THE BRAWNER RULE—NEW LYRICS FOR AN OLD TUNE

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Durham-McDonald is not significantly different in substantive content from the A.L.I. test. . . . As we have already pointed out, we did not adopt the new rule in the contemplation that it would affect a significant number of verdicts.

From Judge Leventhal's majority opinion in *United States v. Brawner*[1]

[O]n the whole I fear that the change made by the Court today is primarily one of form rather than of substance. . . . What should by now be clear is that the problems of the responsibility defense cannot be resolved by adopting for the standard or for the jury instruction any new formulation of words.

From Judge Bazelon's concurring opinion in *United States v. Brawner*[2]

THE "BRAWNER RULE"

The author attended a state bar association dinner some years ago, at which a distinguished member of the bar was being honored on the fiftieth anniversary of his entry into practice (after a half century of doing something, you are generally called "distinguished" whether you really are or not). After the ceremonies, a reporter commented to him: "I imagine you have seen a great many changes in the law in your fifty years of practice"; to which the venerable counselor is said to have replied: "Yep, and I've opposed every damn one of 'em!"

Whatever may be said of the "insanity" rule of the United States Court of Appeals for the District of Columbia Circuit (and a great deal has been!), it must be agreed that it has not been static. The developmental chronology has gone something like this:

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1. 471 F.2d 969, 1005 n.79 (D.C. Cir. 1972).
2. *Id.* at 1010, 1039.

1882—*M'Naghten* "right and wrong" rule adopted[3]

1929—"irresistible impulse" added[4]

1954—birth of the famous (or infamous) "product" rule in *Durham v. United States*[5]

1957—*Carter v. United States*[6] made the rule a *sine qua non* test

1962—*McDonald v. United States*[7] defined "mental disease or defect" as an abnormal condition of the mind which substantially impairs behavioral controls

1967—*Washington v. United States*[8] made both parts of the test essentially "legal" rather than strictly "medical" issues

1972—in *United States v. Brawner,*[9] the court adopted the ALI rule plus "diminished responsibility"

Similarly, peripheral issues, like burden of proof and mandatory commitment following a verdict of not guilty by reason of insanity, have pursued an on-again-off-again course throughout the history of

3. United States v. Guiteau, 12 D.C. (1 Mackey) 498 (1882).

4. Smith v. United States, 36 F.2d 548 (D.C. Cir. 1929).

5. 214 F.2d 862 (D.C. Cir. 1954) ("an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect").

6. 252 F.2d 608 (D.C. Cir. 1957).

7. 312 F.2d 847 (D.C. Cir. 1962).

8. 390 F.2d 444 (D.C. Cir. 1967).

9. 471 F.2d 969 (D.C. Cir. 1972). The statement of the ALI rule adopted in *Brawner* is: "A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law." *Id.* at 973. The "diminished responsibility" rule adopted in *Brawner* is: "Even when there is no defense of insanity, expert testimony of abnormal mental condition will be admissible when it bears on the existence of a specific mental element necessary for a crime, as in the issue of premeditation in first degree murder, provided the judge determines that the testimony is grounded in sufficient scientific support, and would aid the jury in reaching a decision on the ultimate issues." *Id.* at 972.

In connection with the statement, first above, of the ALI rule, it should be noted that the court expressly retained the definition of "mental disease or defect" adopted in *McDonald*—"A mental disease or defect includes any abnormal condition of the mind which substantially affects mental or emotional processes and substantially affects behavior controls"—and that the caveats of *Washington* still apply, with the exception that the expert will now be permitted to testify as to whether or not there is a causal relationship between the defendant's mental disease or defect and his capacity to "appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law." The second paragraph of the ALI rule, as it appears in section 4.01 of the Model Penal Code ("The terms 'mental disease or defect' do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct."), is adopted "as a rule for application by the judge, to avoid miscarriage of justice, but not for inclusion in instructions to the jury." *Id.* at 994.

the insanity rule (the most recent development in these issues being the "product of" Congress, via the District of Columbia Court Reform and Criminal Procedure Act of 1970[10]).

Unlike the practitioner referred to in the first paragraph, the author has not "opposed every damn one" of these changes. In fact, he believes that *Durham*, with its encouragement of full psychiatric testimony, was a significant improvement over *M'Naghten*—whose preoccupation with morality and mono-symptomatic approach to mental illness has been justly criticized. He is inclined to think that the American Law Institute rule is a better statement than *Durham*, if for no other reason than its recognition that criminal responsibility is not a discrete entity, but rather an essentially arbitrary point on a continuum, as reflected in the ALI rule's "deprived of substantial capacity" phraseology. Also, diminished capacity adds a useful dimension to the rule, which may provide a more sensitive means of identifying partial impairments such as mental retardation.[11] However, all these rules proceed from the same, essentially erroneous, premises: that "insanity" (or, more accurately, want of criminal responsibility) is something that can be described in testimony and found by juries; and that labeling one "sane" or "insane" in the course of a criminal trial is a function useful enough to justify the investment of all but a fraction[12] of the very limited behavioral science resources now devoted to the criminal justice system. It is believed that *Brawner* is not the last act in the drama. Perhaps the ultimate "improvement" in the insanity rule will be to abolish it altogether. But more about that later.

The *Brawner* decision had been under consideration by the Court of Appeals for more than a year prior to its announcement late in June, 1972. At the request of the court, briefs amici curiae were filed by a number of individuals and organizations (unhappily not including Monte Durham, who for many years has been proudly telling visitors to St. Elizabeths Hospital about "his" rule). The author will leave to his colleagues discussion of the facts in the case and the specifics of the expert testimony, preferring to comment briefly on the recommenda-

10. D.C. CODE ANN. § 24-301 (Supp. IV, 1971), apparently restoring mandatory commitment, and requiring that "insanity" be affirmatively established by a preponderance of evidence.

