

## **Recidivism Among Treated Criminal Psychiatric Patients**

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Until recently there was a poverty of treatment effort devoted to criminal offenders who were housed in the public mental hospitals of this country. In a nationwide survey of such programs published in 1969, the most frequently mentioned treatment modalities used for "most or all" patients were recreation therapy, drugs and religious guidance.<sup>1</sup>

Recently, more money and concern have been devoted nation-wide to the forensic patient population. At the same time there has been general pessimism about the effectiveness of rehabilitation programs in any area of the correctional field. Others have shared the conclusion of Robert Martinson, who, after reviewing 231 experimental studies on the treatment of criminals, reported: "With few and isolated exceptions, the rehabilitative efforts that have been reported so far have no appreciable effect on recidivism."<sup>2</sup>

There is little basis at this point for arriving at conclusions about the effectiveness of hospital-based treatment programs. Steadman and Cocozza (1974) were able to locate only three published studies of offenders released from hospitalization in this country.<sup>3</sup> In addition to Steadman and Cocozza's study, we know of only two other relevant recently published studies, neither involving a strictly hospital setting: Kozol, Boucher and Garolfalo's 1972 report on Dangerous Sexual Offenders at Bridgewater, and Steadman's (1977) recidivism study at Patuxent.<sup>4</sup> Yochelson and Samenow (1977) have reported at length their fifteen-year effort to understand and treat criminals at St. Elizabeth's, but they present little statistical information.<sup>5</sup> Recent efforts to study treatment effectiveness of forensic programs at Colorado State Hospital at Pueblo and Utah State Hospital at Provo have produced unpublished reports.<sup>6</sup>

The study reported in this paper took place at the Forensic Unit of New Hampshire Hospital. The only state-supported mental hospital in New Hampshire, New Hampshire Hospital has long served as the sole facility to which forensic patients are sent in that state. The population has included men referred for pre-trial evaluation, patients committed as Not Guilty by Reason of Insanity, Defective Delinquents (an obsolete mentally retarded statutory groups), Dangerous Sexual Offenders, and patients transferred from the correctional system.

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In the summer of 1973, as part of a major effort to upgrade the quality of care at New Hampshire Hospital, the hospital recruited more manpower resources for its forensic population. A forensic unit was founded; by mid-February 1974, the entire population of male patients referred to the hospital by the criminal sessions of the Superior Court and by the correctional system was brought together into a single unit.

During the period studied, the unit had a capacity of 112 patients. Physically, it consisted of four wards, ranging from maximum security to an open ward, unlocked from 7:00 a.m. to 11:00 p.m. daily. All patients were admitted to maximum security and advanced to the open ward gradually as they gave evidence of readiness to handle increased privileges and responsibilities.

An underlying premise of the treatment program was that patients could not adequately prepare themselves for successful adjustment to the outside world in a locked ward situation. The patient thus moved gradually to dealing with the ordinary outside world as he seemed prepared to make the move without endangering society. The court was not approached for discharge until the patient was successfully involved in work or other activity off grounds. Patients on fixed sentence were encouraged to remain as voluntary patients until they seemed prepared for community transition. Patients experiencing difficulty after discharge were encouraged to return to the unit for outpatient assistance, and during the time of the study could return to inpatient status as it appeared indicated.

It was perceived as appropriate for the unit to concern itself with both mental illness and crime, to attempt to understand and treat disposition to crime as well as to illness. Treatment was thus focused on the entire functioning of the individual rather than to mental illness alone.

Patients were assigned to case coordinators — primary therapists — among the psychology and social work staff who followed their cases throughout hospitalization. Primary therapists met with ward teams for treatment-planning and decision-making. Complicated cases were staffed as needed on a unit-wide basis. An assumption was that individual psychotherapy was a critical part of treatment and that it was essential that major effort be made to develop an open, honest relationship, difficult as that might be for many members of the treatment population. Most of the therapy staff were psychoanalytically oriented. There were none who identified themselves as behaviorists. The founding unit director, a psychoanalyst, and three of the social work-psychology staff had previously worked with criminal populations, two in a court clinic and two in prisons.

