Crime and the Insanity Defense, An International Comparison: Ontario and New York State*

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> An individual acquitted of a criminal charge ordinarily leaves the courtroom a free man. But not the accused 'acquitted' by reason of insanity. He is, in fact, often worse off than if he had been convicted. The judge is required to order him 'held' in a place of 'safe custody,' 'until the pleasure of the Lieutenant Governor is known.' The usual consequence is indeterminate detention under a Lieutenant Governor's warrant. To characterize such a result as an 'acquittal' is, to say the least, inappropriate.
>
> — The Law Reform Commission of Canada[7]

The plea of insanity has a very long history dating from the time of the Norman conquest of England in the 11th century.[14] As a defense against the death penalty, it made good sense. But in recent times, with the abolition of capital punishment, the value of this defense has been substantially reduced. As the Canadian Law Reform Commission points out in its report on Mental Disorder in the Criminal Process, this kind of 'acquittal' may be more punitive than a conviction. This fact has not been overlooked by defense lawyers. In a recent case involving a murderous assault by an extremely paranoid man, the issue of insanity, raised by the Crown, was successfully resisted by the defense lawyer. As a result, the offender, who had a long history of mental illness, was sentenced to five years imprisonment.

In this case an extremely psychotic and dangerous man who could probably benefit from psychiatric treatment will be released after a few years in prison and continue to menace his neighbors. Equally anomalous are the cases involving, for example, suicide pact survivors or depressed mothers who kill their children. They could be treated as out-patients, but are compelled by law to spend years in mental hospitals. Unfortunately the arguments for and against the insanity defense are usually based on rival philosophical notions rather than on empirical knowledge.

The need to examine public policy regarding the disposition of mentally ill offenders, on the basis of fact rather than conjecture, has been recognized in a number of recent studies.[1,3,8,11] As a contribution to such endeavors the aim of this paper is to present data on Crime and the Insanity Defense in

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Ontario from 1961 to 1970. These data will be compared with similar statistics from New York State. Apart from its inherent interest the main purpose of this comparison is to explore the similarities and differences in practices and outcomes between two legally quite different jurisdictions. The results of this comparison are presented in three parts. Part I contains data on circumstances prior to the index offense. Part II provides data relating to the offense. Part III provides data on events subsequent to the hospitalization.

The legal background to the insanity defense in New York is as follows. "A person is not criminally responsible for his conduct, if at the time of such conduct, as a result of mental disease or defect, he lacks substantial capacity to know or appreciate either: (a) The nature and consequences of such conduct; or (b) That such conduct was wrong." After acquittal the defendant is automatically committed to an appropriate mental institution until such time as his or her mental state has been restored and he or she no longer poses a threat to self or others.[9] The situation in Ontario is described in the following background statement.

Background

Since part of the data presented here comes from the files of the Advisory Review Board of Ontario a brief account of its constitution and functions will help to explain the purposes served by the records. When an accused person is found insane at the time of the offense or at the time of the trial, the court must order the accused to be kept in custody until the "Pleasure of the Lieutenant Governor of the Province is known."[13] This warrant does not specifically provide that the accused shall be detained in hospital for observation and/or treatment. But persons subject to warrants are usually detained in a maximum security psychiatric hospital such as Oak Ridge in Penetanguishene. This facility for mentally disordered male offenders is operated in Ontario by the Ministry of Health. In recent years a similar facility for women has been established at St. Thomas, about twenty miles west of London.

Following the recommendations of the Canadian Committee on Corrections,[2] provision for an annual review of offenders detained under warrants of the Lieutenant Governor was introduced into the Canadian Criminal Code, 1968-9 (Section 547). This arrangement was anticipated in Ontario under its Mental Health Act (1967). Section 31 of the Mental Health Act, Ontario (1979), permits the Lieutenant Governor in Council to appoint an advisory review board composed of a judge or retired judge of the Supreme Court, to serve as chairman, a psychiatrist, and three other members. The board's duty is to review annually the case of every patient detained in a psychiatric facility under the warrant of the Lieutenant Governor. The chairman is then required to prepare a written report for the Lieutenant Governor containing the recommendations of the advisory review board. The decision of the Cabinet of the Provincial Government is, in effect, required for the discharge of the warrant.

