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THE DANGEROUSNESS OF PATIENTS RELEASED FROM
MAXIMUM SECURITY: A REPLICATION
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The dangerousness of patients released from maximum security: a replication

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Two hundred six male discharges from a maximum security psychiatric institution were followed up for a 37-49 month period. Failures were defined as men with new convictions or a readmission to the security hospital. Forty-six percent of the sample failed, usually by the commission of minor property offenses, and 17% of the total committed at least one violent offense against persons. As in earlier studies of patients discharged from this hospital, younger, personality disordered patients were more likely to fail. Younger, personality disordered patients were also more likely to commit a violent offense than older, nonpersonality disordered patients.

An earlier follow-up study¹ of men released from the maximum security Oak Ridge Division of the Mental Health Centre in Penetanguishene, Ontario resulted in the development of a 0-5 point scale which was related to whether a patient failed by either being readmitted to the maximum security hospital or being convicted of a new offense. The scale was scored by giving each patient 1 point for: having been diagnosed as a personality disorder, being under 31 at discharge, having spent less than 5 years in psychiatric hospitals, not being sent to Oak

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Ridge for a violent offense, and not having lived with both parents until age 16. Patients who scored 3 or higher were predicted to fail.

Although predictive methods which employ only demographic and historical data are inevitably statistically inefficient, they are useful in establishing expected failure rates for particular subgroups to be used in the evaluation of different treatment programs and release procedures. Unfortunately, there are several factors which limit the usefulness of the predictive scale derived in our earlier study for program evaluation purposes. First, the scale was derived on a relatively small sample ($N = 60$) and has not been cross-validated on another sample. An additional concern with regard to cross-validation is that the initial study used patients who were kept at Oak Ridge for longer periods than those treated at Oak Ridge more recently and, therefore, our earlier data may not apply to more recent patients. The final limitation of our earlier study was that because of the low rate of violent recidivism and small sample size, we could not statistically compare violent and nonviolent discharged patients. The purpose of the present study, therefore, was to replicate our earlier follow-up on a more recent and larger discharge sample.

Method

Subjects The subjects were all patients released from Oak Ridge during 1972, excluding those who had been returned to the courts from Oak Ridge or who were known to have died during the follow-up period. There were 206 patients in total: 18 had been held on Warrants of the Lieutenant Governor (WLGs) after being found not guilty by reason of insanity or unfit for trial; 183 had been certified as mentally ill and involuntarily detained under the Ontario Mental Health Act; and 5 were treated under their own volition as informal patients.

Procedure The patients were followed-up on February 1, 1976 by obtaining their records of criminal convictions from the Royal

Canadian Mounted Police and, separately, determining whether they had been readmitted to Oak Ridge. The minimum follow-up time was 37 months.

Subjects were assigned to a "failure" category if they had been either convicted of any new offense or readmitted to Oak Ridge. They were also assigned to violent and nonviolent categories according to whether they had been convicted of or returned to Oak Ridge because of a violent offense. Any patient who was released twice in 1972 was counted twice; although this very rarely occurred. Violent offenses included homicide, assault, threatening, any sexual offense involving bodily contact or coercion, and armed robbery, but neither possession of a weapon nor robbery.

The patients in the fail-not fail discharge groups were compared, using Yates chi square (cs) with one degree of freedom, on each of the variables found to discriminate failures from nonfailures in our earlier study. The two subgroups were also compared using their scores on the 0-5 point predictive scale. These analyses were repeated comparing the violent and nonviolent discharge groups.

Results and discussion

Comparison of present discharge sample with previous sample The present 206 patients were compared to the 60 patients studied by Quinsey, Pruesse, and Fernley² on each of the five variables which comprised the prediction scale used in the earlier study. The samples were significantly different on two variables: the patients in the present study were less likely to have spent five or more years in psychiatric hospitals before their relevant release ($cs = 9.10, p < .01$) and were less likely to have been sent to Oak Ridge for a violent offense against persons ($cs = 6.18, p < .02$). Since patients detained on WLGs are much more likely to have committed an offense against persons and are likely to be detained longer than involuntary patients, these differences between the samples reflect the fact that WLGs made up 33% of the previous sample but only 9% of the present sample.

The failure rates in the two samples were very similar. Among the 40 involuntary patients in the previous samples, 45% were classified as failures; of the 183 involuntaries in the present sample 49% failed. The respective failure rates of the WLGs in the previous and present samples were 10% (of 20) and 22% (of 18), respectively. The overall failure rate in the present sample was 46% and the rate of violent failures was 17%.

**Failures
and
nonfailures
compared**

The 112 successes and the 94 failures were compared on each of the five variables comprising the predictive scale. Two of the variables were significantly related to the dichotomy. Failures were more likely to be diagnosed as personality or character disordered ($cs = 15.4, p < .001$) and more likely to be less than 31 years of age upon their discharge ($cs = 8.25, p < .01$). Despite the nonsignificance of three of the five variables comprising the predictive scale, the scale was related to whether patients failed or not. Patients with scores greater than 2 were more likely to fail ($cs = 18.8, p < .001$). There was, nevertheless, a drop in the predictive accuracy of the scale from 78% for the sample on which it was derived to 65% correct prediction in the present sample.