Because this was a new program and gradually staffed there were fluctuations in staff cohesiveness, in detail of treatment approaches, and in the size of caseloads during the study period. However, there was only one resignation among the primary therapist staff during the study period. Caseloads at the beginning of the study period were as high as 25 patients

and gradually reduced to 10 or 12.

The unit has not been without recognized and continued inadequacies. It has been housed in an old and inadequate physical plant. The absence of full staffing, space and equipment for adequate recreation, occupational therapy and vocational training programs and work has been especially felt on locked wards.

In addition, political and newspaper attacks were, at times, quite demoralizing to staff and patients though they may have had a positive, unanticipated benefit in encouraging unit cohesion.

The model of increased freedom, as the patient appears prepared for it, is one which carries with it political risks. Society does not have the comfort of knowing the patient is locked away until the day of discharge. The very appearance of the patient in a public situation can lead to criticism of the program and has done so in New Hampshire. The unit at New Hampshire Hospital has been under considerable pressure to shift to a more restrictive model. It, therefore, seemed especially important to study the effectiveness of the model that has been in existence.

## **Methodology**

### *Data Collection*

Evidence of recurrence of crime is the only kind of data that is generally accepted as a relatively objective indicator of the effectiveness of forensic treatment programs. While restoration or enhancement of mental health is a basic goal of a forensic treatment program, society's major concern with the released criminal is that he not be involved in behavior injurious to the well-being of others. Risk of further dangerousness is the central issue in his release. Our major concern has, therefore, been evidence of recurrence of crime.

Criminal recidivism has been measured in a number of ways, often making the results of one program impossible to compare with another. Some researchers emphasize arrest; others, conviction and/or incarceration. Some define recidivism as recurrence of serious crime. In order to make our data generally comparable, we have collected information on arrest, conviction, reincarceration, and on the nature and severity of crime. We have emphasized conviction. (In urban areas overwhelmed with crime and with long delays in the court system, conviction rates so badly underestimate actual crime that arrest rates are frequently emphasized.)

For research purposes, we have equated a finding of Not Guilty by Reason of Insanity with a conviction and a criminal court-ordered post-trial hospitalization as equivalent to a sentence. (In New Hampshire a patient committed by the Criminal Courts to hospitalization cannot be discharged without court approval.)

In addition to data on re-involvement in the criminal justice system, we have gathered data on re-hospitalization. We were interested in the interaction between our study group's careers as patients and as criminals. Areas of concern were the interaction between subsequent

crime and re-hospitalization, the extent to which the hospital was used voluntarily as a resource, the extent to which the group were able to maintain themselves in the community. Because patients were encouraged to seek further hospitalization if needed, especially to avoid crime, it seemed particularly important to distinguish voluntary and involuntary hospitalization.

Data was gathered on past hospitalization and past criminal history to provide a measure of subsequent adjustment. Only adult criminal history was known while life-long history of hospitalization was available if that hospitalization had occurred at New Hampshire Hospital. Hospitalization elsewhere is known from the patient's records but probably slightly underestimated. The primary sources of data were State Police RAP sheets and the patient's hospital record. Information about past and subsequent criminal history came solely from RAP sheets, except in two instances where disposition of recent arrests had not been recorded on the RAP sheets and thus had to be obtained elsewhere, and a few confusing entries which were clarified by the patient's hospital record. Disposition was available on crimes committed in New Hampshire, but not always on crimes committed out of state.

While we have looked at crime which came to the attention of authorities in a long term perspective, obviously we cannot assume that we have studied all crime committed by this group of patients. All crime does not result in arrest. We cannot know with certainty the effect a career as a mental patient had on whether or not subsequent arrest occurred. We have concerned ourselves only with behavior that led either to arrest or hospitalization.

### *Subjects*

The study group is composed of all patients discharged from an open or semi-open ward of the Forensic Unit *to the community* after a stay of at least 90 days between February 21, 1974 and March 10, 1977. Excluded from the study were patients discharged from closed wards who had not participated in the gradual release program we were studying, and patients discharged to the criminal justice system to await trial or resume stays disrupted by hospitalization for treatment. Sixty (60) discharged patients were identified and studied. Following are some of their characteristics:

1. Mean age of the group was 31.9 years at admission; 34.1 at discharge. However, 58% of the patients were under age 30 at admission; 46.3% at discharge.

