet all of the requirements some believe necessary. One of these is confrontation of the author of previous reports. Some credence must be given to past history if we consider for enforced treatment only those offenders who have repeatedly committed unacceptable offenses. I would be reluctant to force treatment on first offenders. Remember that I speak as a concerned therapist and not a constitutional expert. I am not an attorney.

There is another important factor that I feel you must keep in mind with reference to my comments as opposed to the comments of the other speakers whom you have heard today and will hear later. You must remember that I am mainly speaking of those individuals who have committed crimes against persons and have been found guilty, and in a different context those whose behavior has interfered with their industrial performance. I am not speaking about the mentally ill, whom I naturally do not see as criminals and whom I do not even see as being particularly dangerous. On the other hand, there are many convicted criminals who I believe have proven themselves to be dangerous and who I believe will continue to be dangerous. Another important factor to keep in mind is

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that while the mentally ill may, in Nicholas Kittrie's terms, have a right to be different, this right may be allowed only as long as this difference does not "interfere" with someone else.<sup>1</sup> It has generally been accepted and recognized that the criminal convicted of a crime against persons may not have a right to continue such behavior and remain free. The law, whose very essence is the protection of society, has a right to prevent him from continuing such behavior by incarcerating him or, at least, placing him under special supervision. It would then seem to follow that the law also has the right to force him to enter a treatment program which will change his behavior so that he no longer harms other persons. He does not have a right to be *that* different, or, in other terms, he does not have the right to be harmfully different. I will leave it to others seriously to propose the argument that if he harms others and does not want treatment we should merely lock him up and throw away the key, a very coercive form of treatment in itself.

Let us now look at some of the results of enforced therapy. We might first glance at the success achieved with the classically mentally ill. We all know that involuntarily committed mental patients have been treated successfully. In that direction, Otto Will says, "When I become the therapist of a coerced person, I don't pass the buck to anyone; I say that I accept my position willingly and I share, more or less directly, the responsibility for setting limits to behavior. If I knew something better to do, I'd do it. . . . I do not deny that I am a prison-keeper, but I do suggest that the patient is also one. He lives within a prison of the self—keeping himself in and others out. I often have some reluctance to become involved with this imprisoned person, as I know that he will for a time imprison me in his own fears and hates, and that he will beat on me as a substitute for all of those people and ideas that have led to his incarceration. But I gladly seek his true freedom because only through it can I find my own."

As for the treatment of the convicted criminal, there are numerous programs, both inpatient and outpatient, in which treatment has been forced upon individuals as a condition of their sentence. The APTO (Association for Psychiatric Treatment of Offenders) programs in several cities offer one example. A currently outstanding example would be those treatment programs for drug addicts, whether involving Methadone or abstinence, in which an individual is given a suspended sentence and probation on condition that he attend such a program. He may have to submit to routine urine tests, psychotherapy, group therapy, etc. and will violate his probation if he does not follow these conditions. The same applies to individuals who, after serving part of their sentences, are paroled to such programs. I think we can accept, without delving deeply into statistics, the fact that for at least 50% of the addicts who have appeared before the courts, enforced outpatient treatment has been useful in varying degrees. This figure is opposed to the very high recidivism (90%) resulting from simple incarceration.

The alcoholic, who represents another type of addiction, has for many years been treated quite successfully under coercion. The simple commitment of the alcoholic to a state hospital has not, in itself, seemed to be very beneficial. Alcoholics Anonymous, in my opinion the most useful form of help for the alcoholic, is not generally visualized as a coercive form of treatment. Many patients, however, have in fact been forced to attend AA either as part of their sentences or by their wives, families, or employers on the threat of separation. Those who work with alcoholics believe that the alcoholic must reach his own bottom before he will accept treatment. Several hundred industrial programs for alcoholic employees operate under what I would consider coercion. I have been informed that these are not coercive programs. The industrial alcoholic counselor does not coerce the patient. It is the alcoholism which is coercive. All that the industrial counselor tells the employee is that management is convinced that he has a serious alcoholic problem. His production has gone down; his absenteeism on Fridays and Mondays has gone up; etc. He has shown a recognizable alcoholic pattern. If he wishes, his superiors will be happy to consider his case from the usual union-management standpoint in terms of his productivity and decide whether to discharge him. They are quite willing,

however, to forego such a consideration at this time if he will accept their recommendation to become involved in a treatment program for alcoholism. If he cooperates, the program will report regularly that he is doing so. As long as he continues in treatment and begins to show some improvement in his productivity, his superiors will not consider him for termination. If he fails to follow through, however, they will have to consider him as they would any other unproductive employee. Is this process coercion? In the words of the National Council on Alcoholism, "The most important aspect of a successful recovery from alcoholism is the motivation to accept treatment, rather than treatment itself."<sup>2</sup> Through a certain kind of coercion, the alcoholic employee may become motivated.

