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CHAPTER 2

Dangerousness of the Mentally Ill— A Methodological Reconsideration

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Introduction

The Issue: Are the Mentally Ill Dangerous?

The mentally ill are a group of deviants who suffer a particular burden more extensively than many other deviant groups; *they are feared*.¹ To most people the apparently unpredictable or bizzare behavior of the mentally ill suggests the possibility of imminent violence.

Popular concern over the dangerousness of the mentally ill is reflected in Western legal history.² In common law, the restraint of an insane person without judicial approval has been limited to situations involving imminent danger to people or property. This common-law principle became statute law in the United States shortly after the Colonial period, with the modification that restraint was to be necessary for medical treatment. The legal history of mental illness is elaborated elsewhere in this monograph by Robitscher. As of 1971, of the 43 States which provided for judicial hospitalization, 9 made dangerousness the sole criterion, and 18 other States also included need for care or treatment as an acceptable reason for hospitalization.

Today, concern for the civil rights of powerless groups is being manifested in revisions of statutes and in court decisions. As forced treatment for a person's own good is being discarded as a violation of his civil rights, dangerousness (variously defined, or indeed, even undefined) has become the residual acceptable justification for involuntary hospitalization.

All of the public concern and legal provisions beg the question as to whether the mentally ill are in fact dangerous or, more precisely,

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whether they are any more dangerous than the general population. While psychiatry provides clues to the theoretical relationships between mental abnormality and violence, social science has provided the empirical data on which consensus on this issue is based.

The methodology of existing research on the dangerousness of the mentally ill is reviewed critically in this treatise to determine whether this consensus is soundly based.

Literature Review

Over the last half century, the most widely adopted method for assessing the dangerousness of the mentally ill has been to study the extent of dangerous behavior among large cohorts of patients discharged from State mental hospitals and then to compare the dangerousness of the former patients with the dangerousness of the general population. In practice, dangerousness has been operationalized as officially recorded arrests for violent offenses, though not all studies have differentiated among types of offenses.

Seven major studies, conducted between 1922 and 1967, form the basis for most informed generalizations about the dangerousness of the mentally ill.³ In the first of these studies, Maurice C. Ashley (1922), Superintendent of Middletown Homeopathic Hospital in New York State, reported on 1,000 cases paroled from his hospital over the preceding 10 years. Approximately one-third of the patients had been readmitted, but only 12 had been arrested (for vagrancy, assault and battery, forgery, swindling, and profiteering).

In February 1938, Pollock (1938) followed up on all 9,563 patients (5,092 men and 4,471 women) paroled from New York State civil mental hospitals during the fiscal year ending June 30, 1937. He found rates of arrest for all offenses committed by former patients of both sexes to be lower than arrest rates for the general population: 12.5/1,000 versus 184.4/1,000 for males and 1.03/1,000 versus 15.1/1,000 for females, or total rates of 6.9/1,000 for all patients versus 99.7/1,000 for the general population.

Cohen and Freeman (1945) reported on all 1,676 patients who were either discharged or paroled during the 4-year period, November 1, 1940 to October 28, 1944, from the Norwich Connecticut State Hospital. Transfers from the State prison and out-of-State residents were excluded. After an estimated average of 2 years outside the hospital, 5.2 percent of the subjects had been arrested, presenting an arrest rate of 4.2/1,000 for the patients versus 27/1,000 for the general population. Comparison with biannual arrest rates of the general population for individual offenses revealed lower rates for every offense among the patients. Breakdowns for arrests of male and female patients were not given.

Brill and Malzberg (1962) followed up the largest group of patients, studying all 10,247 male patients over the age of 16, discharged from New York State mental hospitals in fiscal 1947. The fingerprints of 5,354 of these men were registered in the State central fingerprint file. Postdischarge arrest records for this sample were obtained by a search of the files at the end of 1952. The selection of patients for fingerprinting had not been random, but it had stressed including cases "where there was any probability of anti-social activity in the past." Therefore, arrest rates for the unregistered patients were estimated from the presence in the unregistered group of background characteristics which were strongly associated with arrest in the registered group.

For the followup period, averaging 5.6 years after release, Brill and Malzberg found arrest rates among former patients of 44.65/10,000, compared with 491.09/10,000 for the general population of males in New York State age 16 and over. Annual arrest rates for various offenses were lower for patients for almost every offense.

