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THE INSANITY DEFENSE IN MASSACHUSETTS

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INTRODUCTION

Since John Hinckley's attempt to assassinate President Reagan and subsequent acquittal by reason of insanity, there have been numerous public and legislative outcries for reform or abolishment of the insanity defense. Such dramatic and controversial events contribute to the belief that there is widespread abuse of the insanity defense. Mental health, legal and law enforcement professionals, as well as the general public, appear to greatly overestimate the frequency and success with which the insanity defense is used (Pasewark, 1981). The small number of studies which have been done have found that only a small percentage of criminal defendants use the insanity plea and only a minority of these use it successfully (Pasewark, 1981; Cooke, 1974; Criss, 1980).

Nevertheless, there is a continuing public concern over the use (and misuse) of the insanity defense. As Pasewark (1981) has pointed out, substantial sums of money are spent annually on conferences and commissions that serve as forums to complain about the insanity plea and advocate for its change or abolition. Yet, there is little factual information about the manner in which systems actually operate or on the possible effects of legislative changes. The research which has been done indicates considerable variability from state to state and among jurisdictions within states in the frequency of finding a defendant not guilty by reason of insanity (NGI). Thus, it is important to establish for Massachusetts how frequently the insanity defense is used successfully and what consequences are associated with its successful use.

In Massachusetts, the Hinckley verdict provided added impetus to the existing controversy over the release of potentially dangerous mental patients. Extensive media coverage of previously hospitalized mental patients who later committed homicide brought about concerns for public safety. During 1983 Massachusetts House Minority Leader, William Robinson, proposed legislation that would, among other things, extend civil commitment periods; place the burden of proof in commitment hearings and NGI cases on the defense; extend the observation period for insanity acquittees from forty days to one year; and impose a mandatory five year period of court supervision for released acquittees. (See H343-H350, 1983). A similar bill (H2107) was proposed during 1984.

One of the primary concerns expressed by the Legislature, the Superior Court Committee on Mental Health, and the public, seems to be about the length of hospitalization and follow-up procedures for these individuals. Research studies done in Michigan (Criss, 1980), New York (Pasewark, 1982), and New Jersey (Singer, 1978) indicate a trend toward shorter lengths of stay for insanity acquittees in general, as well as a trend toward shorter lengths of stay for NGIs than comparable offenders found guilty and sentenced to correctional facilities (Pasewark, 1982). Although all of these studies found that seriousness of offense was a major factor associated with length of stay, other factors varied widely.

The present study focused on factors associated with length of stay for NGI acquittees in Massachusetts and a comparable group of offenders sentenced to state and county correctional facilities.

The key purposes of this study were as follows:

- To determine the lengths of stay for persons committed to Bridgewater and DMH state hospitals after being found NGI;
- To determine whether those lengths of stay are influenced by the type of criminal offense and other factors;
- To determine whether those lengths of stay are similar to lengths of stay for persons found guilty of similar offenses and sentenced to state and county correctional facilities;
- To determine the frequency with which persons found not guilty by reason of insanity become involved in the criminal justice system or with mental health hospitals following release;

In order to address these issues, data were obtained from individual records from three primary sources: the Department of Mental Health, the Department of Correction, and the Department of Probation. We also requested some summary information from each of the Commonwealth's district attorneys. The study focused upon three recent years, 1978, 1980, and 1982. These years were selected in order to represent fairly the recent use of the insanity defense while keeping the data collection effort within reasonable bounds.

Information for those years was obtained regarding 166 persons who were found not guilty by reason of insanity of criminal charges, 522 person who were found guilty of one of four major offenses (homicide, attempted homicide, assault and battery, and arson) and were sentenced to a Department of Correction facility, and 203 persons who were found guilty of one of the same four offenses and sentenced to a county house of correction. A more detailed description of the methodology of this study is included in Appendix I below.

RESULTS

In this section, the results of the study are described. The first three sections include a description of the study subjects, including demographic, offense, and victim information. The next section describes psychiatric diagnoses of the NGI group. This is followed by a presentation of the data on length of stay for NGIs and comparable samples of convicted prisoners. A comparison of numbers of NGIs sent to Bridgewater and DMH facilities is then presented. This is followed by a description of the hospitalization and arrest histories of the NGI sample. Finally, the results of the district attorney survey are described. The results of the one day survey of current inpatient NGIs is provided in Appendix II.

Characteristics of Persons Found NGI

The majority of the insanity acquittees were male (91.6%) while 8.4 percent were female. One hundred nine (65.8%) reported never having married. With regard to race, 81.9 percent were white, 15.7 percent black and 2.4 percent hispanic. The mean age of the NGIs was 32.8 with a range of 17-66. The median age was 31.

Comparable demographic data for all state prisoners (1982) included ethnicity, marital status, and median age. The ethnic composition of this group was 69.8 percent white, 29.4 percent black, .55 percent hispanic and .25 percent other. Sixty-four and six tenths percent were never married.

Table 1 shows available demographic characteristics for both groups (demographic data were not available for county prisoners). These data suggest an NGI population that is older and more likely to be white than the prison population.

Table 1

Demographic Characteristics of NGIs and State Prisoners*

ETHNICITY	NGI		PRISONERS	
	Frequency	%	Frequency	%
White	136	81.9	1399	69.8
Black	26	15.7	589	29.4
Hispanic	4	2.4	10	0.55
Other	-	-	5	0.25
TOTAL	166	100.00	2003	100.00
MARITAL STATUS				
Never Married	109	65.8	1295	64.6
Married	11	6.6	378	18.9
Separated	8	4.8	105	5.2
Divorced	23	13.8	202	10.1
Widowed	2	1.2	22	1.1
Unknown	13	7.8	1	0.05
TOTAL	166	100.00	2003	100.00

AGE	NGI	PRISONERS
Mean	32.8	Not Available
Median	31.0	25
Range	17-66	Not Available

*State prisoner figures are based on all 1982 commitments to state prisons. No data on prisoners in county houses of corrections is included.

Offense Data

Table 2 presents the distribution of offenses for individuals found not guilty by reason of insanity for the three sample years (1978, 1980, 1982). Since the numbers are generally small and there appeared to be no significant differences in the types of crimes, the data for all three years are combined in most further analyses.

As shown, murderers represent a very small proportion (4.8%) of those found NGI. Other crimes against persons including assault and battery, attempted homicide, rape, attempted rape, simple assault and other violent (robbery and kidnapping) represent an additional 57.1 percent of the offenders.

Tables 3 and 3A presents the comparison of NGI hospital admissions with state and county correctional admissions by offense category for 1978, 1980, and 1982 combined. Less than one percent of all persons who were determined to have committed a crime and were subsequently institutionalized, were found not guilty by reason of insanity.

Attempted homicide appears to have a relatively high proportion of NGIs (15.5%); this is most likely due to the infrequency of plea bargaining prior to or during a trial where the insanity defense has been raised. Only four percent of our sample were found NGI on a lesser charge than the one he/she was originally arrested for. In contrast, plea bargaining is far more common during the course of usual criminal proceedings. A number of those arrested for attempted murder may have plead guilty to the lesser offense of assault and battery. As the table indicates, the proportion of defendants receiving an NGI for assault and battery is comparatively small(2.4%).