Some of the political implications of this unwelcome responsibility are briefly considered in my paper on The Prediction and Management of Dangerous Behavior: Social Policy Issues.[6] At this point, however, it is only

necessary to mention that the present study is based on the advisory review board records which might also be available to the Cabinet.

Part I

Prior circumstances:

As an introduction to the data on the circumstances prior to the offense, some preliminary observations on the cohort of L.G.W. patients in Ontario are presented first.

Table I shows the number of warrants issued in Ontario from 1961 to 1970. The substantial increase in the late 1960's should be noted. Males outnumber females by four to one. During the ten-year period 1961-1970, seventy men and eighteen women were hospitalized under the authority of a Lieutenant Governor's Warrant (L.G.W.). All were charged with Criminal Code offenses and acquitted after being found N.G.R.I. Nine were initially found unfit to stand trial, but were acquitted later due to mental illness.

The trend in New York State is similar to Ontario. There were 53 insanity acquittals between 1965 and 1971 and 225 in the period from 1971 to 1976.[8]

Relative to the participation in violent crime, the proportion of women found N.G.R.I. is much greater than for men. This is true in Ontario as well as in New York State.

Age and Sex:

Table 2 shows the age and sex distribution of persons found N.G.R.I. in New York State and Ontario. In terms of age structure, the cohorts are quite different. Over half of the male and female patients in Ontario were between 15 and 29 years of age. The comparable proportion in New York State was 10 per cent. The average age for men in the New York State cohort was 36 years, and 33 years for women. In Ontario the average age for men was 27.5, and for women, 34 years. The age range for men was 15 to 63 years, and for women 20 to 52 years.

Previous Mental Illness:

In the New York State cohort, 44 per cent of the men and 28 per cent of women had a previous admission to a psychiatric hospital before being charged with the offense. Eighty-seven of the men who had been hospitalized had a total of 227 separate hospitalizations. Twelve of the men had been hospitalized under Criminal Code procedures on 19 separate occasions. Several of the women had been hospitalized previously on 15 occasions. One woman had been hospitalized five times under civil statute and twice under the Criminal Code.

There was a much higher incidence of psychiatric morbidity in the Ontario cohort. Thirty-five (50%) males and ten (55%) females had been hospitalized and treated for mental illness at some time prior to their L.G.W. offense. Four other men, who were described as mentally defective, had also been institutionalized for varying periods before committing their crimes. One of them had lived in an Ontario mental hospital for fifteen years, from age twenty to thirty-five. He had been out of hospital for four years when he murdered a casual acquaintance.

Among the L.G.W. patients with psychiatric histories were seven men whose offenses were committed either inside a mental hospital or while they were absent from hospital. Two of the men killed fellow patients.

Two men committed their L.G.W. offenses while away from hospital without permission. The first man, 24 years old, robbed a bank during his elopement. During the preceding four years he had been in and out of two Ontario mental hospitals and a private psychiatric clinic. Police had arrested him for female impersonation, and several times took him to hospital. In the second case, a 24-year-old man shot and killed a policeman who was attempting to return him to hospital. Described as mentally defective, he had a long history of hospitalizations, elopements and assault behavior.

At least nine other patients were receiving psychiatric treatment or had been discharged from a mental hospital shortly before committing their L.G.W. offenses. In this group is a 28-year-old male with criminal convictions dating back nine years for car theft, robbery, theft and possession of an offensive weapon, and with several reformatory sentences. He had been an involuntary patient at Oak Ridge for three years after being transferred from reformatory. After transfer to and then discharge from another Ontario mental hospital he committed his L.G.W. offense a few weeks later. This involved indecent assault on a female, possession and unlawful carrying of an offensive weapon.

In the last example, a 50-year-old man left the psychiatric ward of a general hospital against medical advice. Within six weeks he killed his estranged wife, tried to burn down his house, and tried to kill himself. His diagnosis included depression, paranoia, and alcoholism.