2. Legal status during the index hospitalization: twenty-six patients were committed to New Hampshire Hospital: 18 as Not Guilty by Reason of Insanity, 4 as Dangerous Sexual Offenders, 3 as Defective Delinquents (mentally retarded), one as a Program on Alcohol and Drug Abuse charge. Twenty-eight had been sentenced to the Correctional System; of this group, 15 were prison transfers, 3 House of Correction transfers, 4 on parole, 5 on probation or suspended sentence, 1 with a

case continued for sentencing. Six members of the sample were on pre-trial basis from which status they were discharged to the community; only one subsequently faced trial on the original charges (found NGRI and hospitalized briefly).

3. The most common primary diagnoses were: depressive neurosis, 12; schizophrenia, 11; mental retardation, 10; and personality disorder, 8. Other diagnoses were organic brain syndrome, 4; hysterical neurosis, 2; anxiety neurosis, 2; sexual deviation, pedophilia, 2; drug dependency, 2; alcoholism, 2; adjustment reaction, 3; social maladjustment, 1; psychophysiological disorder, 1. It is likely that some of the people diagnosed as neurotic or reactive would have been diagnosed as personality disorders in many other settings.

4. 57% of the group were hospitalized more than a year; 43%, less than a year. Of the 34 patients hospitalized more than a year, 21 were hospitalized 1 to 2 years and 13 over two years. (Most of the group had been incarcerated immediately prior to hospitalization.)

5. 73.3% of the subjects had at least one previous hospitalization, 58% had at least one prior arrest and 53% at least one prior conviction.

6. For the 35 subjects who had been arrested on at least one occasion prior to the index charge, the average period of time between first adult arrest and the charge resulting in index hospitalization was 10.22 years. This group had accumulated 220 charges (6.29 per person) and 179 convictions (5.11 per person) prior to the index charges. They had previously received 104 post-trial incarcerations (2.98) and 61 post-trial incarcerations longer than a year (1.74 per person). The mean age of the group on admission was 30.43, slightly younger than the sample at large.

7. Mean time at risk to recidivism following discharge from the studied hospitalization was 1.67 years. Median time at risk was a year and three quarters.

## Results

### *Criminal Recidivism*

Twelve of the 60 discharged patients (20%) were found to have been convicted of at least one crime after discharge. Two of the twelve (3.3%) were convicted of crimes only classifiable as felonies;\* ten of lesser crimes. Of the 36 patients whose index crimes included crimes classifiable only as felonies, only one (2.9%) subsequently committed a felony.

In addition to the twelve former patients convicted of a crime, three others were arrested but charges against them subsequently dropped.

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\*We struggled with the issue of how to define severity of criminal charges and convictions. It is customary to divide crimes into felonies and misdemeanors. However, a number of crimes can be classified as either. With crimes that fell into this middle category, our data did not always make it clear which classification was appropriate. This was especially a problem when the outcome was hospital commitment rather than sentence. We have, therefore, included a middle category of those crimes classifiable as either felonies or misdemeanors.

Thus, 25% of the sample were known to have been arrested following discharge.\*\*

Table 1 summarizes criminal activity following hospitalization and places it in historical perspective. Table 2 summarizes severity of crime, also placing it in historical perspective. It should be noted that severity of crime decreased after the index hospitalization. To place post-hospitalization crime into some perspective in relation to time at risk, see Table 3.

