The commission of violent and non-violent crime is an area that both intrigues and repels society. The non-criminal population may find such acts of violence unfathomable. They may seek an explanation as to how and why a human being could act in such a manner. The presence of a mental illness that drives a crime may be an explanation that soothes the more questioning mind or it may leave one with even more of a moral dilemma; does a mental illness excuse criminal behaviour? Is the behaviour truly criminal if a person is mentally unstable?

Criminal recidivism is the act of committing another crime subsequent to the first offence. This review will critically discuss existing literature on the topic of recidivism within forensic psychiatry. The intention is to identify gaps in content and applicability of existing literature. Before delving into an in-depth analysis of recidivism, it is important to provide a context i.e. an overview of the practice and scope of forensic psychiatry as well as defining a ‘state patient’. Thereafter to provide a discussion on recidivism. The major part of the review will discuss criminological, demographic and clinical risk factors for recidivism.

FORENSIC PSYCHIATRY AND STATE PATIENTS

Forensic psychiatry is a sub speciality of psychiatry that deals specifically with mentally ill patients that commit crimes (Kaliski, 2006). Between 20% and 40% of persons with severe mental illness encounter the criminal justice system at least once in their lifetime (Swanson, 2001). Countries differ vastly in their delivery of care to mentally disordered offenders (MDOs). Some models are based on retaining most MDOs within the judicial system while others make every effort to divert MDOs to forensic psychiatric facilities for the purpose of receiving treatment and sometimes for incarceration as well. These differing models of management of MDOs will be of significance later in the review when various studies on recidivism are compared and contrasted.
State patients are certified by the court under Section 42, Chapter 6 of the Mental Health Care Act (MHCA) No. 17 of 2002. The process of becoming a state patient begins when a MDO is charged with a crime and then appears in a court of law. Within the South African criminal justice system it is incumbent on the legal team to refer alleged perpetrators that are suspected of having mental illness to a forensic psychiatric institute for an assessment. The stated assessment is usually conducted over a 30 day period in a designated state forensic psychiatric unit. This assessment is conducted by a multidisciplinary team. After the evaluation is complete, forensic psychiatrists provide a report to the court pertaining to the accused’s fitness to stand trial and their criminal capacity at the time of the alleged offence and recommend further management for the accused. Most often if the accused is not fit to stand trial or not criminally responsible due to the presence of a mental illness the magistrate will divert the MDO from the criminal justice system to a forensic mental health facility (Kaliski, 2006).

IN CASES OF MAJOR OR MORE SERIOUS OFFENCES THE MDO IS SENT TO THE FORENSIC INSTITUTE UNDER SECTION 42 OF THE MHCA AS A STATE PATIENT. IN CASES OF LESS SERIOUS CRIME THE MDO MAY BE REFERRED TO THE INSTITUTE AS AN INVOLUNTARY MENTAL HEALTH CARE USER, UNDER CHAPTER 5 OF THE MHCA. INVOLUNTARY MENTAL HEALTH CARE USERS ARE MANAGED WITHIN THE GENERAL PSYCHIATRIC FACILITY AND NOT THE FORENSIC UNIT.

Once declared a ‘state patient’ there is no specific time frame for which this status applies. Various restrictions are automatically imposed on state patients. For example, the patient may not leave the hospital unless a custodian is willing to sign responsibility and a psychiatrist authorises the leave of absence. During admission into a forensic psychiatric institute state patients are under the care of a multidisciplinary team. The team comprises of psychiatrists, nurses, psychologists, occupational therapists and social workers. Leave of absence (LOA) is a period of time when a state patient is granted permission to leave the hospital for a specified period of time. During this time legal restrictions are imposed on all state patients in the community and a breach of these conditions can result in immediate readmission. Examples of these restrictions include adherence to medication, abstinence from substance use and regular review at the local clinic. The restrictions are largely decided by the treating team and the guardian of the patient is required to sign a document in agreement with the conditions of LOA.

If a state patient has been successfully managed in the community for a minimum period of two years, forensic psychiatrists may apply to the court for a conditional discharge. The two year period of successful LOA is used as a rough guide by certain clinicians (e.g. Sterkfontein Hospital’s forensic service); however this is not explicitly stated by the Mental Health Care Act. After a successful period of ‘conditional discharge’ a state patient may be discharged form his/her status as a state patient by means of an order from the judge in chambers (Zabow, Van Rensburg, & Voster, 2001).