The close chronological ties between psychiatric care and L.G.W. offenses are equally evident among the female patients. Eight (57%) women were in active care or had recently received psychiatric care. One woman, 23 years old, killed her two young children just two weeks after being discharged from a mental hospital. She had talked with doctors at the hospital within twenty-four hours of the tragedy, expressing her fears for the harm she might bring to her family. Another woman, age 42, killed her husband the day following a discussion with her doctor about going into a mental hospital. She had been acting strangely for some time before this episode, experiencing hallucinations and expressing fears about causing harm. She wounded her son in the same tragedy. A third woman was being treated as an out-patient at a mental hospital when she killed her young daughter. Her psychosis developed after the birth of another child the preceding year.

Another woman, age 40, killed her two children and attempted suicide while being treated by her family doctor for "nerves." She had been taking a prescribed tranquilizer for several years. Three days before the murders she wrote a note describing her intentions and also called the police. She had a history of suicide attempts and an unhappy marriage.

In two other cases involving women, psychiatrists had attempted to treat depression. The first woman was given electro-convulsive therapy in a general hospital before drowning her two children and trying to kill herself. The second woman, age 25, shot at her husband several times at the climax of an unhappy marriage characterized by his infidelities and verbal and physical abuse. She saw a psychiatrist four months before the shooting complaining

of depression, fatigue, and sleeplessness. Anti-depressant medication was prescribed.

The heavy burden of pathology prior to the index offense, resulting in an acquittal after being found N.G.R.I., is characteristic of the Ontario cohort. Although not as great, the New York State cohort also contains a substantial proportion (44% men and 28% women) of people with histories of mental illness. Despite this, Pasewark, Pantle, and Steadman,[9] the co-authors of the New York State study, are inclined to deny the evidence of mental illness. Their opinions will be mentioned later.

Previous Criminal History:

44 per cent of the New York State cohort had previous arrest records. Those with prior records included 5 (17%) women, and 95 (48%) men. The 100 persons previously arrested produced 492 arrests. Of these, 151 (31%) were against persons, including 9 murders, 1 negligent homicide, 69 assault, 31 robbery and 19 sex offenses.

The situation in the Ontario cohort regarding previous criminal history was strikingly similar to New York State. Thirty-five (50%) of the men and 1 (5.5%) woman had previous arrests as adults.

Of these men with previous convictions, twenty-one had committed offenses involving violence against persons, or possession of a dangerous weapon. Assaults and sexual attacks were the most common crimes. Four of the group had been convicted of armed robbery.

One man committed his offense after escaping from reformatory. He had been in trouble with the law since the age of 18. Following his escape from reformatory, he broke into a house where he encountered the owner and beat him to death. Unmanageability, disciplinary difficulties, and "adolescent maladjustment" were cited as problems for four men. Three exhibited violent behavior. One young man was sent to Training School for attacking a policeman. His L.G.W. offense at the age of 18 occurred just three weeks after release from penitentiary. He killed an elderly woman and fired shots at several other people from his rooming-house window. The second man, as a fifteen-year-old, carried a loaded gun during a break and enter episode. He went on to set a fire in a men's hostel, killing three young residents. He had a record of sixteen mental hospital admissions. The third man sexually assaulted several young boys while he himself was only eleven years old. His L.G.W. offense, rape, was committed when he was fifteen. Six years later, while living outside hospital on a loosened warrant, he killed a cocktail waitress.

Part II

Offense related data:

Table 3 shows the offenses resulting in acquittal by N.G.R.I. in the New York State and Ontario cohorts. Murder, manslaughter and "other violent" offenses accounted for almost three-quarters of the male offenses in both cohorts. The large majority of women in both cohorts were similarly involved in the most violent offenses, murder and manslaughter.

Although the proportions are small, under 5 per cent, there were, surprisingly, some relatively minor offenses, such as passing bad checks and

auto theft in Ontario and motor vehicle violation and selling "controlled substances" in New York State.