TABLE 1  
CRIMINAL ACTIVITY

Group	N	$\bar{X}$ Charges	$\bar{X}$ Con-victions**	$\bar{X}$ Post-Trial Incar-cerations	$\bar{X}$ Incar-cerations over a year	% with Arrest	% with Con-viction	% with Incar-ceration	% with Incarcer-ation over one year
<b>PRIOR CRIMINAL ACTIVITY*</b>									
Non-recidivists	48	3.77	3.06	1.98	1.23	54%	50%	33%	19%
Recidivists	12	3.25	2.67	.75	.17	75%	75%	33%	8%
Total	60	3.67	2.98	1.73	1.02	58%	53%	33%	17%
<b>CRIMINAL ACTIVITY PRECIPITATING INDEX HOSPITALIZATION</b>									
Non-recidivists	48	1.40	1.33	—	.94	96%†	96%	—	94%††
Recidivists	12	1.25	1.08	—	.33	100%	75%	—	33%
Total	60	1.37	1.28	—	.82	97%	92%	—	82%
<b>CRIMINAL ACTIVITY FOLLOWING HOSPITALIZATION</b>									
Non-recidivists	48	.06	0	0	0	6%	0%	0%	0%
Recidivists	12	1.17	1.17	.42	.17	100%	100%	42%	17%
Total	60	.28	.27	.08	.03	25%	20%	8%	3%

\*Excludes crime precipitating index hospitalization

\*\*Includes hospital criminal commitments

†One Defective Delinquent had no recorded arrest; one conditionally discharged NGI was rehospitalized voluntarily

††Includes correctional system incarceration when it immediately preceded hospitalization

TABLE 2  
SEVERITY OF CRIMES FOR WHICH CONVICTED  
PERCENTAGE WHICH FELL IN EACH OF THREE CATEGORIES

Group	Felony Convictions	Felony/Misdemeanor Convictions	Misdemeanor Convictions
<b>PRIOR CONVICTIONS*</b>			
Non-recidivists	35%	41%	24%
Recidivists	19%	38%	44%
Total	32%	41%	27%
<b>INDEX CRIME CONVICTIONS</b>			
Non-recidivists	61%	30%	9%
Recidivists	33%	42%	25%
Total	56%	31%	12%
<b>POST-HOSPITALIZATION CONVICTIONS</b>			
Non-recidivists	—	—	—
Recidivists	14%	29%	57%
Total	14%	29%	57%

\*Excluding index conviction

\*\*The only known behavior which resulted in civil hospitalization, but possibly could have resulted in arrest, was threats of violence against family members by two study group members. It is our impression that previous hospital commitment does not excuse criminal behavior in New Hampshire.

TABLE 3  
CRIMINAL ACTIVITY IN RELATION TO TIME AT RISK

35 Patients with Previous Criminal History

	$\bar{X}$ Arrests	$\bar{X}$ Convictions
Pre-treatment*	7.68 (.75/yr.)**	6.43 (.63/yr.)**
Post-treatment†	.37 (.21/yr.)†	.29 (.16/yr.)†

\*Pre-treatment is time period between first arrest and the index arrest. Index changes and convictions are included.

\*\*Pre-treatment time at risk  $\bar{X}$  = 10.22 years

†Post-treatment time at risk  $\bar{X}$  = 1.80 years

25 Patients without Previous Criminal History

	$\bar{X}$ Arrests	$\bar{X}$ Convictions
Pre-treatment††	1.28	1.24
Post-treatment	.16 (.11/yr.)*†	.16 (.11/yr.)*†

††No pre-treatment time at risk. Index changes only.

\*†Post-treatment time at risk.  $\bar{X}$  = 1.48 years.

### *Characteristics of Criminal Recidivists and Non-Recidivists*

As indicated in Tables 1 and 2, recidivists in our study group had a prior record of fewer arrests or convictions for serious crime, fewer previous incarcerations and many fewer incarcerations of over a year. The index crimes of recidivists were less serious than those of non-recidivists.

TABLE 4  
DIFFERING CHARACTERISTICS OF RECIDIVISTS AND NON-RECIDIVISTS\*

	Total	Recidivists	% with Post-Discharge Convictions
Age at first arrest			
25 or younger	45	11	24
Over 25	14	1	7
No arrest record (Defective Delinquent)	1	0	0
Age at admission			
Less than 30	35	10	29
30 or above	25	2	8
Length of index hospitalization			
Less than a year	26	10	38
More than a year	34	2	6
Previous psychiatric hospitalization			
Previous hospitalizations	44	11	25
No previous hospitalizations	16	1	6
Severity of index conviction			
Convicted of crime classifiable only as a felony	36	3	8
Convicted of a lesser crime	24	9	38
Legal status, index hospitalization			
Criminal commitment to hospital	26	2	8
Prison transfer	15	1	77
All other categories**	19	9	43

\*Recidivists are defined as those convicted of crime following discharge.