Rappeport and Lassen (1965) did the first major study in which findings appeared to contradict those of previous researchers. They found that for two cohorts of male patients, released in Maryland in 1947 (N=708) and 1957 (N=2,152), arrest rates for some serious violent offenses were higher than for the general population. Former patients were arrested more often, almost every year after discharge, than were the general population, with diminishing variation in the differences between patient and population arrest rates in each of the 5 years after discharge.

In a parallel study of two female cohorts (for 1947, N=693 and for 1957, N=2,129), Rappeport and Lassen (1966) found significantly higher rates of aggravated assault among the 1957 cohort than for the general female population in 4 of the 5 years following release.

Finally, Giovannoni and Gurel (1967) studied 1,142 male patients discharged from Veterans Administration hospitals in California, following their arrest histories from 1957 through 1960. Considering only those patients who remained outside the hospital at least 30 days and alive 4 years after admission, they found homicide, aggravated assault, and robbery rates which exceeded those of the general population by factors of 21, 3, and 1.6, respectively.

Consensus on the Issue

The opinion commonly held by mental health professionals and social scientists is economically summarized in the following statement by the Professional Advisory Council of the National

Association for Mental Health, submitted to the National Commission of the Causes and Prevention of Violence (Mulvihill and Tumin, 1969. p. 444):

(1) The popular idea that the mentally ill are overrepresented in the population of violent criminals is not supported by research evidence.

(2) Generally, persons identified as mentally ill represent no greater risk of committing violent crimes than the population as a whole.

To this the Commission staff added:

Most studies indicate that the discharged mentally ill, as a whole, are significantly *less* prone than the general population to involvement in violent behavior. *All* studies, to date, indicate that the mentally ill are no more likely than the general population to be involved in crimes such as assault, rape, or homicide. (*Italics in original.*)

The violence commission staff did not indicate whether it had considered the studies cited here, which present apparently contradictory findings.

In the face of some contrary evidence, mental health professionals share the belief that mentally ill persons, as a group, are not especially dangerous. It remains to be seen whether the available research evidence warrants their confidence.

Selection of Research Populations

A basic problem of all studies cited here was not created by the researchers, but rather results from the dispersion (throughout and outside treatment programs) of the group known as "the mentally ill." All seven studies used former patients of mental hospitals; six used State hospitals, and one a Veterans' Administration hospital. Therefore, generalizations drawn from these studies would apply only to discharges from this type of institution, not to all mentally ill persons, unless it could be shown that these discharged patients were representative of all the mentally ill.

The concept "mental illness" has never been operationalized adequately in epidemiological studies to permit comparisons between mental hospital patients and all persons to whom the label might apply. However, there is evidence that State mental hospital residents are not representative of all persons who *receive treatment* for mental disorders.

In their landmark study on social class and mental illness, Hollingshead and Redlich (1958) found that two-thirds of their research

population, under treatment, were patients in State hospitals. However, persons suffering from the two major diagnostic categories of mental disorders received treatment in very different ways; 10 percent of neurotics versus 84 percent of psychotics were in State hospitals (p. 258). Furthermore, Hollingshead and Redlich found among psychotics an inverse relationship between social class and length of hospitalization, with patients from the lowest social class staying nearly 50 percent longer than persons from the highest class, 14 versus 7 years (p. 229). Because lengths of hospitalization of psychotics were so substantial, the lower class members of discharge cohorts would be substantially older than upper class members.

A further confounding variable is presented by the fact that hospitals select patients for discharge partly on the basis of predictions of low probability of postrelease violence. Historically, these predictions have been very conservative, leading to long periods of hospitalization for many patients (Steadman 1972). If such predictions do result in better-than-chance selection of potentially dangerous patients, from among all patients, those patients who would, in fact, be dangerous would be spending longer periods, on the average, in the hospital. Their longer stays would mean older average ages at time of release; and older ages are known to be associated with lower rates of violence. Therefore, discharge cohorts would be underrepresented in proportions of patients likely to be dangerous.

One of the major problems in assessment of the dangerousness of the mentally ill is the rapidly changing form of institutional response to mental illness. The Community Mental Health Centers Act of 1963 created a massive construction program, resulting in the establishment of over 300 community mental health centers. Meanwhile, other psychiatric clinics have been established or have expanded their services. Thus, increasing numbers of mentally ill persons have been diverted from State mental hospitals and into inpatient and outpatient programs of other facilities.