TABLE 2

Distribution of NGIs By Offense and Sample Year

OFFENSE	Sample Year Frequencies for Each 1978	1980	1982	Total	Percent
Homicide	5	2	1	8	4.8
Forcible Rape	--	2	2	4	2.4
Attempted Homicide	6	9	3	18	10.8
Attempted Rape	2	--	4	6	3.6
Assault and Battery	14	23	20	57	34.3
Other Violent	1	2	2	4	3.0
Arson	2	4	5	11	6.6
Simple Assault	1	3	1	5	3.0
Lewd & Lascivious	--	2	2	4	2.4
Property Offenses	7	7	9	23	13.9
Trespassing	3	5	5	13	7.8
Disturbing the Peace	2	1	1	4	2.4
Other Minor Crimes	3	2	3	8	4.8
	48	62	58	166	100.0

TABLE 3

Distribution of Admissions by Type of Offense and Institutional Assignment

(column percents)

Offense	NGI		DOC		HOC	
	n	%	n	%	n	%
Homicide	8	(4.8)	303	(7.4)	17[1]	(.09)
Rape	4	(2.4)	211	(5.2)	7	(.04)
Attempted Homicide	18	(10.8)	90	(2.2)	8	(.04)
Attempted Rape	6	(3.6)	77	(1.9)	48	(.26)
Assault and Battery	57	(34.3)	168	(4.1)	2141	(11.9)
Other Violent[3]	5	(3.0)	1397	(34.4)	323	(1.8)
Arson	11	(6.6)	45	(1.1)	145	(.80)
Simple Assault	5	(3.0)	85	(2.1)	--[2]	
Lewd & Lascivious	4	(2.4)	7	(0.2)	17	(.09)
Property Offenses	23	(13.9)	903	(22.2)	7865	(43.5)
Extortion/Conspiracy	--		27	(0.7)	114	(.63)
Drugs	--		331	(8.1)	1127	(6.2)
Other Sex	--		2	(0.04)	86	(.47)
Disturbing the Peace	4	(2.4)	73	(1.8)	740	(4.1)
Trespassing	13	(7.8)	5	(0.1)	193	(1.1)
Other Minor	8	(4.8)	341	(8.4)	5260	(29.1)
	166	(100.0)	4065	(99.9)	18091	(100.0)

(DOC=Department of Correction, HOC=House of Correction)

Note: *These figures apply only to institutionalized persons. The addition of the number of persons receiving probation would decrease the percentage of NGIs, especially for minor offenses.

1. Figure for 1978 was estimated
2. Included with assault and battery.
3. Includes Armed Robbery and Kidnapping

TABLE 3A

Percentage of NGI Findings for All Institutional Admissions

Offense	Total		%NGI*
	n	%	
Homicide	328	(1.5)	2.4
Rape	222	(1.0)	1.8
Attempted Homicide	116	(0.5)	15.5
Attempted Rape	131	(0.6)	4.5
Assault and Battery	2366	(10.6)	2.4
Other Violent	1725	(7.7)	.3
Arson	201	(.90)	5.4
Simple Assault	90	(.40)	NA
Lewd & Lascivious	28	(.12)	14.2
Property Offenses	8791	(39.4)	.3
Extortion/Conspiracy	141	(.63)	0.0
Drugs	1458	(6.5)	0.0
Other Sex	88	(.39)	0.0
Disturbing the Peace	817	(3.7)	.5
Trespassing	211	(.94)	6.1
Other Minor	5609	(25.1)	.1
	22322	(99.9)	.74

Victims

Table 4 presents the relationship of the victim to his/her assailant. The majority of the offenses (90.3%) in which there was a victim were violent crimes. As shown, strangers represent only 22 percent of the victims. Thus, the notion that mentally-ill offenders are randomly assaulting public citizens is not substantiated here. Similar results were seen in studies in New York (Pasewark, 1979) and Missouri (Petrila, 1982). It should be noted that in 22 percent of the cases where there was a victim, we could not identify the relationship from information in the patient record.

Diagnosis

Table 5 presents the diagnostic categories for persons found not guilty by reason of insanity. The most prevalent diagnosis was schizophrenia. Diagnostic categories were grouped further into serious and less serious disorders. Serious disorders included organic brain syndrome, schizophrenia, affective disorders, paranoia, and psychotic depression. Less serious disorders included the neuroses, personality disorders, alcohol abuse, retardation, and other non-psychotic disorders.

One hundred and one (95.3%) of those charged with a violent offense were found to suffer from serious disorders while five (4.7%) of those charged with violent offenses received less serious diagnoses. Of the 56 persons charged with non-violent offenses, 85.7 percent were seen as having serious mental disorders while 14.3 percent were seen as having a less serious disorder. Looking at the group as a whole, eight percent received less serious diagnoses. This does not necessarily mean that eight percent of the cases did

TABLE 4

Distribution of Victims' Relationship to NGI Offender

Relationship to Victim	Frequency	Percent
Spouse	2	2.4
Lover	5	6.1
Parent	7	8.5
Other Relative	8	9.7
Friend	3	3.6
Acquaintance	14	17.1
Stranger	18	22.0
Police Officer	17	21.0
Institutional Employee	8	9.7
	82*	100.1

*There were no victims in 33.7% of the cases.

TABLE 5

Diagnostic Distribution of Offenders Found NGI

Diagnosis	Frequency	Percent
Organic Brain Syndrome	2	1.2
Schizophrenia	111	66.9
Bipolar Affective Disorders	28	16.9
Paranoia	4	2.4
Psychotic Depression	4	2.4
Neurotic Disorder	3	1.8
Personality Disorder	5	3.0
Alcohol Abuse	1	.6
Retardation	2	1.2
Other (non-psychotic)	2	1.2
Undiagnosed	4	2.4
	166	100.0

not warrant an NGI finding. A number of other factors that may have prompted the NGI finding could have been offered during these trials, such as prior hospitalization history or conflicting diagnostic testimony from participating psychiatrists.

Although the reliability of the application of diagnostic criteria used by clinicians is often challenged, these results indicate that the great majority of those receiving NGIs had mental disorders severe enough to suggest that their actions could well have been a result of mental disease or defect.

Length of Stay

Table 6 presents the mean and the median length of hospital stays for insanity acquittees by type of offense. Although the serious offenses tend toward longer lengths of stay and higher percentages of persons still hospitalized, the range of stays varies widely. The mean length of stay for all violent offenders combined is 415 days (n=69) compared with 172 (n=61) days for all non-violent offenders. When the NGI group is divided into those diagnosed as having serious versus less-serious psychiatric diagnoses, those with serious diagnoses have a mean length of stay of 309 days (n=121) compared with a mean of 200 days (n=9) for those with less serious disorders.