Victims:

Table 4 shows the relationship of the victim to the offender, where this information is relevant. The differences between male and female offenders, in both cohorts, are remarkable. Women, much more frequently than men, kill family members, most frequently their children. Men, on the other hand, are much more likely to attack strangers and authority figures such as policemen.

Psychiatric Diagnosis:

Table 5 shows the major psychiatric categories of the persons, by sex, found N.G.R.I. in New York State and Ontario. The standard diagnoses have been collapsed for ease of presentation.

The most frequent diagnosis in both cohorts was paranoid schizophrenia, included under psychosis. 67.8 per cent of men and 76.0 per cent of women in New York State were classified as suffering from a major psychotic illness. The comparable proportion in the Ontario cohort was 47.5 per cent men and 43.4 per cent women.

A major difference between the cohorts concerns the category of neuroses. This diagnosis was applied to 3 per cent of the New York State patients and 10.0 per cent men and 34.8 per cent women in the Ontario cohort. A possible explanation for this substantial difference is the practice in Ontario of listing reactive depression as a neurotic rather than a psychotic condition. The practice in the U.S. is to treat this condition, under psychosis, as an affective disorder.

30 per cent of the men in the Ontario cohort were diagnosed as "psychopathic" personalities compared to 10 per cent in New York State.

In-hospital Experience:

Although comparable U.S. data is not available, the in-hospital experience of the Ontario cohort illuminates some of the problems involved in treating L.G.W. patients.

Sixty-six (94%) of the male L.G.W. patients were admitted to a maximum-security facility. The remaining four men and all the women were sent to other provincial mental hospitals. Once in hospital, the L.G.W. patients are subject to the same basic procedures and treatment programs as other patients. L.G.W. patients are not, however, free to leave hospital except according to the terms of their warrant. Leaves of absence, inter-hospital transfers, must be approved, in advance, by the Lieutenant Governor through an Order-in-Council.

A variety of problems, including unauthorized leaves and escapes, arose in the management in hospital of L.G.W. patients. At least ten L.G.W. patients were violent in hospital. Some others made verbal threats or wrote threatening letters. One of them, a woman, threatened to kill her adult son because of his plans to proceed with a sex change operation. She had already killed another son whose lifestyle she did not approve.

The most serious violence was perpetrated by a 24-year-old man who

twice physically attacked members of the hospital staff. On one of these occasions he poured boiling water on an attendant. This patient also tried to kill himself. Another 24-year-old patient proved to be destructive, assaultive, and uncooperative. He was assigned to three different wards within three months in an attempt to find a suitable setting. His L.G.W. offense occurred during an escape from hospital when he killed a policeman who had captured him.

Twelve patients (four women and eight men) attempted suicide in hospital. Two women and one man were successful. One woman had been under warrant for seven years. During her first year in hospital she made several suicide attempts. Then she began to show dramatic improvement, and within two years her warrant was loosened to permit her to live and work outside the hospital. Over the next four years, her condition fluctuated until finally she was re-hospitalized. In the last year of her life she made numerous suicide attempts. She was 43 years old and had been originally charged with the murder of her two children. The other woman who killed herself had been under warrant for less than six months. One man who killed himself in hospital had been under warrant for five years. He was originally charged with the stabbing death of an old woman.

Transfers:

Forty-three male patients and three female patients were transferred between two or more hospitals in Ontario. Forty-one of the forty-three men were transferred from Oak Ridge to regional mental hospitals in preparation for return to the community. Some patients also may have been transferred from Oak Ridge because they no longer required a maximum-security setting. The average length of stay in Oak Ridge before transfer to another hospital was 5.5 years.

Ten patients were returned to Oak Ridge after having been transferred to regional hospitals. These returns generally occurred within a few months of the transfer to the new hospital. Six of the ten patients sent back to Oak Ridge eventually were re-transferred to regional hospitals.