The general trend toward decentralization of mental health care is reflected in the changing distributions of patient care episodes among various types of facilities. State and county mental hospitals, which accounted for half of the patient care episodes in 1955, accounted for only one-fourth in 1968 (NIMH 1970).

This decentralization causes studies of discharged State hospital patients to include increasingly smaller proportions of all persons receiving treatment. Therefore, it becomes ever more tenuous to maintain that these studies include representative samples of all mental patients, let alone all mentally ill persons.

For all the above reasons, it is not justifiable to assume that post-release dangerousness of State hospital patients is equivalent to

dangerousness of all persons receiving treatment for mental disorders. It is an even larger leap of faith to assume that the dangerousness of hospital discharges is equal to the dangerousness of the unknown number and character of all mentally ill persons.

It is to the credit of the authors of studies cited here that none took that leap. All restricted their conclusions to statements about the dangerousness of discharged mental patients, not the mentally ill in general.

The issue of nonrepresentativeness is raised here because other authors *have* drawn more general conclusions from the studies reviewed here, primarily because these studies constitute the best available evidence. Some writers have acknowledged the problem (see, for example, Gulevich and Bourne 1970, p. 310). However, logical and linguistic rigor sometimes give way to pressure to draw general conclusions, particularly when there is a felt need for generalizations on which policy can be based. Note, in the quotation at the end of the preceding section, the ease with which the violence commission slipped from a statement about studies of "the discharged mentally ill" to a conclusion about "the mentally ill."

Common Methodological Problems

If the seven studies are considered in light of what they are— attempts to determine the dangerousness of discharged mental patients, they are still flawed in several crucial ways. Here each of the flaws is discussed along with the sensitivity of the researchers to the underlying issues.

Use of Arrest Records

The first problem, involving the use of police arrest records as the sole basis for assessing dangerousness after discharge, generates several difficulties. One problem with using police records is the incompleteness of central record files. Practices vary among cities and States, but not all police agencies report all offenses to a central State agency. Only Rappoport and Lassen avoided the pitfalls of depending on central files by checking the arrest records of all police jurisdictions in the State.

Though Rappoport and Lassen were more thorough than other researchers in checking police records, they, as well as others, overlooked patient offenses committed in another State. Cohen and Freeman sought to diminish the effect of subject mobility by excluding out-of-State residents. None of the studies included methods

for uncovering offenses by the more mobile subjects who could, by virtue of their relative youth, be more prone to violence than residentially stable subjects.⁴ Excluding out-of-State arrests causes underestimation of mental patient dangerousness rates.

The general inadequacy of police records as indicators of the extent of crime is well documented. The major problem in using official arrest data is that not only are officially recorded offenses only a small proportion of all offenses committed, but they are likely to be unrepresentative of all offenses. Furthermore, we cannot assume that arrests of mental patients are either representative of all offenses by mental patients or that these arrests are unrepresentative of mental patient offenses in the same ways and to the same degree that general population arrests are unrepresentative of all offenses. This aspect of the use of police records, therefore, may create bias whose direction cannot be inferred from available evidence.

Different contingencies may come into play when the police encounter an ambiguous situation involving someone who is apparently mentally ill or who is known as a former mental patient. The suspect's apparent or alleged condition may weigh heavily in the investigating officer's decision to make an informal adjustment, make an arrest, or attempt to have the suspect hospitalized.

Various factors, such as State law, local police practice, proximity of a mental hospital, severity of alleged offenses, and desires of victims and family, would no doubt affect this decision. Readmission to a mental hospital is a viable and frequently employed alternative to arrest, but it was generally ignored in the studies cited.⁵

As noted, Ashley (1922) showed an awareness of the incomplete picture drawn by the exclusive use of arrest rates. He reported the percentage of subjects readmitted to the hospital, their economic condition, and adjustment problems, indicating a broader awareness that post-hospital adjustment includes factors in addition to arrest. Unfortunately, he did not pursue the issue further, omitting the reasons for readmission.

All the other studies missed the point completely; an unknown number of former patients are returned to hospitals by the police, relatives, or others without an arrest being recorded, even though the precipitating event may have been a violent incident. In addition to the possibility of new civil commitment, informal readmission to the hospital is greatly facilitated in the 46 States which provide for conditional release, where no further judicial process is required to return a patient on that status to the hospital (Brakel and Rock 1971, p. 134-135). The exclusion of rehospitalization data results in underestimation of subject dangerousness.