The U. S. Navy reports that the incidence of alcoholism among its personnel may be as high as 15%.<sup>3</sup> The Navy's Alcoholism Prevention Program, which operates much like the industrial program I just described, reports a 70% restoration to active duty rate, for those so seriously alcoholic as to require initial inpatient care. Several industrial programs report results of 90% from what I feel is enforced treatment. The employed alcoholic whose job is so important to him that its prospective loss can be used as an inducement to obtain treatment is forced into treatment with successful results, and without such an "inducement" he would not seek help. Melitta Schimideberg, in speaking of the treatment of offenders, says, "Rehabilitation is possible only if the offender wishes to change. To make the very great effort which is necessary the offender needs a strong motivation. This usually stems from a deterrent that has really shaken him. Thus, rehabilitation depends on the (open or implied) threat on the one hand, and on the hope on the other.

"If a man, for psychological, physical or social reasons is unable to earn a living honestly, no amount of fear will socialize him. Thus, rehabilitation presupposes the right combination of positive and negative incentives."<sup>4</sup>

What of the outpatient programs for the sex offender? I am not here speaking of the sexual psychopath laws requiring inpatient care. I am speaking of the exhibitionist, the voyeur, the pedophile or child offender, and possibly some rapists for whom outpatient facilities have been established in Toronto,<sup>5</sup> Philadelphia, Oklahoma, California and Baltimore. While certain of these offenses, such as voyeurism or exhibitionism, are not generally considered serious threats to other persons, there are some exhibitionists who enjoy carrying on their activities before young children. Such an experience is believed to be frightening and probably seriously disturbing to the immature child. In those communities in which outpatient treatment facilities exist, these offenders may be placed on probation on the condition that they attend the special clinic for treatment for a specified period of time. In Baltimore we are, under such enforced conditions, currently treating both sex offenders and a group of individuals who have committed crimes of violence, such as assaults, rapes, and attempted murders.

The sex offender statistics published by Turner and Mohr from Toronto and by Peters in Philadelphia, and the initial data that we have developed from almost two years of an enforced group therapy program, have indicated that when close probation supervision forces patients to attend, very satisfactory results can be obtained by outpatient treatment of those with repeated offenses. Those clinics that have no means of enforcing attendance at treatment sessions have repeatedly reported poor results.

These data reflect the common experience of the private practicing psychiatrist who becomes involved with such patients. The story usually goes as follows: The psychiatrist sees the offender prior to trial and writes a letter to the court stating that the patient recognizes his problem and is interested in obtaining therapy, and that the doctor agrees to treat the patient. The patient persuades the judge that he is willing to get treatment. He is given a suspended sentence and placed on probation on the condition that he attend therapy. Any of you who have been in this position know exactly what usually follows. The patient may come to several sessions and then cancel. Frequently he

commits the greatest sin against the psychiatrist—he doesn't even pay his bill. What is the psychiatrist to do? Is he to write the judge? Is he to write or call the probation officer? With whom does the doctor have a contract? The patient, the judge, or both? When the contract is clear, as in Mellitta Schmideberg's work with probationers and parolees, the results have been gratifying. Usually the psychiatrist, feeling that the contract is with the patient, does nothing. Of course, one might ask why doesn't the probation officer do something? For various reasons such cases are generally assigned to probation officers with large caseloads. When the officer understands that the patient is in treatment he writes the case off in terms of any close supervision and then completely forgets about it. Should he be interested enough to call on his client, he may then be told that the patient stopped treatment because the psychiatrist "never said anything" or that the psychiatrist's fees were too high and the patient could no longer afford them. Of course, the patient has assured the court at the time of sentencing that he can manage quite adequately. The probation officer is quite sympathetic with anybody who is expected to pay \$35 or \$40 an hour to see a "shrink," so he carries out his duty by referring the patient to one of the public clinics, who are not interested in such patients; and by the time this dance is over, so is the probation period.