Table 7 presents length of stay comparisons for NGIs and county* and state prisoners for four major offenses. While NGIs are

*Nine county prisoners (two convicted of manslaughter, one of arson, and six of aggravated assault) were given weekend sentenes. Length of stay for these individuals was computed by adding the total number of days served prior to parole.

TABLE 6

Length of Stay for Released NGIs - Male Only (in days)

	Released				Still in	
	Frequency	Mean	Median	Range	Frequency	Percent
Homicide	3	724	416	43-1714	3	50.0
Forcible Rape	3	857	474	450-1647	1	25.0
Attempted Homicide	11	582	613	49-1440	7	38.9
Attempted Rape	3	52.3	57	18-82	2	40.0
Assault & Battery	46	351.5	230	10-1789	6	11.5
Other Violent	4	185	154	62-370	1	20.0
Arson	7	222	166	31-489	1	12.5
Simple Assault	5	551	783	75-872	0	0.0
Lewd & Lascivious	3	63	66	40-83	1	25.0
Property Offenses	19	211	57	1-1799	2	9.5
Trespassing	10	127	82	12-399	0	0.0
Breach of the Peace	3	85	50	41-164	1	25.0
Other Minor	4	69	53	27-145	2	33.3
	121				27	

*Three subjects who died (2 murderers and 1 arsonist) and one whose discharge was unknown (attempted rape) were excluded from the table.

TABLE 7

Length of Stay Comparison[1] in Days for NGIs and State and County Prisoners Controlling for Offense Committed (Males Only)*

	Released				Still In	
	Frequency	Mean	Median	Range	n	Percent
Homicide						
NGI	3	724	416	43-1714	3	50.0
Combined HOC & DOC	43	785.4[3]	634	20-1648	241	84.9
HOC	10	178.9	180	20-642	0	0.0
DOC	33	807.5	651	46-1648	241	88.8
Attempted Homicide						
NGI	11	582	613	49-1440	7	38.9
Combined HOC & DOC	24	678.3[3]	479	90-1658	63	72.4
HOC	6	316	405	90-502	1	14.3
DOC	18	710	704	140-1658	62	77.5
Assault & Battery						
NGI	46	351.5	206	10-1789	6	11.5
Combined HOC & DOC	1109	167.85[3]	150	51-1578	89	7.4
HOC	1060[2]	124[2]	90	5-678	10[2]	.9[2]
DOC	49	534.5	365	47-1578	79	61.7
Arson						
NGI	7	222	166	31-489	1	12.5
Combined HOC & DOC	94	382.6[3]	180	3-1718	25	21.0
HOC	78	194.6	180	3-1000	1	1.3
DOC	16	754	674.5	194-1718	24	60.0

*Subjects who died, escaped, or had unknown discharge dates were excluded from the table

[1]Includes only those who were released.
[2]Estimated from a sample of 107.
[3]Weighted means.

hospitalized for significantly shorter lengths of stay than those sent to state prisons, they stay longer than those sentenced to county correctional facilities. When county and state prisoners are combined, the comparison of prisoners and NGIs shows small differences in length of stay. While NGIs still have somewhat shorter lengths of stay for homicide, attempted homicide, and arson, they spend over twice as much time in the hospital for assault and battery as individuals found guilty and sent to the correctional system.

At the conclusion of the study, the NGI group had a smaller proportion of individuals still institutionalized than did the state prison group and a much larger proportion still institutionalized than the county prisoner group. When county and state prisoner groups were combined, the NGI group had proportionately fewer institutionalized for all crimes except assault and battery.

For the three violent, less common crimes, the lengths of stay for persons found NGI tends to be shorter than the lengths of stay for persons found guilty and committed to a correctional facility. The numbers involved are too small to detect statistically significant differences. However, for the most common violent crime, assault and battery, the NGI lengths of stay exceed the lengths of stay of prisoners found guilty of the same offense. This difference is statistically significant. No clear differences emerge with respect to length of stay comparisons for violent crimes overall.

We have chosen to highlight the comparison of NGI lengths of stay with lengths of stay for combined samples of state and county correctional prisoners. The differences between the state and county

prisoners are themselves striking. In general, we suspect that prisoners sentenced to state rather than county facilities are more likely to have a substantial arrest history and to have committed a more serious offense. As is shown below, persons found not guilty by reason of insanity do not generally have long arrest histories.

The Role of the Department of Mental Health

Table 8 presents a comparison of NGI admissions to Bridgewater and Department of Mental Health facilities by offense category. As shown in the table, most acquittees go to Bridgewater after an NGI finding. It should be noted, however, that six DMH facilities did not record changes in legal status, so DMH admissions will be slightly underestimated. Thus, it is likely that DMH and Bridgewater are relatively equal in number of NGI admissions. When offenses are divided into violent and non-violent categories, a significantly greater percentage (72.4) of those charged with violent crimes are admitted to Bridgewater while the greater proportion of non-violent acquittees are admitted to DMH facilities.

Of the 76 persons discharged from Bridgewater during the course of the study, 45 (59.2%) were transferred to DMH facilities. The mean length of stay in the DMH facility for those released was 217 days. Seven individuals remain hospitalized. The remaining persons discharged from Bridgewater were released to court (22.3%) and community programs or private hospitals (14.4%). An additional three persons died during their hospitalization at Bridgewater.

Discharge information was available for 59 of the 70 individuals who left DMH facilities during the course of the study. Of these,

TABLE 8

NGI Offense by Type of Admitting Facility

(row percents)

Offense	Bridgewater		DMH		Total
	n	(%)	n	(%)	
Homicide	6	(75.0)	2	(25.0)	8
Rape	4	(100.0)	---	---	4
Attempted Homicide	15	(83.3)	3	(16.7)	18
Attempted Rape	5	(83.3)	1	(16.7)	6
Assault & Battery	38	(66.7)	19	(33.3)	57
Other Violent	4	(80.0)	1	(20.0)	5
Arson	5	(45.5)	6	(54.5)	11
Simple Assault	4	(80.0)	1	(20.0)	5
Lewd & Lascivious	1	(25.0)	3	(75.0)	4
Property Offenses	8	(34.8)	15	(65.2)	23
Trespassing	1	(7.7)	12	(92.3)	13
Disturbing the Peace	1	(25.0)	3	(75.0)	4
Other Minor	2	(25.0)	6	(75.0)	8
TOTALS	94	(56.6)	72	(43.4)	166

27 (45.3%) were discharged to home or community programs, 15 (25.4%) to court, five (8.4%) to other state or private hospitals, eight (13.5%) to halfway houses, three (5.0%) to escapes and two (3.4%) to other locations.

Previous and Subsequent Inpatient Mental Health Treatment

Of all individuals in the 1978, 1980, and 1982 groups of persons who were hospitalized following a finding of NGI, almost seventy percent had been hospitalized previously in a state-operated inpatient unit. (We did not have access to records of private hospitalization in Massachusetts or hospitalizations in other states.) The mean number of prior hospitalizations was three. Table 9 shows the frequency distribution of prior hospitalizations.