Controlling for Demographic Variables

Giovannoni and Gurel (1967), in puzzling over the apparently contradictory findings of Rappeport and Lassen to previous studies, stated:

. . . the numbers and kinds of patients released from New York State hospitals in years past, were undoubtedly different from the numbers and kinds of patients currently being released from other hospital systems . . . (p. 152)

Unfortunately they did not clarify what they meant by "kind," or attempt to make corrections in their own study for this changing phenomenon, but then none of the preceding studies took into account the different kinds of patients.

All except Ashley (1922) and Cohen and Freeman (1945) reported arrest rates separately for male and female subjects, recognizing that males have an overall arrest rate in the general population of about five times that of females. They saw that it is necessary to compare subject arrest rates with base rates computed on general population members of the same kind (in this case, sex). Yet, none pursued this commonsense notion further than the sexual distinction.

Other demographic factors besides sex are known to be associated with arrest rates. None of the studies controlled for any of them. This is particularly surprising in the case of Brill and Malzberg (1962), who reported, in detail, the association of a variety of background factors with arrest for their subjects and concluded:

Arrest rates among the patients (sic) group are directly related to the same factors as are the crime rates of the general population. These factors include recidivism, metropolitan residence, unmarried status, age, sex, alcoholic and drug addiction, and residence in delinquency areas. (p. 6)

Pollock (1938), Brill and Malzberg (1962), and Rappeport and Lassen (1965) took into account the very low incidence of mental hospitalization of people under age 16 (less than 1 percent of the mental hospital population, compared to over 20 percent of the general population). They computed base arrest rates for the general population over age 15. However, Cohen and Freeman, and Giovannoni and Gurel, did not report adjustments for the attenuated age distribution of mental patients in computing base rates. Even correcting for low incidence of hospitalization of the young may not be sufficient to create comparable base rates. None of the studies took into consideration the well-documented association between age and criminal offensivity. If it were the case that the

age distribution of a particular patient discharge cohort differed from the age distribution of the general population, one would expect different offense rates based on this difference alone.

Comparison with Base Rates

Once a full accounting of all arrests and violent episodes of released patients is made, the task would appear to be nearly over. All that remains is to compare the arrest rate with a base rate for the general population to determine whether patients are arrested more or less often, are more or less dangerous, than the general population. Again, on this apparently simple point, most studies fail, in various degrees, because they ignore certain factors in computing arrest rates for patients and comparison base rates for the general population.

To note that hospitalized mental patients have very low arrest rates is to state the obvious; hospitalized patients are not "at risk." They have little opportunity to commit offenses which would be reported to, or recorded by, the police. Only Pollock, and Giovannoni and Gurel, took into account, in computing patient arrest rates, the well-known fact that mental hospitals have revolving doors; a large proportion of discharged patients return to the hospital.⁶ They recognized that it makes sense to compute annual arrest rates based on 365 patient-days at risk, outside the hospital. This involves knowing how much time, cumulatively, the subject population spent in hospital or jail during the followup period, subtracting this total from the gross number of patient-days since discharge, and recomputing arrest rates on the deflated time base. Of course, the same correction should be made for the general population, but the affect would be much less, since released patients are a much greater risk for hospitalization than are the general public.⁷

Pollock based his calculations on the average daily population of patients on parole from the hospital, but he appeared to ignore time spent in jail. Giovannoni and Gurel did the same calculation, reporting "the average number of patients in community on any one day" was 764 out of a possible 1,461. Thus, they demonstrated the tremendous importance of considering the factor of diminished period at risk; the correction caused a 48 percent inflation of annual arrest rates for discharged patients.

Giovannoni and Gurel made the best attempt to take into account factors other than rehospitalization which decrease time at risk apparently, only they deducted, from the time base, subject-days spent in penal institutions. They also reported a method of

controlling for the affect of mortality, which differs considerably between mental patient and general populations.⁸ They included in their analysis only subjects who remained alive at the end of the followup period.

However, this maneuver excluded those subjects who might have been too frail to commit offenses requiring much physical prowess, while, at the same time, excluding subjects who may have died through participation in violent crimes. It is difficult to say in which direction the resulting bias would be.

A Suggested Research Design

The existence of such a variety of methodological deficiencies suggests we attempt to plan a study which avoids errors of the past. The following sketchy outline touches on the major methodological features which might be included in an ideographic study of the dangerousness of the mentally ill.