Obviously such "therapy" is not "enforced." Further examples of successful enforced therapy, however, exist in the so-called sexual psychopath programs. I understand that some of these are not treatment programs but merely excuses for indeterminate incarceration, and I cannot accept such programs. California, Wisconsin<sup>6</sup> and Massachusetts,<sup>7</sup> however, have reported excellent results from programs that do offer what most of us would consider treatment. (What is and what is not treatment is a separate topic, although I will say that most offenders appear to require treatments different from the usual one-to-one, office-bound, classical psychiatric relationship.) These programs consistently report a 6–8% recidivism rate for those fully treated, and a 30–40% rate for those partially treated (those who are released before the staff feels they are ready for release).

Before going on to the Patuxent Institution and the enforced treatment of the psychopath, I would like to comment further upon those recalcitrant patients of whom I have just spoken. Why are these individuals, whose symptomatic behavior has resulted in serious trouble for them, unwilling to accept treatment which will help them with their behavior? These patients seem to be entirely uncomfortable only when caught. I will not say that many of them may not feel guilty or inadequate at other times, as a result of the problems their symptomatic behavior produces; guilt or inadequacy feelings may, in fact, operate to produce such behavior in the first place. Nevertheless, such patients do not seem to be well motivated for suffering the rigors of treatment in order to rid themselves of symptoms about which they feel guilty and which jeopardize, at times, their very lives. In a psychological sense it would seem as if such a patient's symptom is not ego-alien; that is, he does not find it so unacceptable that he really wants to change it. After all, a major factor motivating the voluntary psychiatric patient is his discomfort with his symptoms, whether they be hallucinations, delusions, severe depression, anxiety neurosis or a phobia. The symptom is something that interferes with his life. It is something that he does not enjoy, that makes him uncomfortable, and that he wishes to change. On the other hand, the alcoholic, addict or sex offender often does not respond this way, even though, under certain conditions, he may verbalize to the contrary. One obvious conclusion is that the patient must get some pleasure from his symptom if he is not willing to try his best to obtain relief. While I know and understand that the willingness to change or to attempt to obtain change is a very complex, multi-determined matter, it does seem that the symptom itself must give sufficient pleasure to impede the desire for change. To look at the problem another way: if the law were changed so that heterosexual behavior became a crime and homosexual behavior was legal, how many of those of us who are heterosexual would be willing to become involved in extensive therapy in order to change?

I am convinced that it is generally not possible to treat "acting-out" patients unless an external force requires that the patient attend treatment sessions regularly for an extended period of time. Those of you who disagree have had, I suspect, very little experience in treating such patients. Levenson describes enforced group therapy for juvenile delinquents.<sup>8</sup> They had to attend therapy until they obtained an infraction-free institutional record for three months. They behaved in order "to stay out of your damned group." Chawst, who has worked with offenders in APTO programs, speaks of inner and outer controls being inversely related.<sup>9</sup> He says, "In treating offenders, the overall aim could be seen as one of shifting from recourse to open-outer controls to the development of controls from within."

I do not believe that it is within my expertise to state whether it is proper for the law to so force people to obtain treatment. The basic decision whether to force people to take treatment is a societal-legislative-judicial determination. The psychiatrist can clarify what he can do and how. Some serious ethical considerations, of course, require constant surveillance lest our efforts at treatment be abused for political purposes or used inconsiderately, as exemplified in "Clockwork Orange."<sup>10</sup> Halleck has recently spoken to these problems and has suggested guidelines to be used in enforced therapy programs.<sup>11</sup> Successful surveillance of such programs is possible, as proven by our knowledge of certain programs that have been considered undesirable when attention has been focused on them. In our zeal to prevent unethical coercion, however, we must not forget that, in my opinion, we cannot, with our present tools, treat so-called "acting-out" patients unless they are forced to attend treatment sessions.

At this point I would like to mention that I personally will not treat any court-ordered patient in my private office regardless of his offense unless the court requires me regularly to report three items: (1) whether the patient is regularly attending treatment sessions, (2) whether he pays his bills regularly, and (3) whether he is doing the best that can be expected of him in treatment. The patient must understand these conditions. Unfortunately, I cannot give you any real data about this procedure, since I have only recently set these conditions for myself. I do know, however, that prior to my instituting such a plan I was rarely able to keep court-ordered patients in private treatment.