\*\*Includes jail or House of Correction transfers, hospitalization as condition of parole or probation, pre-trial status.

We found a number of characteristics shared by most recidivists (summarized in Table 4). Recidivists were likely to have been first arrested at a young age (25 or under) and to have been admitted or discharged from the index hospitalization before age 30. They were likely to have been hospitalized previously and to have been discharged from the index hospitalization after a stay of less than a year. They were likely on this hospitalization not to have been convicted of a crime so serious that it could be only classified as a felony although most of their fellow sample members had been convicted of a clear cut felony. They were unlikely to have been sentenced to prison or committed to New Hampshire Hospital as a consequence of their index crime. Instead, their legal status fell into a miscellaneous grouping reflecting either lesser crime, or less harsh consequences for them of that crime.

#### *Subsequent Hospitalization*

Nineteen of the 60 patients (31.7%) were re-hospitalized, 15 on a voluntary basis. Eight of the 15 voluntary re-hospitalizations were requested, as far as is known, by the patient alone.

Of four involuntary hospitalizations, three involved criminal commitments and one a civil commitment. One of the three criminal commitments resulted from processing of the index crime and not from new crime. There were, thus, only two patients whose subsequent hospitalizations by Superior Court order resulted from new crime. Both of these were felony recidivists. (The only two in the study group.) The single civil commitment came from a petition brought by the person's probation officer, concerned about suicidal potential. We, therefore, have only three subsequent involuntary commitments resulting from patient behavior after discharge. *This is an involuntary hospitalization recidivism rate of 5%.*

Table 5 details the requests for hospitalization subsequent to discharge.

TABLE 5  
SUBSEQUENT HOSPITALIZATION

Who Requested Voluntary	Criminal Non-Recidivists	Criminal Recidivists
Patient alone	6	2
Relative	—	—
Friend	1	—
Patient and Therapist	—	1
Patient and Parole Officer	1	1
Police (on voluntary basis)	—	2
Unknown	—	1
	8	7
<u>Involuntary</u>		
Civil Commitment		
(petition brought by probation officer)	—	1
Superior Court pre-trial evaluation	—	1
NGRI commitment	1*	1
	1	3

\*This person's index hospitalization was a pre-trial one from which he went into the community on bail. He was subsequently committed briefly. This hospitalization does not, therefore, reflect a new situation.

Of 19 patients who re-entered the hospital, 10 were among the 12 criminal recidivists. Recidivists accounted for 53% of all subsequent hospitalizations. 83.3% of the criminal recidivists were re-hospitalized compared with 18.9% of the non-recidivists. The criminal recidivists were much more likely to have had their re-hospitalization facilitated by others.

*No patient was re-hospitalized because of overt violent behavior.* However, one criminal non-recidivist and one recidivist were re-hospitalized because of threats of violence toward their families. Two of the recidivist group were re-hospitalized because of suicidal threats.

There is a discrepancy between the criminal recidivists and the non-recidivists in time on the streets before re-hospitalization. Six of the nine patients (2/3) without subsequent criminal conviction who were re-hospitalized were back in the hospital within four months of discharge. Of the criminal recidivist group, only three (30%) were returned within four months. One half of the recidivist group, six patients, returned more than a year after discharge, while only two non-recidivists returned after such a long time-lapse.

Diagnostically, schizophrenics and personality disorders were the most likely groups to be re-hospitalized. Six of eleven schizophrenics returned to the hospital; four of eight personality disorders returned. Two members of each group were recidivists.

## **Discussion**

The data demonstrate that some psychiatrically disturbed people who commit crime can respond positively to treatment:

1. There was a decrease in the severity of crime following the index hospitalization.
2. Most subsequent hospitalizations were voluntary and not precipitated by crime or incidents of violent behavior.
3. The rate of criminal recidivism was lower and of a less severe nature than is generally found for a population with such serious records.