Given the current impossibility of directly assessing any characteristic of all the mentally ill, we are forced to focus plans on patients under treatment. After a geographical area is selected, the first consideration would be to describe a research population which represents the distribution of patients who had received inpatient or outpatient treatment from all sources: State, county, and private mental hospitals; psychiatric units of Veterans' Administration and general hospitals; psychiatric clinics and mental health centers; and private psychiatric practice.⁹ There are several ways in which the research sample could be selected, each with advantages and disadvantages, and each leading to different results. One reasonable choice would be all patients who had received treatment within a brief, given time period (day, week, or month), whether or not this was the first treatment episode.

To permit calculation of annual rates of dangerous behavior, based on time at risk, entire postdischarge histories of the inpatient sample of the research population would be followed, including dates and circumstances of any deaths which occur, reasons for arrest, lengths of imprisonment, and reasons for and lengths of rehospitalization. Outpatients would be considered at risk during periods when their treatment does not involve 24-hour residential treatment. Since it appears that peak arrest rates occur within 2 years after discharge, it would probably not be necessary to extend the followup period much beyond 2 years. To insure that arrest and rehospitalization data were conserved, records of mental health and criminal justice agencies in adjoining States would be checked to

supplement national arrest data from FBI files. A factor in selection of geographical location for this study would be the reliability of arrest reporting by all police agencies in the region to a central agency.

It is worth noting, here, the practical difficulties which would be involved in a study like the one proposed. Particularly difficult would be obtaining official and confidential information from a variety of sources. Therefore, this suggested design must be considered a guide and not a refined plan. Supplemental research would be conducted, contemporaneously, to determine the ways in which local police practices determine the disposition of allegedly mentally ill suspects. Of particular interest would be the influence of the knowledge that a suspect was formerly, or is currently, a mental patient. Because the results of such a substudy would be in the form of police *inaction* (i.e., the circumstances in which police failed to arrest in cases involving mental patients), we would probably have to consider these results only suggestive of the affect of local police discretionary behavior. The difficulty of assessing such a phenomenon by survey or participant observation techniques would be formidable.

After all the data were collected, dangerous behavior rates of the mental patients would be calculated by dividing total numbers of rehospitalizations and arrests, for actions resulting in injuries to persons, by subject-days at risk. For comparison with the mental patient rate, a general population dangerousness rate would be computed by first determining from local police records the various arrest rates for violent offenses of subcategories (i.e., sex, age, race, residence, socioeconomic status, and marital status) of the general population. Then, a comparable base-dangerousness rate would be calculated by weighting subcategory rates by the proportion of mental patients in each subcategory and, then, by summing the weighted rates. This sum would be the officially recorded dangerous-behavior rate for a sample of the general population with the same demographic characteristics as the mental patient sample.

The findings of such a study would not be limited to a comparison of two rates, however. They would permit the pinpointing of subclasses of mental patients who might be highly prone to dangerous behavior after discharge, suggesting the most efficient channeling of therapeutic and aftercare attention. This somewhat crude outline of a research design does not contain solutions to all the methodological deficiencies of previous studies. However, if such a study were attempted, and most of the errors of past studies could be corrected, the results would be a better indicator than furnished by previous studies of whether mental patients are

more or less dangerous than the general population. Furthermore, the gap between substantiated empirical generalizations about mental patients and inferences about all the mentally ill would be narrowed.

Summary and Conclusions

Review of the seven major studies of the dangerousness of mentally ill populations after discharge indicated that earlier studies showed fewer offenses among former patients than in the general population, while more recent studies seem to show the opposite. There is consensus among mental health professionals, however, that the mentally ill, as a group, are not especially dangerous. The studies were criticized on a range of methodological deficiencies. Several of these flaws cause an underestimation of the dangerousness of the mentally ill: use of incomplete arrest records, omission of out-of-State arrests, omission of violent incidents resulting in rehospitalization rather than arrest, and failure to take into account decreased time at risk in computing annual arrest rates.

The direction of the effect of other deficiencies is unknown: nonrepresentativeness of arrests of the mentally ill and of the general population, and differences in demographic characteristics between mentally ill and general populations.

Many of the methodological problems discussed here could be solved or substantially alleviated. Others, such as the comparability of patients under treatment with all mentally ill persons, may remain forever imponderable. However, the social consequences of assumptions about the dangerousness of the mentally ill are both clear and serious. In the past, our society has incarcerated many thousands of people for decades because they were believed to be dangerous as a consequence of mental disorder. Rubin (1972) estimates that 50,000 mentally ill persons are preventatively detained each year because they are believed to be dangerous.