I believe that it is now time for us to look at Maryland's unique experience, the Patuxent Institution, established by a legislative act in 1951 as Article 31 B of the Annotated Code of Maryland. I have observed Patuxent as a member of both its Governing and Advisory Boards for the past seven years. Research Report #29 of the Maryland Legislative Council developed the concept of Patuxent. It states the institution's purpose: "For the protection of society from the segment of the criminal population who probably will again commit crimes if released on the expiration of a fixed sentence; thus they should be detained and specially treated unless and until cured." Patuxent's physical plant was completed in 1955, designed as the usual state architecture, somewhat resembling a senior high school. It is located about twenty-five minutes from downtown Baltimore in a rural-residential, farming, and correctional area (there being several other correctional facilities within a few miles of the Institution). It is designed as a prison-hospital, primarily being a correctional facility whose goal is treatment where applicable. A defective delinquent is defined "as an individual who, by the demonstration of persistent, aggravated, antisocial or criminal behavior, evidences a propensity toward criminal activity, and who is found to have either such intellectual deficiency or emotional unbalance, or both, as to clearly demonstrate an actual danger to society so as to require such confinement and treatment, when appropriate, as may make it reasonably safe for society to terminate the confinement and treatment." A request may be made that a person be examined for possible defective delinquency if he has been convicted and sentenced in a court of this state for a crime or offense "coming under one or more of the following categories: 1. a felony; 2. a misdemeanor punishable by imprisonment in the penitentiary; 3. a crime of violence; 4. a sex crime involving: (a) physical force or

violence, (b) disparity of age between an adult and a minor, or (c) a sexual act of an uncontrolled and/or repetitive nature; 5. two or more convictions for any offenses of crimes punishable by imprisonment, in a criminal court of this state." After the individual has been sentenced to an appropriate term, he may be referred to Patuxent by himself (through his own attorney), the judge, the state's attorney, or the Department of Correction. He is then evaluated by a staff of psychiatrists, psychologists, social workers and internists, and generally within six months or less a report is submitted to the court stating whether, in the staff's determination, the individual fits the requirements for the status of being a defective delinquent. If the Institution states that he does not fit these criteria, then he is automatically returned to the care of the Department of Correction and serves his sentence as would any other sentenced prisoner. If, however, the Institution feels that he does meet the requirements of a defective delinquent, the court sets a date for a hearing under civil proceedings in which the burden of proof is upon the state to prove that the individual is a defective delinquent by a preponderance of the evidence. He is allowed to have legal counsel and a psychiatrist of his own choice—if necessary, at state expense. He has the right to trial by judge or jury. If the results of his trial indicate that he is not a defective delinquent, then he is returned to the Department of Correction to serve his terminate sentence as would any other sentenced individual. If, however, he is found to be a defective delinquent, his terminate sentence is suspended and he is given a fully indeterminate sentence from one minute to life.

I recognize that the very thought of an indeterminate sentence is probably totally unacceptable to most attorneys in view of their training and the basic premise upon which they view the loss of liberty. The punishment is to fit the crime and not the criminal. The sentence is to be terminate and not indeterminate or indefinite, and the whole concept of treatment is one that is not fully endorsed by many of my brethren from the Bar. Despite this, a large segment of society has become convinced that those old rules and that old system have not been very effective or productive of the results that society has a right to expect. Of course, we all know that in a free society, if we are to remain free, the civil rights of all must be protected. As Jefferson said, "The price of freedom is eternal vigilance." I believe Article 31 B has a framework that protects the civil rights of the offender and offers the due process requirements necessary for this protection better than any other indeterminate sentence law. I doubt, however, that all of you here will be so satisfied. Yet to be resolved is the problem that the defective delinquent hearings are established under civil law and not criminal law and that the degree of proof required is a preponderance of evidence and not proof beyond a reasonable doubt. I do not know whether a standard of proof "beyond a reasonable doubt" would be realistically applicable, although I doubt that it would, in practice, make a lot of difference.