It is critical to note that in South Africa under the Mental Health Care Act of 2002 a state patient is sent to a psychiatric institute, not as a means of sentencing but to receive care, treatment and rehabilitation. Psychiatric rehabilitation is the process of restoration of community functioning and well-being of an individual who has psychiatric disability (Lindqvist & Skipworth, 2000). Arguably one of the greatest challenges in forensic psychiatry is the rehabilitation of patients (Neville & Vess, 2001). The risk of the patient reoffending whilst in the community is of paramount concern to health professionals, the public and the criminal justice system. It is therefore essential that forensic psychiatrists have adequate evidenced based knowledge on the factors associated with recidivism and risk assessment.

RECIDIVISM IN FORENSIC PSYCHIATRY

“A recidivist is one who, after release from custody for having committed a crime […] falls back, or relapses into former behaviour patterns and commits more crimes” (Maltz, 1984, p.54). Within studies on recidivism, re-offence is most often the outcome that is measured. Each researcher may however define recidivism differently; for example, re-arrest, revocation of community leave (either for violation of leave conditions or new offence) or re-incarceration (Skeem, Manchak & Peterson, 2011). Furthermore recidivism can be separated into specific recidivism, violent recidivism or general recidivism. Specific recidivism describes re-offence which matches the index offence, violent recidivism includes only violent/major re-offence and general recidivism describes any offence after the index crime (Pflueger, Franke, Graf, & Hachtel, 2015). Despite these nuances, there is common ground in that a recidivist is generally understood as an individual who after committing a first offence commits another. For the purposes of this review recidivism or a recidivist encompasses broad parameters and there are no specific limitations on the re-offence type or outcome.

Studies looking at factors associated with recidivism have emerged as a significant body of research within psychiatry. Contributions however have roots in many different disciplines such as law, sociology, psychology, anthropology and psychiatry. Each discipline mentioned above attempts to assess recidivism from their perspective of proficiency. For example a sociological approach to recidivism may look at environmental factors such as homelessness or family structure while a study from the legal sciences may assess legislature or the impact of mental health courts on recidivism. Irrespective of the discipline, it can be agreed that it is important
to study recidivism within the psychiatric population in order to understand its prevalence in society and the management thereof (Lamberti, 2007).

One of the challenges of analysing studies in recidivism is that different sample populations have been used. Many studies compare MDOs with general offenders (Bonta, Law, & Hanson, 1998). Some studies follow up psychiatric patients discharged from mental health facilities and compare them to MDOs released from prison (Castillo & Alarid, 2010). MDOs that reoffend (recidivists) may also be compared to MDOs that have not reoffended. Therefore despite researchers attempting to assess the same variables, challenges in validity and applicability may arise (Nilsson, Wallinius, Gustavson, Anckarsäter & Kerekes, 2011).

THE MENTALLY ILL AND VIOLENCE

Before considering the mentally ill ‘reoffender’ it is worth looking at whether a psychiatric patient is more dangerous than a general member of the public without a mental illness. In the 1990s there was a growing body of literature linking mental illness with violence (Eronen, Tihonen & Hakola, 1996; Hodgins, 1992; Woodward, Williams, Nurosten, & Badger, 1999). The MacArthur study (1998) however was a hallmark study that refuted these findings and thereby attempted to dispel the stigma attached to psychiatric patients. The MacArthur study (1998) found that unless a psychiatric patient had a comorbid diagnosis of substance abuse, psychiatric patients were not more dangerous than other members in their neighbourhood (Steadman et al. 1998).


Studies have also assessed risk factors for re-offence amongst MDOs and compared these with risk factors in the general offender population. The first large meta-analysis by Bonta et al (1998) found that having a major mental illness was actually protective and inferred reduced risk of re-offence. A similar meta-analysis was replicated by Bonta, Blais and Wilson (2013) This study examined articles on MDOs and recidivism from 1959 to 2011 with peak number of studies published in 2004. This meta-analysis once again confirmed that the same major risk factors for recidivism amongst general offenders apply to MDOs. However the second analysis found that the presence of a mental illness did not infer less risk for recidivism rather it found that having a major mental illness did not have any effect on re-offence.