Considerable heat is generated whenever the dangerousness of the mentally ill is discussed. Advocates of deinstitutionalization cite the studies which indicate low rates of violence among released patients and bemoan the enormous human and financial waste resulting from the unnecessary prolonged incarceration of many allegedly dangerous mentally ill persons. Those opposed to rapid deinstitutionalization, sometimes with vested interests, easily find sensational examples of the horrible consequences of prematurely releasing violent mental patients: A recent study (Zitrin et al. 1976) of 867 mental patients in New York, which indicated higher rates of crime among released patients, prompted

a furious attack by a citizens' group concerned with the rights of mental patients (McDonald 1975). The attack involved not only a criticism of the methodology of the study, but also an indictment of the objectives of the researchers.

The public believes that there is an association between dangerousness and mental illness. The behavioral and social sciences are faced with the obligation to provide answers about the direction and degree of this relationship, to inform public opinion, and to provide hard data for policymakers. In the face of substantial flaws present in existing studies, it seems necessary that we reconsider empirically, with all the methodological sophistication we can muster, the validity of the generalization that the mentally ill are not particularly dangerous.

Footnotes

1. Rabkin (1972) has provided a fine review of the literature on opinions of mental illness held by the general public, mental health professionals, and mental patients.

Nunnally (1961) found that the mentally ill are regarded with "fear, distrust, and dislike by the general public" (p. 46). Furthermore, "Old people and young people, highly educated people, and people with little formal training all tend to regard the mentally ill as relatively dangerous, dirty, unpredictable, and worthless" (p. 51).

2. The following brief summary of the legal response to mental illness is taken from Brakel and Rock (1971, p. 36).
3. This paper is not represented as an exhaustive review of the literature on the dangerousness of the mentally ill. Excellent reviews already exist. (See for example, Gulevich and Bourne (1970) for studies in the United States, and Wolfgang and Ferracuti (1967) for international studies.) Rather, those major studies were selected which were performed in the United States and are often cited as evidence of the level of dangerousness of the mentally ill.
4. Lystad (1957) studied the geographic mobility after discharge of all first admissions in 1953 and 1954, diagnosed as schizophrenic at the State mental hospital serving New Orleans. Though her findings are only suggestive, due to the small sample size (N=94), she found significantly higher rates of geographic mobility among younger than among older discharged patients.
5. In a study of commitment practices in several major cities, great differences were found in police practices in disposition of allegedly mentally ill persons. While in most jurisdictions police commonly charge mentally ill persons with disorderly conduct and hold them in local jails preliminary to judicial commitment, Los Angeles police formally arrest few such persons. In 1 year, in the early 1960s, the special police hospital detail which acts as a screening and petitioning agency for the entire Los Angeles Police Department, processed 1639 persons taken into custody as mentally ill. Temporary commitment was obtained for 40.5 percent, while only 6.3 percent were booked on criminal charges. This situation has most likely

changed in Los Angeles, with drastic changes in California's mental health laws.

As counterpoint to the low proportion of arrests, the same source cites an unpublished study of hospital admission notes of 100 randomly selected patients. In 71 percent of the cases, the precipitating events leading to admission were one or more chargeable criminal offenses, 24 of which were considered felonies, and 124 misdemeanors. Of the misdemeanors, more than half were assaults, batteries, or disorderly conduct offenses (Rock 1968, p. 98-99).

6. Additionally, readmission frequently occurs within the time span covered by most followup studies. Gorwitz (1966) reported on the hospitalization experience of a cohort of all persons aged 25 to 54, admitted between July, 1961, and December, 1962, to the three major Maryland State mental hospitals. Of the 4,263 subjects, 94 percent were released within 18 months. Of those released, 37 percent were rehospitalized within 18 months of their first admission, averaging 1.6 rehospitalizations for subjects rehospitalized.
7. In the year 1969, 47 percent of all admissions to State and county mental hospitals had been admitted previously to such institutions. Broken down by age, the percentage of previously admitted patients varied from 13 percent for ages under 18, to 56.3 percent for ages 45-64 (NIMH, 1971).
8. In the study by Gorwitz (1966), mental patients grouped into 10-year age intervals had mortality rates 4.3 to 6.5 times higher than the general Maryland population of the same age groups. Of the deaths occurring during the 18-month study, 56 percent occurred in the community. It should be noted that this study excluded patients over age 54, the age group which would be expected to have the highest mortality rate.