Like the law itself and like all new laws and organizations, Patuxent has had its problems in growing and developing, and certainly errors have been made there—none of us is perfect. Despite the explicitness of the definition of a defective delinquent, certainly in 1955, when the Institution first opened, interpreting that definition proved difficult. The concept of dangerousness changes with societal standards and the acquisition of knowledge. The law's attitude towards marihuana is a case in point. Dangerousness, fortunately, is not a completely static concept. In 1955 we did not have the information we have today concerning such sex offenders as the exhibitionist and the pederast. In fact, it is because of the establishment of such institutions as Patuxent and some of the outpatient clinics about which I have spoken that we have been able to reexamine some of our ideas about dangerousness. In the beginning, however, some exhibitionists and peeping-Toms were referred to Patuxent and recommended by the staff for commitment. Fortunately, all of them are gone. Also, as the law's concepts of what determined a dangerous individual changed along with those of modern psychiatry, it became rare for an individual who had committed only property offenses to be recommended

by the Institution for commitment as a defective delinquent. In my opinion, Patuxent has grown and changed, keeping pace with societal and legal attitudes in its nineteen years of existence. Some of the growth and change in Patuxent has been spontaneous, while some has been the result of direction and guidance furnished by the staff or the Governing or Advisory Boards. Other changes have been forced upon the Institution by the courts. Patuxent has probably been involved in more litigation than any other correctional institution in the United States. In a way, I think this is fortunate, because it has, in fact, enabled the institution to be repeatedly examined, dissected and resurrected. Unfortunately, litigation has required an inordinate amount of the staff's time, valuable professional time that might have been otherwise used for treatment or research. As you know, the courts, including the Maryland State Court of Appeals, the Federal 4th Circuit Court of Appeals, and the United States Supreme Court, have upheld the concept of Patuxent and the indeterminate sentence while, at the same time, offering guidance and changes when indicated. Some questions still need to be answered, and we look forward to their being raised and finally decided. I doubt that the day will ever come, however, as long as the indeterminate sentence exists at Patuxent, when we will be allowed to become complacent.

The Institution has been operating for almost nineteen years. It is certainly now time to see what this experiment has wrought. As you know, there are always weaknesses in statistics and statistics can be twisted. Some of you here have already raised questions about the data I am going to present. Some of your concerns have been answered; I hope I can answer others today. Still others will have to await the day when we have more data.

The basic modalities of treatment at Patuxent are group therapy and milieu therapy associated with educational and vocational training and a form of behavioral modification known as the tier system. (A tier is a closed unit varying from 22 to 32 cells, similar in some ways to a ward in a hospital.) As an individual shows himself able to deal with increased freedom and opportunities, he moves up to the next highest tier, where he is given more privileges and responsibilities. The Institution, of course, has work release (live-in work-out) programs and a multitude of extended and special parole programs, followed by a half-way house or close supervision in the community. There is a graded recall to the Institution, i.e. a paroled patient may violate parole and be returned to the Institution but may continue going to his job in the community. As soon as he has restabilized he may go out again. While this method has produced an artificially high parole violation rate, it does allow that necessary individual flexibility not available in conventional "all or none" parole violation procedures generally used in regular correctional systems. Our rates are always higher because inmates are brought back the first time they start indicating they may be in trouble. We do not wait until they are arrested for a new offense. If an inmate's previous offenses have been related to family stress or alcohol, as soon as his therapist at the outpatient clinic recognizes signs of impending loss of control he may be returned to the Institution temporarily and then, of course, have a hearing. Or he may be called in for a hearing without premature loss of his freedom. He will probably be allowed to keep his job but will be supervised closely until the problems can be examined and dealt with. I guess this is preventive detention.

Some of you have visited Patuxent and have been appalled by what you saw as compared to what you had expected. I am always amazed at the expectations people have when the words "psychiatric treatment" are added to the goals of an institution: white coats and couches appear to be the association. Some of you have read about Patuxent and been appalled by some of the descriptions. In this direction, Nicholas Kittrie, in his recent book, *The Right to be Different*, has, unfortunately, perpetrated some exaggerations and distortions, as have other authors. Those who are opposed to Patuxent seem so zealous that they avoid the facts and present a biased and distorted picture.