### ***Other Studies***

What level of recidivism would one expect from a discharged group of offender patients? Studies of convicted felons released from prison suggest that it is likely that around 30% of released felons will be re-imprisoned within a year and that around 1/3 to 2/5 will be re-imprisoned in 2 to 5 years.<sup>7</sup>

Our own results are much lower than this, with only 8.3% re-incarcerated as the result of crime and the felon level re-incarceration rate only 3.3%.

While there have been a number of large-scale studies of criminal recidivism among the correctional population, there are only a handful of published reports of the criminal fate of offenders released from psychiatric treatment programs. They use varying definitions of recidivism. However, some remarks can be made about them:

(1) Early studies known to us came from programs which offered little active treatment and tended to hold patients for long periods of time — their results are summarized by Steadman and Cocozzo in 1974 as: “not much can be generalized except that upon return to the streets the criminally insane appear to fare as well or better than released or paroled inmates in the same areas.”<sup>8</sup> Their own study of the Baxtrom patients released into the community indicated only 20.4% subsequently arrested and 11.2% convicted after being at risk during some portion of the 4½ year study period. However, 45% of their sample were re-hospitalized, over 60% on an involuntary basis. This group, with a mean age of 52 at discharge, was much older than our own.<sup>9</sup>

(2) Studies reported in the '70's have usually presented themselves as studies of treatment effectiveness. Three of these — Kozol *et. al* at the Institute for Dangerous Sexual Offenders at Bridgewater, Owen and Kelly at Provo, and Steadman at Patuxent — make distinctions between patients who completed treatment programs and those who did not. All report those who completed treatment did better than those who did not.<sup>10</sup>

(3) Three studies report departures from the two single factors established as most predictive of criminal recidivism, age and previous record: Crime declines as age increases. The longer and/or more severe the previous criminal record the more likely is crime to recur. Koppin, unpublished, at Colorado State reported an unusual finding in relation to age: conditionally released patients in their twenties did considerably better than those in their thirties or forties. Many of the younger patients were released from an intensive young adult program.<sup>12</sup> Steadman at Patuxent found inmates who completed the program did at least as well as comparison groups of partially-treated and of prisoners, even though the subject-group had prior criminal records more severe than comparison groups.<sup>13</sup>

Perhaps the most surprising and significant finding of our own study is its departure from the expected finding in regard to prior criminal record. Our study members who were re-arrested and re-convicted had less extensive criminal histories and had committed fewer felony-level crimes as a group than had the group of study members who avoided criminal charges and convictions after treatment.

#### *Prior Criminal Record and the New Hampshire Hospital Study Population*

Our surprising finding in regard to criminal record prompted us to look more closely at our population in relation to this factor. (See Table 3).<sup>b</sup> When we separate those with no previous records from those with previous records, we find that those without any previous criminal records have done best, as would have been expected.

(1) Of 25 patients without previous arrest, only three (12%) were arrested or convicted of any crime after treatment. (Within this group, those whose hospitalizations were precipitated by crimes against persons did especially well with only 1 of 16 people (6%) subsequently arrested

or convicted of any crime. The one crime was, however, a felony.)

(2) Patients with previous records have a much higher recidivism arrest rate of 36.4% and a conviction rate of 27%. However, only one subsequent conviction involved a clear cut felony, a felony level recidivism rate of only 3% for the group with previous criminal records. Within this group, those with the most serious previous records were less likely to be re-arrested or re-convicted, leading to the finding for the entire study population that patients with lengthy and more serious records did better than patients with less serious records.

For purposes of comparison, objectivity and replicability, we have used the term "recidivism," a term which refers to a complete spectrum of criminal offenses. The recidivists in this particular study should not be viewed simplistically as "failures." From the standpoint of crime, identified recidivists are generally doing well. All but the two felony recidivists were free of criminal incarceration at the time they were studied.