We examined hospitalizations that occurred after each individual was released from the NGI hospitalization. Table 10 shows the distribution of lengths of stay for prior and post-NGI hospitalizations and a comparison to all inpatient discharges from DMH inpatient units during August, 1982. These data show that the non-NGI hospitalizations (both previous and subsequent) for persons found not guilty by reason of insanity are dramatically longer than the stays of the average mental health inpatients.

Because the period of time from release to the present was relatively short, we converted the number of hospitalizations into yearly rates for the two years prior to and the two years following the NGI hospitalization. The per person rates of hospitalization were .37 (previous) and .26 (subsequent) per year, respectively, for the 1978 sample (n=44), and .48 and .39 for the 1980 sample (n=50). Thus the number of episodes of hospitalization is less in the two

TABLE 9

Frequency Distribution of Number of Hospitalizations Occurring Prior to NGI Admission

Number of Prior Hospitalizations	Number and Percent of Prior Hospitalizations by Sample Group		
	1978	1980	1982
0	15 (32.6)	19 (30.6)	18 (31.0)
1	10 (21.7)	12 (19.4)	8 (13.8)
2	6 (13.0)	5 (8.1)	7 (12.1)
3	4 (8.7)	5 (8.1)	6 (10.3)
4	1 (2.2)	4 (6.5)	5 (8.6)
5	1 (2.2)	2 (3.2)	5 (8.6)
6-10	7 (15.1)	11 (17.7)	6 (10.3)
More than 10	2 (4.4)	4 (6.4)	3 (5.1)
TOTALS MEANS	46 (2.8)	62 (3.1)	58 (2.9)

TABLE 10

Comparison of Lengths of Stay for Hospitalization Episodes of NGI Samples and a Sample of State Mental Health Inpatient Discharges.

Length of Stay (Days)	Discharges of NGI Patients		All Inpatient Discharges
	Previous	Subsequent	August 1982
1 - 15	98 (21.8)	18 (20.9)	438 (46)
16 - 30	70 (15.6)	19 (22.1)	213 (22)
31 - 90	136 (30.3)	21 (24.4)	174 (18)
91 - 180	41 (9.1)	11 (12.8)	88 (9)
181 - 365	46 (10.2)	11 (12.8)	
More Than One Year	57 (12.7)	6 (7.0)	44 (5)
TOTAL	449	86*	957

*Excludes 19 persons not released.

years subsequent to the NGI hospitalization than in the two years previous to the NGI hospitalization.

By contrast, the number of days hospitalized is greater during the period following the NGI hospitalization. For the same periods the average number of days hospitalized were 13.8 (previous, n=20) and 106.5 (subsequent, n=10) days per year (1978 sample). These data suggest that many persons who are found not guilty by reason of insanity are chronically mentally ill, that they will continue to have periodic (although fewer) hospitalizations throughout their lives, and that the average length of stay will be longer after the NGI finding than before.

Table 11 shows the distribution of legal status on admission for all prior and post NGI hospitalizations and the comparison to all admissions to DMH mental health inpatient units in FY 1982. Two aspects of this table are worthy of comment. First, more than half of the non-NGI hospitalizations for the NGI groups are under the civil sections of the commitment laws -- particularly the voluntary and temporary civil commitment sections. Second, in comparison to all 1982 inpatient admissions the NGI group does show a significantly greater frequency of admission under legal sections associated with criminal observation and with transfers from prisons. To summarize, the NGI group is as likely to have civil commitments for prior and post NGI hospitalizations as criminal commitments; however, they are more likely than the average inpatient admission to utilize the criminal commitment sections.

TABLE 11

Comparison of Legal Status for Hospitalization Episodes of NGI Samples and a Sample of State Mental Health Inpatient Admissions

Legal Status	Admission of NGI Inpatients		All Inpatient Admissions FY '82
	Prior	Post	
10/11 Voluntary	91 (18.5)	14 (12.8)	3492 (34.5)
12 Temp. Civil	98 (20.0)	28 (25.7)	5091 (50.3)
7/8 Civil Comm.	7 (1.4)	0	—
13 B'wtr Trans.	7 (1.4)	3 (2.8)	—
15 B Comp/Crim Respb	128 (26.0)	29 (26.6)	822 (8.1)
16 A NGI/IST Exam	17 (3.5)	8 (7.3)	65 (0.6)
16 B NGI/IST Comm.	9 (1.8)	4 (3.7)	—
16 C NGI/IST Continue	0	0	—
18 A Transfer from Prison	52 (10.6)	12 (11.0)	—
Unknown and Other	82 (16.7)	11 (10.1)	659 (6.5)
TOTALS	491	109	10129

Previous and Subsequent Arrests

We examined the court appearance histories of the NGI group, as well as their hospitalization histories. Table 12 shows the frequency distribution of number of arrests previous to the NGI hospitalization for each group. These are divided into violent and non-violent charges. The NGI group shows less prior involvement with the criminal justice system than with the mental health system, particularly with respect to violent crimes. Just under half of the sample has a history of arrest on violent charges prior to the arrest resulting in the NGI finding.

We also examined the post-NGI hospitalization occurrence of arrests on violent and non-violent charges and compared these with the prior arrests. Again these were converted into rates. For the two years previous to and following the NGI hospitalization, the per person rates of arrest were .31 (previous) and .16 (subsequent) per year respectively for violent offenses and .51 (previous) and .41 (subsequent) per year for non-violent offenses (1978 sample, n=45). The prior and post arrest rates for violent charges for the 1980 sample (n=55) were .37 (previous) and .06 (subsequent), and .24 (previous) and .21 (subsequent) for non-violent charges. Overall, there appears to be less involvement with the criminal justice system during the period subsequent to the NGI hospitalization than in the period previous to it.

Finally, we did an analysis of the likelihood that persons found not guilty by reason of insanity of a particular charge, would be charged with the same or other offenses at a later time. Table 13 shows this relationship for all sample years. In general, it appears

TABLE 12

Frequency Distributions of Court Appearances Resulting from Violent and Non-Violent Arrest Charges Prior to NGI Hospitalization (all samples)

Number of Court Appearances	Number (and percent) of Arrest Charges for each sample group: Violent 1978	Violent 1980	Violent 1982	Non-Violent 1978	Non-Violent 1980	Non-Violent 1982
0	26 (61.9)	30 (52.6)	23 (42.6)	15 (35.7)	17 (29.8)	16 (29.6)
1	5 (11.9)	15 (26.3)	18 (33.3)	3 (7.1)	10 (17.5)	7 (13.0)
2	8 (19.0)	5 (8.8)	5 (9.3)	7 (16.7)	7 (12.3)	7 (13.0)
3	1 (2.4)	4 (7.0)	3 (5.6)	2 (4.8)	3 (5.3)	5 (9.3)
4	1 (2.4)	0 –	1 (1.9)	6 (14.3)	4 (7.0)	3 (5.6)
5	1 (2.4)	2 (3.5)	2 (3.7)	1 (2.4)	1 (1.8)	1 (1.9)
6 - 10	0 –	1 (1.8)	2 (3.7)	5 (12.0)	9 (15.9)	9 (16.7)
More Than 10	0 –	0 –	0 –	3 (7.1)	6 (10.7)	6 (11.1)
Total Court Appearances	42	57	54	42	57	54
Mean Court Appearances	.79	.95	1.17	3.24	3.72	3.94