RATE OF RECIDIVISM AMONGST MDOs

Typically studies would follow up patients over different intervals to derive specific rates of recidivism within their respective cultural context. An acclaimed study by Swanson (2001) in North America reports that the rate of violent re-offence of MDOs was approximately 30% while another American study by Lovell (2002) found that 70% of MDOs released from prison received charges for new minor crimes and 2% re-offended with very serious crimes. In the United Kingdom, Coid, Hickey and Kaftan (2007) conducted a large scale cohort study on MDOs discharged from medium secure forensic hospitals and found that on a six year follow up period an average of one third of more MDOs reoffected while another United Kingdom prospective study by Maden, Scott, Burnett, Lewis and Skapinakis (2004) found that 15% of MDOs were reconvicted in a two year follow up and only 6% committed violent offences. Grann, Belfrage, and Tengstrom (2000) from Sweden made a significant contribution to the body of research in a number of studies on recidivism and found that 26% of MDOs with personality disorder and 14% of MDOs with schizophrenia committed violent crimes within two years post discharge. A more recent Swedish study by Lund, Hofvander, Forsman, Anckerster and Nilsson (2013) followed up MDOs for 13 to 20 years post offence and found that 47% were reconvicted for violent crimes. This study aimed to look at the difference between psychiatric patients that received different sentences post trial – a prison sentence, forensic psychiatric treatment or non-custodial sanctions. The study did not find major differences in each group (Lund et al, 2013). A Swiss study by Pfueger et al (2015) recorded a rate of reconviction amongst MDOs as follows: of a total of 259 MDOs, 51% were reconvicted and of those 13% committed violent re-offences.

THESE FINDINGS SHOW THAT RECIDIVISM STUDIES ARE A FLORISHING FIELD OF RESEARCH. THERE IS HARDLY ANY RESEARCH DONE IN THIS AREA IN SOUTH AFRICA - AND THE REST OF THE DEVELOPING WORLD - DESPITE THE PRESSING NEED FOR SUCH STUDIES.

STATIC AND DYNAMIC RISK FACTORS

Risk factors can be broadly divided into static and dynamic factors (Chaimowitz, 2008). Static risk factors are also known as non-modifiable factors. Typical examples of non-modifiable factors are age, marital status, offence type and age at first conviction. Static risk factors are historical and do not fluctuate. Dynamic risk factors, as the name suggests are modifiable factors. A few commonly mentioned modifiable factors are active mental illness, medication adherence, insight into their mental illness, and involvement with criminal associates (Chaimowitz, 2008). Static risk factors have been more extensively studied and shown to be the strong predictors of recidivism. They also tend to be the focus of risk assessment tools (McDermott, Edens, Quanbeck, Busse & Scott, 2008). Dynamic risk factors are particularly valuable to clinicians as once the factor is addressed there may be a
reduction in recidivism (McDermott et al, 2008). The rest of this report discusses risk factors grouped into three main categories; criminological, demographic and clinical. The first two incorporate static variables whilst the latter includes mostly dynamic factors.

CRIMINOLOGICAL FACTORS ASSOCIATED WITH RECIDIVISM

Generally criminological factors include variables such as age of first conviction, number of criminal charges, heterogeneity of charges, type of index offence (e.g. minor offence versus violent offence), previous convictions and incarcerations.

The meta-analysis by Bonta et al (1998) is a frequently quoted study on risk factors for recidivism. This analysis, as well as a second meta-analysis by Bonta et al (2013) revealed that criminological factors such as number of previous convictions and age of first crime are the strongest predictors of recidivism. Maden, Rutter, McClintock, Friendship and Gunn (1999) in the United Kingdom reported that the average age of a recidivist on admission was 29 years old compared to 35 years old for a non-recidivist; and recidivists had a mean of 13 previous convictions compared with six for non-recidivists.


The relationship between the type of index offence and recidivism has also been noted. A large scale Canadian National Trajectory Project analysed MDOs with regard to rate of and risk factors for recidivism (Charette et al, 2015). The project yielded interesting results in that it found the rate of recidivism amongst MDOs less than that of general offenders. It also revealed that MDOs with more serious index offences were less likely to reoffend. Similarly, Pfueger et al (2015) stated that MDOs with less serious index offences were more likely to reoffend. Public opinion may assume that an offender with a more serious offence is more dangerous and more likely to reoffend however these studies tell of an opposite association. The relationship between offence type and recidivism is complex and should be studied further.