Our findings, together with indications of positive results from other forensic programs which made serious efforts at treatment, would appear to make it a top priority to re-examine attitudes that have led to the present trend toward asserting that "nothing works," especially in regard to efforts at psychiatric rehabilitation. Further attention needs to be devoted to the potential value of treatment programs similar to ours, as well as variations of our approach. Any such programs should have adequate funding, not only for treatment but especially for adequate follow-up studies as on-going verifiable indicators of effectiveness.

### **Acknowledgment**

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8. Steadman and Cocozza, 3, p. 41. Early studies include Morrow WR and Peterson DB: Follow-up of discharged psychiatric offenders. "Not Guilty by Reason of Insanity" and "Criminal Sexual Psychopaths." *The Journal of Criminal Law, Criminology and Police Science*. 57:31-34, 1966. McGarry AL: The fate of psychotic offenders returned for trial. *American Journal of Psychiatry*, 127: 101-104, March 1971. Zeidler JC, Haines WH, Tikuisis V and Uffelman EJ: A Follow-up study of Patients Discharged from a Hospital for the Criminally Insane. Morrow and Peterson found an NGRI criminal recidivism rate of 37% and a sexual offender rate of 25% at three year follow-up. Recidivism was defined as conviction of felony-type crime. McGarry found of 50 incompetent men returned to the community 48% were subsequently arrested and 10% accused of felonies. Time at risk was not indicated. Zeidler *et al* reported 30.2% of 63 released incompetent men arrested and three others re-committed to mental hospitals over five years. A survey of the research on criminal behavior among the general psychiatric population has recently been reported by Rabkin J in *Criminal behavior of discharged mental patients: A critical appraisal of the research*. *Psychological Bulletin* 86: 1, pp. 1-27, January, 1979. She found a strong association between arrest prior to hospitalization and subsequent arrest. For patients arrested before hospitalization and subsequent arrest ranged between 19% and 56%. Only 2% to 4% of patients without prior arrests were arrested afterward, p. 25
9. Steadman and Cocozza, note 3, pp. 138-142
10. Kozol, Boucher, Garofalo, n. 4, pp. 389-390. They reported that of 82 treated Dangerous Sexual Offenders released with approval of staff that five (6.1%) subsequently committed serious assaultive crime, while of 49 released against the advice of staff, 17 (34.7%) did so. Release occurred at some point during a ten-year period. Owen and Kelly, note 6, reported on 23 patients released from a program aimed at selected anti-social, characterologically disturbed offenders. Of 14 whose release was approved, three (21.4%) were subsequently arrested. Eight of nine whose releases were disapproved spent time in jail or prison or were arrested after release. Six of the nine disapproved went directly to jail or prison, confusing the results for the disapproved group. It was noted the three who went to jail were all re-arrested after jail release. Steadman HJ: A new look at recidivism among Patuxent inmates. *The Bulletin of the American Academy of Psychiatry and the Law* V: 200-209, 1977. Steadman found at Patuxent Institution in Maryland a 60.4% arrest and 23.6% conviction rate among the paroled with three years or less at risk. However, the conviction rate is misleading since parolees could be re-institutionalized without conviction. Among the partially-treated, released by court order,

74.3% were subsequently arrested and 54.3% subsequently convicted.

11. Levin, n. 7, p. 24, reports that the studies of factors affecting recidivism all indicate that offenders who have received probation generally have significantly lower recidivism rates than those who have been incarcerated. However, for all those who receive probation, the recidivism rates are highest for the youngest and for those with the greatest prior record, p.24. Glaser, note 7, states that an inverse relationship between age and recidivism is firmly established in criminological research, p. 36. He further indicates that all evidence supports a correlation between extent of prior criminal record and the likelihood of becoming a recidivist, p. 49. He distinguishes the nature of the offense and recidivism with the highest rate for economic offenses and the lowest for unusual circumstances in the offender's life, notably murder, rape and embezzlement, p. 44. Guze, note 7, found the two factors most closely associated with recidivism to be age and prior criminal behavior, p. 80. Steadman, note 3, p. 145, in his study of the Baxstrom patients, also found age and past criminal behavior as most predictive of recidivism.
12. Koppin: A Follow-up Study of Disruption Among Released Forensic Patients, note 6
13. Steadman, note 10