TABLE 13

Distribution of Post-NGI Arrest Charges

NGI Arrest	Percent Arrested on Same Charge	Percent Arrested on at Least one Violent Charge	Percent Arrested on at Least one Non-Violent Charge	No. Released From Hospital
Homicide	0	0	33%	3
Rape	0	0	0	2
Attempted Homicide	11%	22%	22%	9
Attempted Rape	0	0	0	9
Assault & Battery	18%	27%	31%	49
Arson	0	0	0	9
Other Violent	0	0	67%	3
Lewd & Lascivious	0	0	50%	2
Simple Assault	0	0	20%	5
Property	21%	26%	74%	19
Trespassing	9%	9%	45%	11
Breach of Peace	67%	33%	67%	3
Other Minor Crimes	17%	17%	33%	6
TOTALS	14%	18%	36%	125

*NOTE: Does not include persons who have not been released, who died, or whose arrest record was unavailable. The following are the percentages of sample subjects were not arrested following their release:

1978 - 43.6%
1980 - 58.0%
1982 - 64.9%

that persons found not guilty by reason of insanity are not likely to be arrested again on the same charge (only 14 percent were) or arrested on any violent charge after the NGI hospitalization (18 percent were). Thirty-six percent were arrested subsequently on at least one non-violent charge.

Survey of District Attorneys' Offices

Table 14 shows the frequency of NGI findings resulting in hospitalizations for each district attorney's office in the Commonwealth for the three sample years, 1978, 1980, and 1982. The differences from office to office are considerable. In order to account for caseload differences, we compared them to the relative frequencies of combined DOC and HOC commitments for the year 1982. This provides a reasonable measure of the expected differences in level of activity among district attorney's offices.

Four of the district attorney's offices appear to show relatively less frequent occurrences of NGI findings than might be expected (Bristol, Essex, Hampden, and Middlesex). In each case the percent of HOC/DOC commitment is greater than the percent of NGI hospitalizations. Three show relatively more frequent occurrences of NGI findings (Barnstable, Franklin-Hampshire, and Suffolk), and the remaining four are close to what would be expected based upon the relative frequencies of the combined corrections commitments.

The table discussed above is based upon data from Bridgewater and the Department of Mental Health inpatient units. Because we had some concern about the completeness of this information and believed it would be desirable to obtain other information on the overall utilization of the insanity defense, we requested data directly from

TABLE 14

Percentage of NGI Findings in Comparison to the Percentage of Corrections Commitments Attributed to Each Judicial District

District Attorney's Office	NGI Finding Followed by Hospitalization (1978, 1980, 1982 Combined)		Percentage of Combined 1982 DOC and HOC Commitments
	Frequency	Percent	Percent
Barnstable/Dukes/Nantucket	15	9.2	3.6
Berkshire	3	1.9	3.7
Bristol	4	2.5	7.0
Essex	3	1.9	12.4
Franklin/Hampshire	18	11.1	4.0
Hampden	7	4.3	11.4
Middlesex	11	6.8	17.3
Norfolk	12	7.4	7.1
Plymouth	12	7.4	4.3
Suffolk	52	32.1	13.5
Worcester	25	15.4	15.9
TOTAL	162	100.0	100.0

the district attorneys' offices. (See sample letter - Appendix III.) Nine district attorneys were able to respond to this request (Barnstable, Berkshire, Essex, Franklin-Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester).

With respect to the accuracy of the data presented above, we discovered a small number of discrepancies. Where these involved NGI findings that we had not included, they were explained by several problems, as follows:

- DMH hospitals did not note a change of status from 15b to 16a or 16b following adjudication of a case involving a patient who was already a resident in the hospital;
- The NGI finding was listed in the district attorney's records as December, 1980, but the person was not admitted to the hospital until January, 1981 and was, therefore, excluded from the study.
- A person found not guilty by reason of insanity was not subsequently hospitalized;
- The charge which we recorded from the hospital records was different than the charge in the district attorneys' records. We also found that we included cases in the data reported above that the district attorneys did not include in their records for 1978, 1980, and 1982. This was usually the result of the fact that the data from the district attorneys only included cases from the superior courts.

While some differences were unavoidable, they were relatively infrequent. We estimate that the information which we have presented on the number of NGI findings is within a few percent of the actual figures for those years. With respect to violent charges, we are very confident in this estimate; with respect to non-violent charges, we are less certain because of the district attorneys' offices as a group do not maintain this type of information for district court proceedings.

We also asked the district attorneys about the frequency during 1982, with which the insanity defense was raised, with which it was adjudicated, with which there was a finding of NGI, and with which a person found NGI was not subsequently hospitalized. Only four offices were able to respond to this request, and their responses apply only to the superior court cases.

In one office, the assistant district attorneys estimated that the insanity defense had been raised at some point in about 17 cases opened during 1982, but were carried to adjudication in only four; three are still pending. Six cases were closed with a finding of NGI in 1982. In two of these the defendant was not subsequently hospitalized. In both cases the defendant had been under treatment during the period prior to the NGI finding, was no longer considered dangerous, and was expected or required to continue in treatment. In one case, psychiatric testimony also indicated that institutionalization would be harmful to the defendant.

In a second office, there were four cases in which the insanity defense was raised, and it was carried to adjudication in every case. These four cases all resulted in a finding of NGI and all of these persons were subsequently hospitalized. A third office reported that the insanity defense is typically raised only four or five times each year. In 1982, only two cases involving the insanity defense were adjudicated; both defendants were found NGI with the agreement of the prosecution, and both were subsequently hospitalized. Only one insanity defense case has been litigated by this particular district attorney's office at the superior court level in the past 12 years. In the last office, there were only two cases resulting in a verdict

of NGI in 1982; both defendants were subsequently hospitalized.

These data suggest that the insanity defense is rarely raised in Massachusetts. This conclusion is valid if raising the insanity defense is interpreted to mean doing something more than simply requesting an evaluation for criminal responsibility. Pre-trial criminal responsibility evaluations under sections 15a and 15b are quite common. In 1982, there were 1314 conbined DMH and Bridgewater admissions for inpatient competency/criminal responsibility evaluations. However, many of these involved minor, non-violent offenses in which the charges may be continued without a finding or dropped following the end of the hospital stay.

The present study shows that the insanity defense is very rarely carried to adjudication in Massachusetts. When it is carried to adjudication it is probably unusual for the prosecution to oppose it in most districts. Informal conversations with district attorneys and assistant district attorneys tend to confirm this impression. While the district attorneys differ in their philosophical views on the appropriateness of the insanity defense, as a practical matter, the insanity defense does not present major, day-to-day problems for their offices with respect to pre-trial or trial proceedings.

DISCUSSION

In this section, we discuss the implications of this study for allegations of abuse of the insanity defense. In addition, comments are offered on proposed statutory changes in Massachusetts and possible future research.