Two patients were sent back to Oak Ridge after leaving regional hospitals without authorization and committing offenses. The first patient stole an automobile and boat. Armed with a gun, he broke into several cottages before police captured him. After trial and sentencing, the Court recommended his return to Oak Ridge. His original L.G.W. offense, committed when he was 30, was rape, attempted murder, robbery with violence and possession of an offensive weapon. The second man was originally charged with armed robbery. Twice after his transfer to a regional hospital he escaped and attempted robbery. On the first occasion charges were not laid, and he was returned to Oak Ridge. Three years later, after his second transfer to a regional hospital, he repeated this offense, was tried and found guilty.

Part III

Post-hospital Experiences:

Loosened and discharged Warrants

Under the system of "loosening" of the Lieutenant Governor's Warrant, a

patient is permitted to live in the community. The aim is to foster the patient's gradual re-integration into society. If the patient's adjustment is satisfactory, the A.R.B. will likely recommend that the warrant be vacated, thus removing all legal restraints.

Although the A.R.B. broadly outlines the terms of a loosened warrant, the actual details are specific to each case. They are usually left to the discretion and supervision of the hospital administrator. For example, the A.R.B. in recommending the loosening of a patient's warrant might refer to the "continuation of rehabilitation and education in the community." The form such rehabilitation might take includes visits to or living at home or in some other approved accommodation, attending school, getting a job, travelling for personal or recreational reasons.

The length of time a person might continue on a loosened warrant is also an individual matter. A warrant may be vacated within a year or less of first being loosened. On the other hand, some patients continue on a loosened warrant for several years. The average length of time spent on a loosened warrant before vacation was 2.8 years for twenty-two men, and 2.6 years for five women. Sixteen patients have been on loosened warrants for an average of 3.7 years.

Violations of the terms of a loosened warrant may result in the recall of the patient to hospital. In most cases the patient is simply reminded of his obligations under the warrant. His future behavior may be more closely monitored to reduce the risk of further violations. Examples of possible violations are drinking (for an alcoholic), not living in agreed-upon accommodations, leaving a specific geographic area such as a city, county, or section of the province without permission, failure to keep hospital appointments, failure to notify the hospital of changes in accommodation or activities, sexual misdemeanors (especially for a sex offender), failure to report potentially serious problems to the hospital. An example of the latter is a 44-year-old man who was driving while disqualified and left the scene of an accident.

A few patients failed to adjust to community life on a loosened warrant. The most serious case involved a 21-year-old man who murdered a young waitress while outside hospital on a loosened warrant. He was found guilty and sentenced to life in prison.

Two female patients committed suicide while on loosened warrants. One was a 49-year-old woman who had been living at home for four years when she killed herself. Nine years earlier she killed her two children and attempted suicide. The second case involved a 28-year-old woman who jumped in front of a subway train. She had been living in the community for less than a year. Five years earlier, she killed her two children.

Current Status of N.G.R.I. Patients:

Table 6 shows the current status of N.G.R.I. patients comparing New York State at June, 1976 and Ontario, January, 1979. At this time, 30 per cent of the New York State cohort had been completely discharged. The comparable proportion for Ontario was 39.8 per cent. 59 per cent of the New York State cohort were still in hospital compared to 28.4 per cent of the Ontario cohort. This includes seven discharged patients who remain in

hospital on an informal basis.

Particular attention should be paid to the high rate of mortality in both cohorts, amounting to 4.0 per cent in New York State and 6.8 per cent in Ontario. Suicide was the most frequent cause of death, especially among the women.

Duration of Stay in Hospital:

Table 7 shows the duration of stay in hospital before discharge into the community. To facilitate the comparison between New York State and Ontario, the durations of stay have been examined by offense and sex of the offender. Taking homicide as an example, it will be seen that the average duration of stay for men, in New York State, was 278.4 days (range 1 – 1,235 days), and women 245.6 days (range 56 – 621).

The durations of stay in Ontario were much greater for all offenses and both sexes. The comparable duration for homicide in Ontario was 2,119 days (5.8 years; range 1 – 17 years) for men, and 1,656 days (4.5 years; range 2 – 9 years) for women.

It must, however, be noted that the New York State and Ontario data are not strictly comparable. The New York State data covers the period from 1971-1976. The time scale in Ontario is 1961-1979. These dates are significant because the work of the Advisory Review Board did not start until 1968.