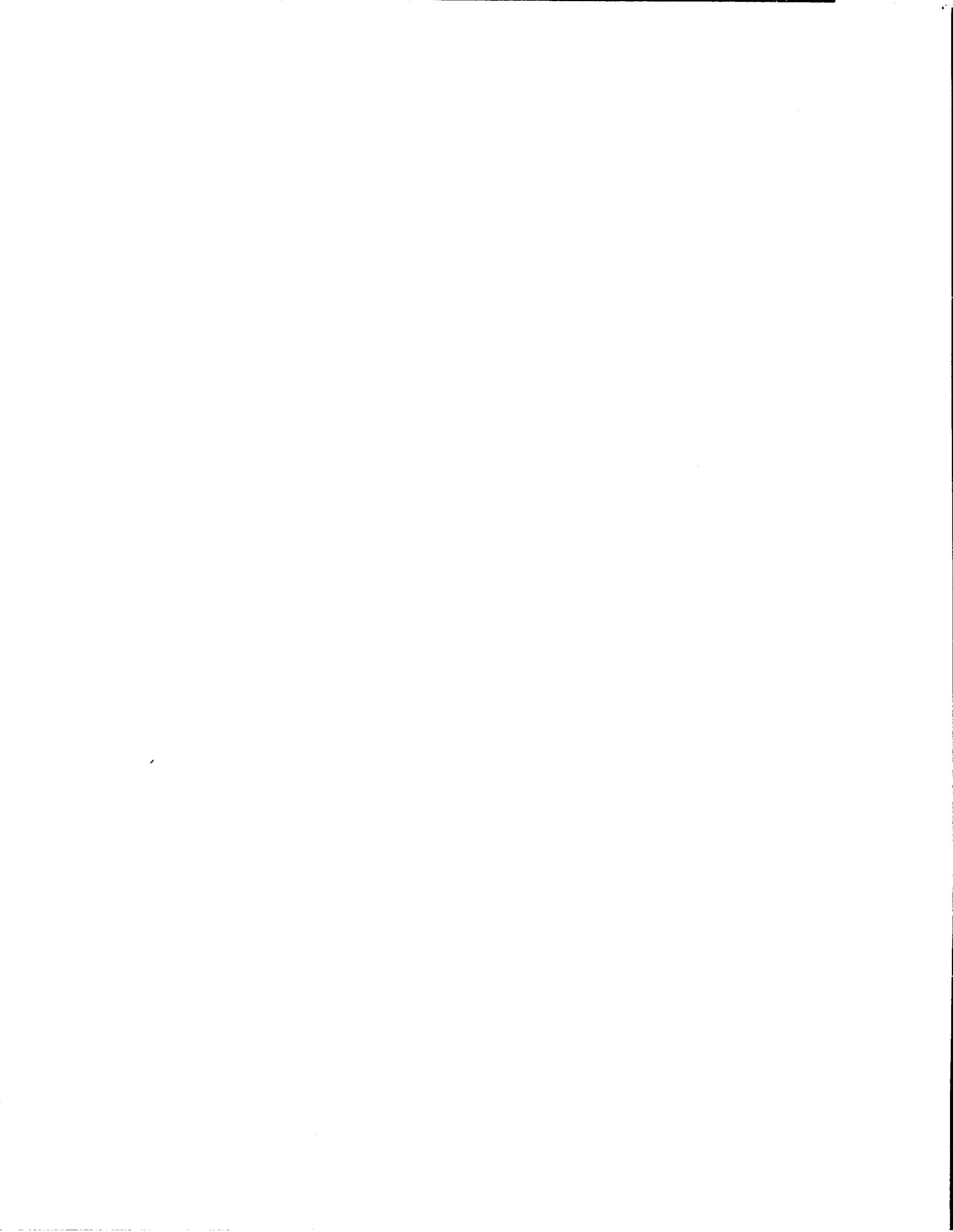
In a continuation of Hollingshead and Redlich's study, Myers and Bean (1968, p. 66) found higher age-specific mortality rates for patients and former patients than for the general Connecticut population in all but the over-85 age group. They explain the difference as a result of the association between psychiatric and physical disorders.

9. There currently exists in the United States, one area, Monroe County, New York, where every treated case of mental illness is recorded in a central register, making this county a likely prospect for the type of study envisioned here.

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