Abuse of the Insanity Defense

A frequent argument of those advocating the abolition of the

insanity defense has been that persons found NGI are frequently allowed to "get away with murder." Our results indicate that this is not the case in Massachusetts. First, murderers represent a very small proportion of those found NGI. In examining the total homicide picture in Massachusetts, insanity acquittals for murder account for only 2.4 percent of those cases resulting in institutionalization of some type. Because the number of NGI murderers in the sample was small (eight) and because two died prior to release and three others had yet to be released, any comparison of lengths of stay with persons imprisoned for murder would be suspect. The one crime, (assault and battery) for which we had adequate data to make reliable length of stay comparisons to prisoners in both state prisons and county houses of correction, suggests that persons found NGI tend to be institutionalized for slightly longer periods of time.

We did find one documented case of a short length of stay (43 days) following an NGI finding on the charge of murder. The individual in question had overdosed on diuretics and subsequently went into a coma. He was then admitted to a general hospital. Shortly after coming out of the coma, he killed another patient in the hospital. He was diagnosed as suffering from a temporary organic psychosis. An EEG showed abnormal patterns. Since the EEG clearly showed an abnormality that would affect one's behavior, defense and prosecution agreed that he should be found NGI. Once the patient was stabilized and an EEG showed normal brain wave patterns, psychiatrists recommended his release. The recommendation was accepted by a superior court judge and the patient was released. This one case of a short length of stay for a violent offense is clearly exceptional.

While these findings may be reassuring to the public in general, it must be remembered that the insanity defense is designed to be genuinely exculpatory of those who are found not to be criminally responsible at the time of their offense (Gutheil, 1983). The recent Supreme Court decision in Jones v. U.S. indicates that the length of sentence for a particular offense should not be used as a basis for retention of insanity acquittees.

A possible explanation of the distorted public perception about the numbers of NGI murderers may be the relatively high number of murder defendants who are sent to state hospitals for pre-trial competency and/or criminal responsibility evaluations. Approximately 25 percent of those arrested for murder in Massachusetts are evaluated for competency/criminal responsiblity. For all crimes in 1982, there were a total of 1314 competency and/or criminal responsibility evaluations performed at either Bridgewater or DMH facilities. Of these, 58 (4.4%) were later found NGI. These findings suggest that even though the insanity defense is considered in a large number of cases, it is rarely carried to successful completion.

In comparison to other states where the insanity defense has been studied, Massachusetts ranks lowest in the proportion of persons found NGI for murder. A 1978 Missouri study (Petrila, 1982) found that 8.9 percent of the insanity acquittees in their state were for murder. Studies in New York (Pasewark, et al, 1982) and New Jersey (Singer, 1978) found the proportion of persons found NGI for murder were 27.1 percent and 26 percent respectively, while a Michigan study (Criss and Racine, 1980) found that murderers accounted for 29.6 percent of all persons found NGI.

Table 15 presents the distribution of offenses for NGI offenders in five states. As shown, Massachusetts is lowest in the murder category, but is highest in the assault category. Massachusetts also appears different from other states in the high proportion of persons found NGI for non-violent offenses. Approximately 31 percent of insanity acquittees in Massachusetts were for property offenses or other minor crimes. Only Missouri, with 39 percent, ranked higher.

Comments on Proposed Statutory Changes

Despite the relatively infrequent use of the insanity defense nationally, a number of states, including Massachusetts, have proposed legislation that would alter the laws surrounding the insanity defense. Among the proposed changes in Massachusetts are: an increase in the post-trial observation period of insanity acquittees from a maximum of 40 days to a mandatory one year (H346, 1983, and H2107, 1984); replacing the "not guilty by reason of mental illness or mental defect" verdict with a "guilty but insane" verdict (H347, 1983, and H2107, 1984); placement of the burden of proof in insanity cases on the defense rather than the prosecution and requiring evidence of insanity "beyond a reasonable doubt" (H350, 1983, & H2107, 1984); and a mandatory follow-up period for all persons found NGI or "guilty but insane" (H345, 1983, & H2107, 1984). We will discuss each of these below.

First, in regard to lengthening the observation period for those found NGI, our observations have shown no indication that the current 40-day period is inadequate. Changing the observation period would probably contribute to overcrowding at state inpatient facilities, especially Bridgewater. In addition, a significant number of

TABLE 15

Relative Frequency Distribution of Offenses Charged Against NGI Populations in Five States

Offense	MA (1978, 1980, 1982) (N=166)	NY (1980-1982) (N=228)	NJ[1] 1977 (N=46)	MO 1978 (N=67)	MI (1974-1979) (N=223)
	Percent	Percent	Percent	Percent	Percent
Homicide	4.8	27.1	26.1	8.9	29.6
Assault[2]	48.1	30.1	34.8	26.9	31.3
Rape	6.0	3.0	8.7	1.5	-
Other Violent[3]	3.0	9.5	6.5	17.9	9.5
Arson	6.6	10.6	8.7	6.0	4.0
Property	13.9	8.5	4.4	24.0	9.0
Lewd & Lascivious	2.4	-	4.4	1.5	-
Other Sex	-	2.0	-	1.5	6.3[4]
Trespassing	7.8	-	-	-	-
Disorderly	2.4	-	-	-	-
Other	4.8	7.0	6.5	11.9	10.4
Info. Missing	-	2.0	-	-	-

[1]Data include only one jurisdiction (Essex County)

[2]Includes attempted homicide, assault and battery & simple assault

[3]Includes kidnapping and armed and unarmed robbery

[4]Includes crimes labeled as criminal sexual conduct.

patients, especially those charged with minor crimes, would be held much longer than if they had been found guilty. The post-NGI observation period has traditionally been used to assess dangerousness and need for security prior to a commitment hearing. Forty days should be adequate time to assess these issues. This proposed statutory change would also include individuals found incompetent to stand trial. This one year observation would violate the constitutional right to a speedy trial if they should become competent during this time.

Second, replacing the not guilty by reason of insanity finding with one of guilty but insane would not benefit defendants or the general public. This proposal seems to only change the wording of the verdict. Current Massachusetts statutes, including Chapter 123, sections 15E (aid to sentencing) and 18A (transfer of mentally-ill prisoners) are already designed to serve individuals who are found guilty but are in need of mental health treatment.

Third, the shift in the burden of proof to the defendant is unlikely to reduce the number of insanity defenses carried to adjudication since this number is already quite small. Informal conversations with assistant district attorneys suggest that most cases in which the insanity defense was adjudicated did not receive a full trial, either before a judge or jury. The prosecution was unlikely to oppose the defense of insanity in cases involving minor charges where there was substantial evidence of mental illness. In most cases involving serious charges, this was also true although, clearly there is variability among district attorney's offices. Prosecutors do not view the requirement of burden of proof as a compelling reason to accept an insanity defense claim which they do not believe.

Whether the behavior of judges, prosecutors and juries would change with a change in the locus of the burden of proof is difficult to determine. However, we suspect that the outcome of very few cases would be altered by changing the burden of proof.