Another difference in the comparability of data is that the Ontario statistics include patients with "loosened" warrant who, although still subject to recall, are well established in the community.

In brief, it can be stated with some confidence that the average duration of stay for N.G.R.I. patients in Ontario hospitals has declined substantially since 1970, but it is still much longer than the average stay of comparable patients in New York State.

Post-Discharge Experiences:

Data on the post-discharge experiences of the New York State cohort (1965-1971) reveal that 3 of the 30 discharged men were re-admitted to a state hospital. Three of the ten discharged women had subsequent re-admission to hospital.

None of the women incurred an arrest, but 11 (36.6 per cent) of 30 discharged males were apprehended by police. This group had experienced 34 arrests or 3.1 per person. Crimes against the person, including: (1) murder, (1) assault, (1) rape, (2) robbery, etc., accounted for two-thirds of the arrests. The remainder were property and drug related offenses.

In Ontario two of the women whose warrants were vacated committed serious offenses. One killed her daughter and wounded her son before committing suicide. Six years earlier she killed her husband and attempted suicide. The second woman robbed a bank and shot a policeman who tried to capture her.

Contrary to the impression created by these ominous failures, researchers in this field are generally optimistic about the post-hospital adjustment of the N.G.R.I. patients. Pasewark *et al.*[9] suggest that these patients are less frequently arrested than comparable groups of felons. This view is supported

by Quinsey and his colleagues[10] in Ontario. In their study of fifty-six L.G.W. patients who were followed up after release, Quinsey found fifty per cent in the community, 43 per cent in psychiatric facilities and five per cent in prison. Nine per cent of the patients were either returned to the maximum security hospital or had committed new offenses.

Conclusions

It is paradoxical that the growing dissatisfaction with the insanity defense has, apparently, been accompanied by an increased use of this ancient remedy.[12] Its original purpose, crudely stated, was to separate the mentally sick from the bad so that the full wrath of criminal sanctions would not be applied unfairly to an offender who was not fully responsible for his actions. This was a vitally important consideration when capital punishment was the ultimate penalty.

In recent years, however, the scope of the insanity defense has expanded to include lesser offenses and offenders who are obviously not "McNaghten" mad. This kind of acquittal has been a matter of concern to the public as well as professionals who are less than dedicated to psychiatry.

The insanity defense has been criticized on a number of grounds. Most significant is the arbitrary nature of its application, and the fact that it results in enforced treatment and indeterminate commitment. My own studies,[5] comparing a cohort of L.G.W. patients and prisoners matched for offenses, show that the two groups share a high incidence of criminality and psychiatric morbidity. The overlap between the male "patients" and the "prisoners" is much greater than among the women. This suggests that courts are inclined to give female offenders the benefit of the doubt. This, in theory, means substituting treatment for punishment. But as the data presented here indicates, this is a very mixed blessing. The Ontario data suggests that female L.G.W. patients are frequently hospitalized for very long periods. The high rate of suicide among them also suggests that treatment is not invariably successful.

Another group which does not appear to be responsive to treatment are the psychopaths who represent 10 per cent of the New York State and 30 per cent of the Ontario cohort. This matter, it should be noted, was considered by the Butler Committee[1] in Britain. They concluded that psychopaths "are not, in general, treatable, at least in medical terms," and proposed that prisons should take care of "dangerous anti-social psychopathic offenders." The Butler report also recommends the use of indeterminate sentences for dangerous offenders.

The issue of indeterminacy brings us directly to the problem of deciding when and under what circumstances the L.G.W. patient should be discharged. Since this responsibility falls upon the Advisory Review Board in Ontario it is appropriate to ask how such difficult decisions are reached and with what degree of success? The follow-up study by Quinsey[10] and his colleagues indicate a failure rate of about 9 per cent. This figure, however, does not take into account the plight of the "false-positives" – the patients not released because they are assumed still to be unfit and/or dangerous. The need for further research[4] into the evaluation of violence associated with mental illness can hardly be over-emphasized. A new approach to this

problem is needed to overcome the apathy of clinicians and others who have been prematurely convinced that it is impossible to predict dangerousness. Although prediction on a purely statistical basis is hardly likely to succeed, there are a number of promising approaches which need to be explored. We hope the Advisory Review Board in Ontario and equivalent bodies in the United States will include such research as part of their mandate.