The 0-5 point predictive scale was also related to which patients would fail by reconviction or not. Seventy-three patients were convicted of a new offense. Patients who scored more than 2 on the scale were more likely to be convicted than those scoring lower ($cs = 29.2, p < .001$). The scale was accurate in 66% of the cases.

**Violent
and
nonviolent
patients
compared**

There were 34 patients classified as violent failures. Twenty-six of these had been convicted of a violent offense. The 0-5 point scale did not differentiate the violent from the nonviolent patients ($cs = 1.81, p > .10$) but personality disordered patients were more likely to commit violent offenses upon release than nonpersonality disordered patients ($cs = 4.85, p < .05$). Also patients younger than 31 were more likely to commit violent offenses than those who were older ($cs = 4.82, p < .05$). In agreement with our earlier studies³ which indicated that discharged WLGs are not a very dangerous group, there were

no WLGs who were convicted of or returned to Oak Ridge because of a violent offense.

**Description
of violent
offenses**

Because the hospital staff and public are concerned primarily about the probability of patients committing serious crimes such as murder or rape upon their release, we examined the nature of violent postrelease offending. Our ability to accurately describe these offenses is, however, quite limited in that we primarily relied upon records of criminal convictions which contained no descriptive information aside from the charge for which the person was convicted.

There were 26 persons who were convicted of 43 violent crimes against persons. Thirty-three of these offenses were assaults (common assault [21], assault causing bodily harm [7], and assaulting a police officer [5]). There were four sexual offenses (attempted rape [1] and indecent assault [3]), three instances of armed robbery, one of robbery with violence, one of threatening, and one of pointing a firearm.

In addition, three patients were found not guilty by reason of insanity for violent crimes. Two individuals committed violent offenses in correctional institutions (a training school and local jail) and were found not guilty by reason of insanity. These offenses were the most serious: manslaughter and attempted murder. One additional patient was found not guilty by reason of insanity for assault causing bodily harm with intent to kill.

Five patients were returned to Oak Ridge because of violent offenses for which there was no judicial finding. One person was returned for sexual offenses (buggery and rape), two for threatening, one for assaultive behavior, and one was "violent in prison."

It is clear from this summary description of violent postrelease offenses, that the Oak Ridge discharge population is much more dangerous than the older group of patients discharged from security hospitals studied by Steadman and Cocozza⁴ or patients released from ordinary mental hospitals.⁵ Thus the

criticism that psychiatric decision-making with respect to releasing patients confined in maximum security is too conservative should not be assumed to be universally accurate. Nevertheless, determining the accuracy of such decisions requires the examination of the dangerousness of patients who were *not* released. This is, needless to say, a difficult methodological problem.

Conclusions

In summary, these data indicate that although relatively few discharged Oak Ridge patients are physically dangerous to others, there were some dangerous patients in the discharged group. It was of interest that younger, personality disordered patients were more likely than others to commit violent offenses. The failure prediction scale developed in our earlier follow-up work was significantly related to the probability of failure upon release but its accuracy was limited. The limited predictive power of the scale is similar to that of other predictive scales which incorporate standard demographic and historical prerelease data.⁶

Further research in the prediction of violent offenses against persons will be hampered as in the current study by their low base rate. Some method must be found of identifying subgroups of patients who will have relatively high base rates of postrelease violent behavior and a prediction scale developed for these subgroups. The data of the present study suggest that such a predictive device must be developed using a very large discharge sample and incorporate predictive variables which are more theoretically meaningful than standard demographic and historical data.

- Notes**
1. V. L. Quinsey, M. G. Pruesse and R. Fernley, "Oak Ridge Patients: Prerelease Characteristics and Postrelease Adjustment." *Journal of Psychiatry and Law*, III (1975), 63-77.
 2. *Ibid.*

3. V. L. Quinsey, M. G. Pruesse and R. Fernley, "A Follow-Up of Patients Found 'Unfit to Stand Trial' or 'Not Guilty' Because of Insanity," *Canadian Psychiatric Association Journal*, XX (1975), 461-467.
4. H. J. Steadman and J. J. Coccozza, *Careers of the Criminally Insane* (Lexington, Mass.: Lexington Books, 1974).
5. G. D. Gulevich and P. G. Bourne, "Mental Illness and Violence," in D. N. Daniels, M. F. Gilula and F. M. Ochburg (eds.), *Violence and the Struggle for Existence* (Boston: Little, Brown, 1970).
6. V. L. Quinsey, R. Ambtman and M. Pruesse, "Institutional Release Policy and the Identification of Dangerous Men," paper presented at the Symposium on Violence in Canadian Society, Qualicum Beach, Vancouver Island, March 1977.