Massachusetts currently requires that the prosecution prove that the defendant was not insane. About half of the other fifty states have the same requirement with the other half placing the burden of proof on the defendant. Both the American Bar and American Psychiatric Associations have declined to take a position on this issue. The American Psychiatric Association's statement on the insanity defense, citing the U.S. Supreme Court's decision in Addington v. Texas, stated that "Psychiatric evidence is usually not sufficiently clear-cut to prove or disprove many legal facts 'beyond a reasonable doubt' " (Insanity Defense Work Group, 1983).

Finally, the follow-up period after release may have some merit but greater flexibility is needed. The proposed legislation would require judges to impose a mandatory follow-up period equal to the maximum sentence for the offense, on all persons found NGI for major felonies. The length of this follow-up should be adjusted to meet the clinical needs of the individual as well as the need to protect the public. It must also be kept in mind that a program designed to follow persons found not guilty be reason of insanity will reach only a small portion of mentally disordered offenders.

The Legislature may want to consider the development of an independent board, similar to Oregon's Psychiatric Security Review Board, rather than requiring individual courts to follow these cases. Prior to the development of this board, Oregon used a review

procedure similar to the one proposed for Massachusetts. They found that assigning release decisions to the original court of jurisdiction led to a number of inconsistencies across counties and made any evaluation of the method or data collection virtually impossible (Rogers and Bloom, 1982).

Limitations of the Present Study

The present study has focused upon persons who have been charged with a criminal offense and who were subsequently found not guilty by reason of insanity. The study does not attempt to examine the many other types of cases in which the criminal justice system and the mental health system come into contact. A number of these did come to our attention and are briefly noted here as areas of potential, future research.

As we indicated earlier, only a very small percentage of persons who receive pre-trial evaluation for competency to stand trial and criminal responsibility are found not guilty by reason of insanity. We know what may happen to the others in a very general way. For some, charges will be dropped after the criminal observation period has ended. Others will be found guilty. Others will be found incompetent to stand trial and may be hospitalized for a long period of time. A few defendants will escape. Two examples of these problems will illustrate their complexity.

During or at the end of the period of pre-trial criminal observation, criminal charges may be dropped. In some cases, this may be followed by a civil commitment, either voluntary (under Section 10) or involuntary (under Sections 7 & 8). This approach is followed in part because it is often difficult to place clients in community

programs if they have criminal charges pending. One mental health center psychiatrist described an informal working agreement between the center and the court to handle cetain cases in this way. Clients whose cases are treated in this manner include only those who are not charged with an offense that involved harm to another person or placed another person in danger.

Security at inpatient units of both mental health hospitals and community mental health centers was a problem spontaneously raised in conversations with both district attorneys and staff of mental health facilities. Respondents indicated that they did not think that security was adequate at several of these facilities, and some gave specific examples of persons who escaped while under criminal observation and subsequently committed serious offenses. Only three (1.8%) persons among the sample of NGIs included in our study escaped from the facility they were committed to. While these data are limited, they suggest the need for further study of the adequacy of security at mental health inpatient units for persons who cannot be accommodated at Bridgewater State Hospital.

Anecdotal examples of problems in dealing with mentally-ill persons who have been charged with criminal offenses like those described above were informally reported to us in the course of this study. However, we did not systematically gather data on the frequency of such problems or associated outcomes of such cases. A larger, more comprehensive study of the interface of the criminal justice and mental health systems would permit better estimation of the extent and significance of such problems.

Another issue that was raised by the present study concerns the

number of inpatient observations for evaluation of competency to stand trial and criminal responsiblity. Beginning in 1971, the law permitted such evaluations to be conducted on an outpatient basis (Chapter 123, Section 15a) and special court clinics administered by the Department of Mental Health were created to undertake this responsibility. The change in the law reduced the overall costs of such evaluations to the State, as well as allowing them to take place in a more appropriate, less restrictive setting. Initially, inpatient evaluations under Section 15b dropped off significantly (McGarry, 1973). However, the number of inpatient evaluations has significantly increased since 1971. This may indicate that judges are using the pre-trial evaluation statutes in order to initiate treatment or as a form of preventive detention for patients who would otherwise not submit to voluntary hospitalization and do not meet the strict criteria for involuntary commitment. Both the extent of this increased use of inpatient beds for pre-trial evaluations, the reasons underlying it, and the associated costs are important issues that should be addressed by a future study.

Conclusion

This research has shown no indication that the insanity defense is abused or misused in Massachusetts. On the contrary, it appears that the Courts, the Department of Correction and the Department of Mental Health are consistently handling those few individuals found not guilty by reason of insanity. There is no evidence that the insanity defense is used successfully to avoid incarceration for murder or other serious offenses. While the moral and ethical debates over the insanity defense will undoubtedly continue, there is

no empirical evidence that would justify eliminating or altering the defense at this time.

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APPENDIX I

METHOD

The study sample included all persons who were found not guilty be reason of insanity (NGI) and subsequently hospitalized in Massachusetts during 1978, 1980 and 1982 (n=166). The names of these individuals were drawn from the Department of Mental Health (central office) files and Bridgewater State Hospital admission reports. Those persons who entered the hospital and had a change of legal status to NGI in the course of their hospitalization were identified from the change of status reports within the monthly admission reports. Two state hospitals and four community mental health centers do not routinely gather or report information on legal status changes. It is likely then that 10-20 cases were missed. An additional five cases were excluded due to missing records.

Demographic, diagnostic, offense, and prior hospitalization data were obtained for each individual. This information was coded from the records of the facility where the evaluation (16A) to determine the individual's dangerousness and need of hospitalization was completed. Most records provided the necessary clinical information on each patient and information on the offense. However, information on the circumstances surrounding the offense was frequently unavailable. In a few instances, the legal papers accompanying the patient were unclear (e.g., a 16A paper had "not guilty by reason of insanity" crossed out and "no probable cause by reason of insanity" inserted; a 16A paper committing someone as <u>both</u> NGI and incompetent, and a 16A paper with <u>both</u> incompetent and NGI crossed out). In cases where there was a question of the legal basis of the commitment, the subject was not included in the study.

Length of stay for hospitalized subjects included time spent in a hospital and/or jail prior to the NGI finding as well as time spent hospitalized after the NGI finding. If the subject was transferred from the maximum security facility at Bridgewater to a DMH facility, the time spent in both facilities was counted.

Data on prior and subsequent arrests for the NGI sample were obtained from the Massachusetts Board of Probation. Board of Probation records include only those in-state arrests for which court appearances are made. Unfortunately, there are no state agencies that routinely gather information on all arrests.

In order to compare lengths of stay for NGI acquittees to those found guilty and sentenced, we drew a sample of offenders who had been found guilty of one of four major offenses: homicide, assault and battery, attempted homicide, and arson, and sentenced to either a state or county correctional facility. These offenses were selected because they are the offenses that persons in the NGI sample were most likely to be charged with. Since data on state prisoners is computerized, we were able to obtain information on all state prisoners (n=522) who were admitted during 1978, 1980 or 1982 and charged with one of the four offenses listed above.