My final comment concerns the lessons to be learned from the comparison of the New York State and Ontario data on the characteristics and status of patients found N.G.R.I. Although the cohorts have much in common, the differences are also substantial. Of particular significance is the age of patients in the two cohorts and the duration of hospitalization. The fact that the Ontario cohort are much younger and remain in hospital for longer periods makes it virtually impossible to equate the two groups, at least in terms of outcomes. On the other hand, it is obviously valuable to continue such comparative studies. If nothing else comes of it, this exercise will serve to remind us of the extent to which Canadians and their American colleagues are still separated by a common language.

Acknowledgments

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List of Tables

TABLE 1
Showing the number of L.G.W. by year in Ontario, for persons found N.G.R.I. 1961-1970

Year	Male	Female	Total
1961	1	–	1
1962	3	1	4
1963	3	–	3
1964	4	–	4
1965	3	–	3
1966	3	3	6
1967	3	1	4
1968	11	7	18
1969	11	1	12
1970	28	5	33
	70	18	88

TABLE 2
Age and Sex of Persons found N.G.R.I. Comparing New York State and Ontario

Age	New York State Total Male & Female* No.	%	Ontario Male No.	%	Female No.	%	Total No.	%
15-19	–	–	13	18.6	–	–	13	–
20-24	–	–	16	22.8	2	11.1	18	–
25-29	–	–	12	17.1	3	16.7	15	–
Sub Total	22	10.0	41	58.5	5	27.8	46	52.3
30-34	–	–	10	14.3	3	16.7	13	–
35-39	–	–	9	12.9	3	16.7	12	–
Sub.Tot.	140	62.0	19	27.2	6	33.4	25	28.4
40-44	–	–	4	5.7	4	22.3	8	–
45-49	–	–	3	4.3	1	5.5	4	–
50-54	–	–	2	2.9	1	5.5	3	–
60-64	–	–	1	1.4	–	–	1	–
N.K.	–	–	–	–	1	5.5	1	–
Sub.Tot.	63	28.0	10	14.3	7	38.8	17	19.3
Totals	225	100.0	70	100.0	18	100.0	88	100.0

*Details not available in New York State data. There were 196 (87.1%) men and 29 (12.9%) women. The age range was 16-77 with a mean of 36 years. Average age for men was 36 and for women 33 years. Distribution of ages by sex was not significant.
In Ontario there were 70 (79.5%) men and 18 (20.5%) women. The age range was 15-63 years. The average age for men was 27.5 and for women 34 years.

TABLE 3
Comparing Offenses in New York State* and Ontario† by Sex

Offenses	New York State Male No.	%	Female No.	%	Ontario Male No.	%	Female No.	%
Murder	96	49.0	24	82.7	39	55.8	14	77.8
Manslaughter	11	5.6	2	6.9	2	2.8	–	–
Rape	5	2.6	–	–	1	1.4	–	–
Other sex offenses	5	2.6	–	–	2	2.8	–	–
Arson	12	6.1	2	6.9	2	2.8	–	–
Robbery & Burglary	20	10.2	1	3.5	2	2.8	–	–
Other violent offenses	38	19.3	–	–	12	17.3	4	22.2
Multiple offenses	**	**	**	**	8	11.5	–	–
Other offenses	9	4.6	–	–	2	2.8	–	–
Totals	196	100.0	29	100.0	70	100.0	18	100.0

*Data abstracted from Pasewark *et al.* (1979). Persons found N.G.R.I. in New York State, 1971-1976.
†Ontario 1961-1971.
**Not available in the New York State data.

TABLE 4
Comparing Relationship to Victims, New York State* and Ontario, of Persons, by Sex, found N.G.R.I.