For example, Kittrie says, "Patient C-930, a single white male forty-five years old, was

committed to the psychopathic institution in 1962 after being charged with assault and maiming." After describing the man's earlier history, he says, "The offense which resulted in his commitment as a psychopath was rather spectacular. He met the victim in Cumberland and took her to his home, allegedly to visit his invalid aunt. The woman went willingly, but upon discovering that he had no whiskey, wanted to depart. When she tried to leave, he took her to the basement, tied her up, and cut her body. He used a small knife, and the cuts did not produce permanent scars. After making the incisions, the patient took the victim to a bedroom, placed her on a bed, and went away. He said that he was sorry he had hurt the woman. The woman testified that he had given her a drink after the incident. The patient was not sentenced for the offense, but instead was indeterminately committed for treatment and rehabilitation. In 1966, after four years in a psychopathic institution, patient C-930 sought release. The reviewing physician on the staff of the institution responded negatively: 'If released, with his lack of insight, he would probably continue a nomadic existence and would be dangerous to others in the environment.' The decision was made, therefore, by the institution's director to continue the commitment of patient C-930 for a further indeterminate period."<sup>11</sup>

Obviously, some of these facts are gross distortions. In the first place, an inmate may not be committed to Patuxent unless he *has* been found guilty of a crime and sentenced. This inmate was sentenced to five years, having been found guilty of the charge of maiming, and then referred to Patuxent. Further, the Director of the Institution does not decide whether an inmate is to be released. An inmate may be released by the Institution's Board of Review, similar to a Parole Board. This Board is composed not only of staff but also of outsiders such as professors of sociology and constitutional law as well as several practicing attorneys. The Board reviews all cases at least once a year. The inmate has a mandatory court hearing on his status as a defective delinquent after he has served two-thirds of his original sentence and every three years thereafter. At his hearing he may have, at state expense, a psychiatrist of his choosing and an attorney. In this case, the inmate had a full hearing before a judge who, despite the Institution's recommendations to the contrary, released the man.

A few weeks after this particular inmate was released from Patuxent by the court, he picked up a twenty-year-old girl and took her to his cabin in the country. He slit her from the middle of her chest to the middle of her pubic bone, disemboweling her, and then went into the corner and blew his brains out. No one found her for several hours, and she died. I would say that Kittrie's implications that this man was harshly treated are, at the least, misleading. Not that Patuxent is always right.

Only in the past few years has the Institution been able to accumulate sufficient data to enable it to evaluate its efforts. Some of you are familiar with this data (reported in January 1973) and have offered a critique of it.<sup>12</sup> Unfortunately, at this time the success or failure of Patuxent's efforts must still be measured by the recidivism rate. We all know that recidivism as a criterion of success has severe limitations, and yet to my knowledge there is no other readily available manner of measuring the success or failure of correctional programs. Super-sophisticated research is, unfortunately, not currently financially feasible. The Federal Government does not seem interested in research programs related to such institutions, and funds at the Institution that might support research frequently end up being used to defend the Institution in the courts. Despite the limitations of the recidivism rate as a test of success, it is what we must use. The overall national rate is generally considered to be 65%. Although I am aware of Glaser's research in federal prisons which lists a possible rate of 40%, I do not feel that his results are applicable to the type of offender we have at Patuxent.

In the first group (1) shown in Table I you will see the listing of the patients who were recommended for commitment but not committed by the courts. In a sense, the courts did not accept the Institution's recommendation. These individuals then were returned to the Department of Correction to serve their terminate sentences. Their recidivism



TABLE I

Recidivism Rates—Comparing Four Groups of Patuxent Patients and the  
National Recidivism Rate (1955–1972)\*

	<i>Number</i>	<i>Recidivism Rate</i>
National Rate Most Frequently Quoted for Adult Offenders		65%
1. Patients recommended for commitment but not committed by the Courts (not treated, subjected to regular correctional system programs)	156	81%
2. Patients released at rehearing against staff advice, in-house treatment only	186	46%
3. Patients released at rehearing against staff advice, in-house treatment plus conditional release experience	100	39%
4. Patients released at recommendation of staff and Institutional Board of Review, in-house and continued treatment for three years on parole	135	7%

\* 217 of the 638 committed patients were not included in Table I. 166 were still under the jurisdiction of the Institution (in-house and on parole). The remaining 51 were released on legal technicalities and/or were too recently released to meet the criterion for inclusion (opportunity to be in society for three years).