Specific offences such as homicide and sexual offences in the MDO population have been studied. A systematic review and meta-analysis of homicide recidivism in schizophrenia reported that approximately 2% of homicide offenders with schizophrenia had committed an earlier homicide (Golenkov, Niellsen & Large, 2014). This study concluded that the rate of homicide recidivism in schizophrenia is likely lower than some reports have suggested. A large-scale study of over 1000 sexual offenders found that any psychiatric diagnosis including psychosis and mood disorders were risk factors for sexual recidivism (Långström, Sjöstedt & Grann, 2004). A more recently published study assessed the relationship between recidivism and mental disorders amongst sexual offenders (Kingston et al, 2015). In this study 95% of sexual offenders had a mental health diagnosis, 27.8% committed sexual recidivism, 51.1% violent (including sexual) recidivism and 69.6% general recidivism (Kingston et al, 2015).

HOWEVER, THIS PROSPECTIVE STUDY AND A STUDY BY ABRACEN ET AL (2014) INDICATED THAT SUBSTANCE ABUSE AND PERSONALITY DISORDER WERE THE ONLY DIAGNOSES ASSOCIATED WITH RE-OFFENCE AMONGST SEXUAL OFFENDERS. PSYCHOSIS OR ANY OTHER PSYCHIATRIC DIAGNOSES WERE NOT SIGNIFICANT PREDICTORS.

DEMOGRAPHIC FACTORS ASSOCIATED WITH RECIDIVISM

Demographic factors related to gender, age, marital status and employment have been linked with recidivism. Age at first conviction is often grouped with criminological factors and has been discussed above.

Male gender has been found to be a predictor of re-offending in some studies (Bonta et al, 1998; Buchanan, 1999; Coid et al, 2007; Davies, Clarke, Hollin, & Duggan, 2007) however many other studies with large sample sizes and long follow-up periods did not replicate this finding (Friendship, McClintock, Trutter & Maden, 1999; Lund et al, 2013; Phillips et al, 2005). Differences in outcome could be attributed to differing methodologies or population sample, however, studies by Coid et al (2007) and Phillips et al (2005) both assessed MDOs released from medium secure units in the United Kingdom but have differing results with regard to male gender. Hence the link between gender and recidivism is unclear.

Some studies that have assessed marital status with regard to recidivism have not found it to be a predictor of recidivism (Edwards et al, 2002; Friendship et al, 1999; Philips et al, 2005). Contrastingly the regularly mentioned meta-analysis by Bonta et al (1998) found that among demographic variables age, gender and single marital status were the strongest predictors of recidivism. The second analysis by Bonta et al (2013) reported that problems with employment, being single and having family problems were predictors of general and violent recidivism. Castillo and Alarid (2011) from the USA examined characteristics of 307 adult MDOs and did not find employment status to be a predictor of recidivism.
NOT MANY STUDIES COMMENT ON LEVEL OF EDUCATION AS A RISK FOR RECIDIVISM. HOWEVER BONTA ET AL (1998 AND 2013) STATE THAT EDUCATIONAL LEVEL WAS NOT A SIGNIFICANT RISK FACTOR FOR BOTH GENERAL AND VIOLENT RECIDIVISM.

These correlates have only been established in developed countries and cannot be extrapolated to a South African population. A socio-demographic study that compared MDOs from Zimbabwe to MDOs in England and Wales showed major differences in population groups in terms of age, marital status and level of literacy. Only employment status was comparable between the two groups and furthermore 53% of Zimbabwean MDOs had committed homicide compared to 20% of English and Welsh MDOs (Menezes, Oyebode & Haque, 2007). The assumption following these contrasting findings is that different geographical groups do not always follow the same trends. It is therefore important that the relationship between demographic factors and recidivism continues to be (re)examined on a local level.

CLINICAL FACTORS AND RECIDIVISM

THE TWO MOST IMPORTANT CLINICAL VARIABLES LINKED TO INCREASED RISK FOR RECIDIVISM ARE SUBSTANCE ABUSE AND ANTISOCIAL PERSONALITY DISORDER (BUCHANAN, 1998; GAGLIARDI, LOVELL, PETERSON & JEMELKA, 2004; MADEN ET AL, 2004; NILSSON ET AL, 2011; LUND ET AL, 2013). THE LIST OF REFERENCES SUPPORTING THIS FINDING COULD EXTRAPOLATE TO THE MAJORITY OF STUDIES ON RECIDIVISM IN MDOS.