Relationship Of Victim	New York State Male No.	%	Female No.	%	Ontario Male No.	%	Female No.	%
Spouse, including common-law partner	3	7.0	2	20.0	12	17.1	6	24.0
Own child or children	2	4.6	4	40.0	2	2.9	16	64.0
Parent(s) or in-laws	6	13.9	1	10.0	4	5.8	–	–
Sibling	–	–	–	–	1	1.4	–	–
Boy or girl friend	5	11.6	1	10.0	1	1.4	–	–
Acquaintance	8	18.7	–	–	18	25.7	1	4.0
Stranger	7	16.3	1	10.0	22	31.5	–	–
Police	3	7.0	1	10.0	10	14.2	–	–
Others	9	20.9	1	10.0	–	–	–	–
Totals	43	100.0	10	100.0	70	100.0	25** (18)	

*Abstracted from Steadman *et al.* (1978). The Use of the Insanity Defense, Table 2, p. 46. In The Insanity Defense in New York.
**There were some multiple offenses.

TABLE 5
Sex and Major Psychiatric Diagnosis of Persons found N.G.R.I.
Comparing New York State* and Ontario

Major Diagnostic Group	New York State Male No.	New York State Male %	New York State Female No.	New York State Female %	Ontario Male No.	Ontario Male %	Ontario Female No.	Ontario Female %
All psychoses[1]	133	67.8	22	76.0	38	47.5	10	43.4
All neuroses[2]	6	3.1	1	3.4	8	10.0	8	34.8
All personality disorders[3]	20	10.2	4	13.8	24	30.0	3	13.0
All mental retardation	5	2.6	–	–	6	7.5	1	4.4
Other diagnoses[4]	10	5.1	1	3.4	4	5.0	–	–
Not Known	22	11.2	1	3.4	–	–	1	4.4
Totals	196	100.0	29	100.0	80+	100.0	23+	100.0

Notes: *Adapted from Pasewark *et al.* (1979), Table 2

1 Paranoid schizophrenia is by far the most frequent diagnosis.

2 Acute depression is the most frequent diagnosis in the Ontario cohort.

3 Anti-social and psychopathic personality is the most frequent diagnosis in both cohorts

4 This includes alcoholism in both cohorts. "Non-psychotic" or "no disorder" is included in the New York State data.

+ Due to multiple diagnoses (*e.g.*, psychosis and mental retardation and mental retardation and psythopathy, etc.) these totals exceed the number of patients.

TABLE 6
Current Status of Persons Found N.G.R.I. Comparing New York State* and Ontario**

Current Status	New York State No.	New York State %	Ontario No.	Ontario %
In hospital†	133	59.0	25	28.4
Completely discharged	67	30.0	35	39.8
Conditional release	8	3.4	13	14.8
A.W.O.L.	6	2.7	–	–
Deceased	9	4.0	6	6.8
Family care	2	.9	–	–
Prison	–	–	2	2.3
Deported	–	–	7	7.9
Totals	225	100.0	88	100.0

Notes: *As of June 30, 1976

**As of January 30, 1979

†Includes 7 in-patients on informal status

TABLE 7
Duration of Stay in Hospital, by Sex and Offense, of Persons Discharged* after being found N.G.R.I.
Comparing New York State** and Ontario

Offense Group	New York State Male No.	New York State Male Average Days	New York State Female No.	New York State Female Average Days	Ontario Male No.	Ontario Male Average Days	Ontario Female No.	Ontario Female Average Days
Homicide	23	278.4	8	245.6	26	2119.8	13	1656.5
Manslaughter	2	151.5	–	–	2	1460	–	–
Sex offenses	3	256.3	–	–	2	2007.5	–	–
Assault	14	332.2	–	–	14	1851.0	4	1095
Robbery	3	104.6	1	62	2	547.5	–	–
Other offenses††	13	–	–	–	3	1460.0	–	–
Totals	58	–	9	–	49	1574.3	17	1375.7

Notes: *Includes "loosened" warrants in Ontario

**Data abstracted from Pasewark *et al.* (1979) Table 8

††Includes two Arson cases in Ontario

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