rate was 81%. It should be expected that this rate would be higher than the general rate, since a person should not be referred to Patuxent unless there is reasonable evidence to believe that he is a dangerous person. The second group (2) are patients who, in a sense, have only completed half of the program. They have never been out on any parole status or live-in, work-out program, although they have advanced from the receiving tier to the third or fourth tiers, the fourth tier being the highest in the Institution. Here we see an improved recidivism rate of 46%. The third group (3) includes patients who have had some conditional release experience and therefore, in a sense, have completed two-thirds of the program. We see their further reduced recidivism rate of 39%. With groups two and three at the time of their hearings the Institution readily admits that the individual has made progress in the Institution but expresses the staff's feeling that he is not yet ready to leave. The fourth group (4) includes patients who have completed the entire program. They have been through the Institution, reached the fourth tier, worked out, moved out, possibly lived in our half-way house and then lived on their own. They have been on parole for a period of at least three years. They have then been relieved by the courts of their status of defective delinquent. Should they commit further crimes and be sentenced and referred back to Patuxent, as usually is not done, they would have to go through the entire commitment procedure again. Otherwise, if they commit new crimes they are treated like any other offenders. The results show a 7% recidivism rate.

Like all statistics, these data are subject to possible misinterpretations. One problem that concerns many is that in group one, since 81% recidivated, 19% did not. These would represent false positive predictions on the part of the staff. Clearly such predictions exist, but perhaps they can be explained. This 19% false positive rate may represent the result of a deterrent effect of the Patuxent evaluation experience. Were some of the patients prevented from recidivating—deterred from committing new crimes—because they knew they had been diagnosed by the professionals as defective delinquents and that it was perhaps only by the grace of God that they were not judged to be defective

delinquents? In any event, complete certainty is not a quality of our art. If society wishes to demand a lower "false positive" level, then we cannot supply it at this time. The false positives of the second and third groups cannot be looked upon as true false positives, since these are patients whom the Institution has stated to be partially cured. The staff does not feel they are quite ready to leave but admittedly cannot state that they are dangerous with the same degree of accuracy as with the first group. The deterrent effect of "labeling" as stated above, which is opposite to the sociologists' theory of labeling, may also be active here.

TABLE II

Characteristics of Patients Recommended and Not Recommended for Commitment by the Patuxent Staff (1955-1972)\*

Variable	Recommended (N = 1163)	Not Recommended (N = 731)
1. Age at admission	24.4	26.8
2. Age at First Conviction	15.3	18.9
3. Prior Convictions	4.8	3.3
4. Sentence	8.6	6.6
5. I.Q.	91.9	90.8
6. Race	62% white/38% non-white	62% white/38% non-white

\* Numbers represent arithmetic means (average). Life sentences were not included when computing average length of sentence.

As shown in Table II, differences exist between those patients who were recommended and those who were not recommended for commitment by the staff. Over one-third of those referred by the courts were not recommended. The figures show the significance of Item 2, age at first conviction: criminals with earlier first convictions are likely to be recommended. Item 3 shows that offenders with more prior convictions are more likely to be recommended. The length of sentence may have some importance. I.Q. seems to be of no importance. Race is consistent for both groups.

TABLE III

Characteristics of Patients Committed and Not Committed by the Courts (1955-1972)\*

Variable	Committed (N = 976)	Not Committed (N = 187)
1. Age at admission	24.6	23.0
2. Age at First Conviction	16.6	15.7
3. Prior Convictions	4.9	4.1
4. Sentence	7.8	4.1
5. I.Q.	91.9	92.1
6. Race	60% white/40% non-white	73% white/27% non-white

\* Numbers represent arithmetic means (average). Life sentences were not included when computing average length of sentence.

With reference to the court's response to the Institution's recommendations, you can see that the court does tend to go along with the Institution but also tends, however, to pick out slightly older individuals, clearly to pick out those with longer sentences, and to show a slight preference not to commit white patients.

I believe these data indicate a successful program and speak to the utility of enforced therapy for those identified as dangerous by virtue of past offenses and current findings.

In summary, I have tried to show that enforced treatment for many repetitive "acting-out" antisocial offenders is effective, but only if a genuine external force motivates the patients to receive and remain in treatment. If I am to treat such persons I must have the necessary tools.

Eternal vigilance, lest we establish a therapeutic state or practice preventive detention irresponsibly, is absolutely necessary. Those of us involved in the programs described have tried to govern ourselves responsibly. As our sights change and our understanding and knowledge advance, so must these programs change. To proscribe universally against such programs would seem to say, "If it works, we can't use it."

Obviously, we tread on dangerous ground in a free society when we force an individual to submit to treatment against his wishes. We have, however, forced inhuman incarceration without treatment on guilty offenders with relative equanimity and, in fact, still do.

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