The presence of a mental illness alone such as schizophrenia or bipolar disorder has not shown to be a significant predictor of recidivism (Coid et al, 2007; Nilson et al, 2011; Phillip et al, 2005) however substance abuse and personality disorders alone or in combination with mental illness are strong predictors of recidivism (Castillo and Alarid, 2011; Grann et al, 2008; Lund et al, 2011). The MacArthur study (1998) reported that among recently discharged psychiatric patients the prevalence rate for violence was 18% for major mental illness without substance abuse, 31% for major mental illness with comorbid substance abuse and 43% for personality-disordered patients with comorbid substance abuse. In a long-term study on schizophrenic patients the risk for violence was increased 30-fold in patients with schizophrenia and substance abuse compared to 16-fold in schizophrenia alone (Wallace, Mullen & Burgess, 2004).

Bonta et al (2013) found that drug abuse was a significant predictor of general recidivism while alcohol abuse was strong predictor of violent recidivism. Overall alcohol is the substance most strongly associated with recidivism (Bonta et al, 1998). Alcohol has been found to facilitate aggression and antisocial behaviour and correlations have been made between alcohol, sexual violence, intimate partner violence and murder (Bonta et al, 2013). Thus, it is not surprising that there is such a strong association between alcohol and recidivism.

Psychopathy and antisocial personality disorder are often used interchangeably. Robert D Hare pioneered studies in psychopathy in offender populations. This research led to the development of the Hare Psychopathy Checklist (PCL). The PCL was revised to a 12-item checklist and is now referred to as the PCL revised (PCL-R) or PCL screening version (PCL-SV). The PCL-R is used extensively both for research and clinical purposes. It has also been used for research that influenced the Diagnostic Statistical Manual (DSM) criteria for ASPD (Hare, 1996). Dr Hare, in an article in the Psychiatric Times (1996), warned against using the terms ASPD and psychopathy synonymously. While most psychopaths will also fulfil the criteria for ASPD, the majority of those diagnosed with ASPD are not psychopathic (Hare, 1996). The DSM IV diagnostic criteria for ASPD states that these patients have a pervasive disregard for and violation of others’ rights and also list seven common characteristics in ASPD. Psychopathic individuals also present with deviant and disrespectful behaviour; however, psychopathy is a personality disorder that denotes more specific problems with affective, interpersonal, and behavioural characteristics. These present with impulsivity, superficial emotions, lack of empathy, guilt, or remorse, pathological lying, lack of responsibility and persistent violation of social norms and expectations (Thomson et al, 2015). Common terms used to describe psychopaths at an interpersonal level are grandiose, arrogant, cold-hearted, superficial, domineering and manipulative. Psychopathic individuals are also quick-tempered and lack the ability to form meaningful emotional bonds (Hare, 1991). The prevalence of psychopathy is less than 1% in general populations (Coid, Yang, Ullrich, Roberts & Hare, 2009). Psychopathy and high scores on the PCL-R are consistently found as strong predictors of re-offence (Coid et al, 2015).

Associations have been made between active major mental illness and violence. Mentally ill patients with threatening or paranoid delusions are twice as likely to become violent as non-paranoid psychotic patients (Buckley, Noffsinger, Smith, Hrouda & Knoll, 2003). Approximately 20% of violent psychotic patients were motivated by their hallucinations or delusions (Taylor, 1985). Anger attacks were reported in 44% of patients with depression (Fava, 1998) and amongst MDOs a diagnosis of depression has been linked with risk for sexual offence (Coid et al, 2007). Patients with dementia and intellectual disability are also a subgroup that pose risks for violence (Rueve & Welton 2008). The study by Swanson et al (1990) showed that the risk for violence increased linearly with the number of psychiatric diagnoses;
were rarely readmitted and violence was overall the most common reason for return to the State Hospital (Duncan, Short, Lewis & Barrett, 2002). A retrospective study by Maden et al (1999) also found a relation between length of stay in hospital and reconviction.


“One hundred patients wait for beds at Sterkfontein” was the title of an article in the Times Live on 22nd June 2011. The sub heading stated “The families of more than 100 mentally-challenged inmates waiting for beds at Sterkfontein Psychiatric Hospital will listen with huge interest to what the head of the hospital has to say in court next week” (Ndlovu, 2011). A guest editorial by Ogunlesi, Ogunwale, De Wet, Roos and Kaliski (2012) highlighted the challenges in forensic psychiatry in Africa – the main ones being lack of knowledge about forensic psychiatry and resource shortages. It is for the above reason that the duration of first admission was of particular interest to the author of this thesis. Due to bed shortages and long waiting lists, clinicians at Sterkfontein Hospital are often under pressure to allow state-patients back into the community on LOA. It is therefore important to know whether specific duration of admittance impacts recidivism as authorising an LOA very soon after admission due to bed shortages may impact society at large.