The county prisoner sample was drawn from manual admissions logs filed at the Department of Correction's central office. Discharge dates were requested from all 13 Houses of Correction. To this date, two Houses have not been able to respond to this request. Since there were few admissions to county facilities for homicide, (not including vehicular homicide) attempted homicide, or arson, all such admissions from the eleven responding facilities were included in the sample.

Assault and battery defendants were much more numerous. Therefore, a sample of 107 were taken from the records of four of the eleven county facilities who responded. The four facilities chosen varied in size and location within the state (Billerica, Plymouth, Greenfield and Worcester).

Length of stay for these corrections groups was defined as the time between the date of commitment and first parole. Jail credits for time served awaiting trial were also included. Subjects who escaped or died during their incarceration were excluded from the study. Since the number of females charged with the four offenses was small, as was the number of female NGIs, all females were excluded from length of stay calculations.

Age, race, prior court appearances, and length of stay were obtained for the individuals sentenced to state correctional facilities. Since corresponding information for county prisoners was not readily available, only length of stay was computed for these persons.

APPENDIX II

Survey of Currently Hospitalized NGIs

On August 1, 1983, a one-day survey of inpatient NGIs was taken at all DMH facilities and Bridgewater. Medical records librarians were asked to count the number of people hospitalized on that day who had been found NGI and whose current legal status came under MGL c.123 S.16. We also requested criminal charge, admission date, and whether or not the DMH patients had been transferred from Bridgewater. Table A1 shows the location of NGIs present in state hospitals and community mental health centers on August 1, 1983.

Table 15 presents the number of NGIs in Bridgewater and DMH by type of offense. As the table indicates, the majority of currently hospitalized NGIs are charged with violent offenses, with the modal offense being murder. Of the 37 NGIs in DMH facilities, 21 (56.8%) were transfers from Bridgewater. Of those 21, 18 (85.7%) were charged with violent offenses including four murders.

We were able to compute length of stay to date for 68 of the currently hospitalized NGIs. (The cases we were unable to calculate included those transferred from Bridgewater. For these, we knew length of stay in DMH facilities but not the amount of time previously spent in Bridgewater).

Of the 21 individuals charged with murder for whom we could calculate length of stay, nine had been hospitalized over five years; ten had been hospitalized for two to five years, and two for less than two years. Other offenses for which NGIs were hospitalized over five years were attempted homicide (1), rape (1), assault and battery (2), and armed robbery (1). Those spending two to five years hospitalized included those with charges of attempted murder (4),

rape (2), assault and battery (1), armed robbery (1), and arson (1). The remaining offenders had all been hospitalized less than two years.

TABLE A1

Location of NGIs Currently Hospitalized

Location	DMH District	Frequency
Bridgewater		52
Northampton	I	5
Worcester	II	7
Danvers	III	1
Solomon	III	1
Metropolitan	IVA	1
Medfield	IVB	2
Westboro	IVB	--
Pocasset	V	2
Taunton	V	2
Corrigan	V	--
Mass. Mental	VI	2
S.C. Fuller	VI	6
E. Lindemann	VI	5
Dorchester MHC	VI	--
Bay Cove	VI	3
West-Ros-Park	VI	--
		89

TABLE A2

NGIs Currently Hospitalized by Type of Offense

	Frequency	(Column Percents)	Location Bridgewater	DMH
Homicide	24	(27.0)	18	6
Attempted Homicide	11	(12.4)	7	4
Rape	5	(5.6)	4	1
Assault & Battery	17	(19.1)	8	9
Attempted Kidnapping	1	(1.1)	1	-
Armed Robbery	2	(2.2)	2	-
Indecent A&B	1	(1.1)	-	1
Arson	7	(7.9)	7	-
Assault/Assault to Rob	3	(3.4)	-	3
Threats	2	(2.2)	1	1
Property	6	(6.7)	3	3
Violation of Restraining Order	3	(3.4)	-	3
Other	4	(4.5)	1	3
Other Minor	3	(3.4)	-	3
TOTAL	89	(100.0)	52 (58.4)	37 (41.6)

(row percents)

APPENDIX III

...es J. Callahan, Jr., Ph. D.
Commissioner

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Mental Health
160 North Washington Street
Boston, Massachusetts 02114

AREA CODE (617)

July 25, 1983

Philip A. Rollins
Superior Courthouse
Barnstable, Massachusetts 02630

Dear District Attorney Rollins:

The State Legislature is currently considering changes in the statutes governing the insanity plea. Because of the importance of this issue, the Department of Mental Health has agreed to provide relevant information to the Joint Legislative Committee on Criminal Justice. For the past three months, we have been collecting data on persons found "not guilty by reason of insanity" in Massachusetts during the calendar years 1978, 1980, and 1982. The primary purpose of this effort is to determine whether these persons have longer or shorter lengths of stays in Bridgewater and other state hospitals than persons who are found guilty and sentenced to correctional facilities for similar crimes. A more complete description of the study is enclosed for your information.

I am writing to seek your assistance in this effort. There are two types of help which we would like.

First, we would like you to verify, if possible, the numbers of persons found "not guilty by reason of insanity" from your judicial district for the years of the study for four serious crimes. A table showing our figures for your judicial district is below:

Crime	1978	1980	1982
Homicide	1	0	0
Attempted Homicide	0	0	0
Assault and Battery*	1	1	1
Arson	0	0	0

*Assault and Battery includes the following:

Assault and Battery with a dangerous weapon.
Assault and Battery on a police officer.
It does not include simple assault or indecent assault and battery.

Our second request is for information that we cannot obtain from any other source. They are:

1. The total number of persons found not guilty by reason of insanity in your judicial district between January 1, 1982 and December 31, 1982.

2. The number of those persons who were not hospitalized either at Bridgewater or a mental health facility, following the finding of not guilty by reason of insanity.

3. The number of persons who entered a plea of not guilty by reason of insanity (not necessarily adjudicated) between January 1, 1982 and December 31, 1982.

4. The number of those persons whose plea of not guilty by reason of insanity was actually adjudicated (not dropped).

Your assistance will enable us to report on the overall use of the insanity plea in Massachusetts during the past year by judicial district and to determine the reliability of the information we have obtained from the records of Bridgewater and mental health facilities. We are particularly concerned that our data may under-represent the true number of persons found not guilty by reason of insanity. This would occur wherever a person found not guilty by reason of insanity was not subsequently hospitalized at Bridgewater or a Department of Mental Health facility. Our goal is to report the extent of this under-representation (if any). We are aware that this may require extra work for your office. However, we hope that this request is limited enough and its significance great enough to gain your cooperation. We are not planning to make any additional request for information from your office.

John A. Hornik, Ph.D., of my staff will call you next week to see if you have any questions about this report or the study. We will also be happy to provide you with a copy of our final report. If it is not possible for your office to retrieve this information, please let Doctor Hornik know when he calls. Thank you for your attention.

Sincerely,

James J. Callahan, Jr., Ph.D.
Commissioner

JJC:kfb

END