The time from discharge to re-offence is an important variable to consider as it may provide information as to when an MDO is at greatest risk for reoffending. Steadman et al (1998) and Yoshikawa et al (2007) found that most MDOs reoffend within the first two years in the community. Castillo and Alarid (2011) and Lovell et al (2002) reported that most reoffended within the first year. Phillips et al (2005) assessed MDOs for an average of six years post discharge and stated the risk for re-offence was highest in the first three years. Coid et al (2007) made a slightly different finding and stated that the risk for re-offence increased each year post discharge and peaked at nine years.

RISK ASSESSMENT

The South African legal system regarding management of MDOs differs considerably from other countries. Most often risk assessments are made by means of clinical judgement as most actuarial tools are not specifically validated for...
a South African population. Countries that have scientifically validated risk factors for recidivism, have gone on to formulate risk assessment tools such as the Violence Risk Appraisal Guide and the Offender Group Reconviction Scale (Snowden, Gray, Taylor & MacCollloch, 2007). Another commonly used and validated risk assessment tool is the Historical Clinical Risk Management rating scale (HCR-20) (Webster, Douglas, Eaves & Hart, 1997). The HCR-20 combines actuarial measures with structured clinical judgement. Many argue that actuarial prediction of risk is more reliable than clinical judgement (Lawlor, 2002; Quinsey, Harris, Rice & Cormier, 2006).


The article also states that there is no one consensus on the best risk assessment tool, however a combination of approaches should be used based on the purpose of the risk assessment (Monahan & Skeem, 2014).

CONCLUSION

In South Africa we have yet to assess whether the internationally known risk variables apply to a South African population of MDOs. It is imperative that one assesses recidivism and MDOs in the context of the current challenges within the South African system.

The MMEd which served as the basis for the literature review addressed risk factors for recidivism in a South African setting. The data is available as follows: Morgan N, Del Fabbro G. Factors associated with recidivism at a South African forensic psychiatric hospital. South African Journal of Psychiatry | Vol 24 | a1125 | 2018 | https://doi.org/10.4102/sajpsychiatry.v24i0.1125.

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Recidivism is one of the most fundamental concepts in criminal justice. It refers to a person's relapse into criminal behavior, often after the person receives sanctions or undergoes intervention for a previous crime. Learn Why Recidivism Is a Core Criminal Justice Concern. oneword/Shutterstock.com (see reuse policy). Description. Recidivism is measured by criminal acts that resulted in rearrest, reconviction or return to prison with or without a new sentence during a three-year period following the prisoner's release. Recidivism is affected by several factors such as the person's circumstances before incarceration, their social environment and community, events during their incarceration, and, arguably the most impactful, difficulty adjusting back into everyday life. Many individuals released from prison have difficulty finding jobs to support themselves and reconnecting with family members. Recidivism affects everyone: the offender, their family, the victim of the crime, law enforcement, and the community overall. Recidivism is a person's tendency to relapse into a previous condition or mode of behavior, especially a relapse into criminal behavior. What Is Recidivism? Recidivism is a much larger problem than most realize, but there is a solution. What is Recidivism? There's a crisis in our country. And most of us have no idea it's even happening. At its heart, recidivism is a person's tendency to relapse into a previous condition or mode of behavior, especially a relapse into criminal behavior. From French récidivisme, from Latin recidivus (‘returning, recurring’). Compare recidivous, -ism. recidivism (countable and uncountable, plural recidivisms). Committing new offenses after a crime committed in the past. The increase in criminal activity was attributed to recidivism. (psychology, psychiatry) Chronic repetition of criminal or other antisocial behavior. (by extension) Returning to a negative behavior after having stopped it for a period of time. alcohol(ic) recidivism. Recidivism. Quite the same Wikipedia. Just better. (Recidivism is a synonym for "relapse", which is more commonly used in medicine and in the disease model of addiction.) For example, scientific literature may refer to the recidivism of sexual offenders, meaning the frequency with which they are detected or apprehended committing additional sexual crimes after being released from prison for similar crimes.[citation needed]. YouTube Encyclopedic. 1/5.