11. *See* Allen, *The Retarded Offender: Unrecognized in Court and Untreated in Prison*, 32 FED. PROBATION 22 (1968).

12. John Suarez, M.D., of the U.C.L.A. Neuropsychiatric Institute, estimates it at upwards of ninety percent. Psychiatric News, August 16, 1972.

tions made by the amici—a distinguished group, including the American Psychiatric Association, American Psychological Association, American Civil Liberties Union, National Legal Aid and Defender Association, National District Attorneys Association, Public Defender Service and the Bar Association of the District of Columbia. Indeed, the significance of the *Brawner* decision may lie less in the rule adopted (which, after all, merely allies the District of Columbia circuit with all the other federal circuits save one) than in the thoughtfully considered analyses contributed by these experts from a variety of disciplines. Following a discussion of the recommendations made by the amici concerning the insanity defense and issues surrounding it, the author will consider a proposal rejected by the *Brawner* court: abolition of the insanity defense.

THE BRIEFS AMICI

On the Insanity Defense

The options considered by the court, on which comment was invited from the amici, were: reaffirmation of *Durham* (or *Durham* as modified by *Carter, McDonald* and *Washington*); return to *M'Naghten*; adoption of Judge Bazelon's suggestion in a recent case that the defendant should be exculpated if the jury finds that his behavioral controls were impaired to such an extent "that he cannot justly be held responsible";[13] enlargement of the *Durham* "mental disease or defect" language to include socio-economic strictures on behavior; adoption of the ALI rule (or one of its variants[14]); and abolition of the insanity defense.[15]

13. United States v. Eichberg, 439 F.2d 620 (D.C. Cir. 1971). *Cf.* REPORT OF ROYAL COMMISSION ON CAPITAL PUNISHMENT 333 (1953), which recommends that the jury be instructed to determine whether, in light of defendant's mental condition, he "ought not to be held responsible."

14. *See, e.g.*, Judge Biggs' thoughtful opinion in United States v. Currens, 290 F.2d 751 (3d Cir. 1961).

15. Coincidentally, the result was announced just six days before the United States Supreme Court issued its 118 pages of opinions in Furman v. Georgia, 405 U.S. 912 (1972), striking down imposition of the death penalty as a cruel and unusual punishment, violative of the eighth and fourteenth amendments, in four cases before the Court, and at least casting doubt on the propriety of capital punishment in future cases. Although not all insanity cases have involved capital charges (*e.g.*, Monte Durham was accused of housebreaking), a high enough proportion of the defendants raising that defense were facing a possible death sentence that it is reasonable to assume that the Supreme Court's ruling—fraught with uncertainty as it is—will substantially reduce incidence of the plea.

As to the various competing "tests," the amici were, understandably, divided. In fact, only four (National District Attorneys Association, Public Defender Service of the District of Columbia, American Psychiatric Association, and appellee) urged adoption of the ALI rule. But the listing is misleading, since none of the four recommended as its first choice the rule ultimately adopted by the Court of Appeals: the NDAA's vigorously expressed first choice was abolition; the Public Defender Service apparently recommended Judge Biggs' Third Circuit Court of Appeals variant;[16] the APA indicated its disapproval of *Washington* (which imposed restrictions on psychiatric testimony); and appellee (prosecution) had objections to diminished responsibility. Three briefs expressly objected to the ALI rule (the District of Columbia Bar Association, and the briefs of David L. Chambers, III, and William H. Dempsey, Jr., amicus by designation of the court).

Five amicus briefs supported *Durham*—though again with variations. Appellant (defendant) would combine ALI with *Durham-McDonald*. The District of Columbia Bar Association, American Civil Liberties Union, and Dempsey briefs all recommended changing the "product of" formulation: the Bar Association would change it to "has a relationship to";[17] ACLU to "substantial connection";[18] and Dempsey to a formulation similar to *United States v. Eichberg*.[19] The American Psychological Association, characterizing *Durham* as a "tyranny of psychiatric experts," would substitute for "mental disease or defect" the phrase "mental disability or defect," defined to include disabilities resulting from "social or emotional causes."[20] Only two of the other amici recommended enlarging the insanity defense to include socio-cultural impairments (Public Defender Service and Cham-

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Perhaps the most significant inhibiting factor in non-capital cases is the relatively longer period of confinement, generally, of persons found not guilty by reason of insanity than of those found guilty of identical crimes and sentenced to prison. However, there is widespread resistance to the "sick" role by persons accused of crime—even where the death penalty may be imposed. *See* Halleck, *The Criminal's Problem with Psychiatry*, 23 PSYCHIATRY: JOURNAL FOR THE STUDY OF INTERPERSONAL PROCESSES 409 (1960), reprinted in R. ALLEN, E. FERSTER & J. RUBIN, READINGS IN LAW AND PSYCHIATRY 43-46 (1968).

16. United States v. Currens, 290 F.2d 751 (3d Cir. 1961).

17. Brief for the Bar Association of the District of Columbia as Amicus Curiae at 9.

18. Brief for the American Civil Liberties Fund of the National Capital Area as Amicus Curiae at 20.

19. 439 F.2d 620 (D.C. Cir. 1971).

20. Brief for American Psychological Association as Amicus Curiae at 13-14.

bers); three expressly opposed such extension (American Psychiatric Association, appellee, and Dempsey).

Abolition of the insanity defense was advocated by the National District Attorneys Association in a lengthy discussion covering some twenty-six pages of its brief, with psychiatric evidence to be admissible only on the defendant's mental capacity to have the mens rea required for the crime with which he is charged. Both the American Psychiatric Association and the Chambers brief spoke favorably of abolition,[21] but their views were quite different from those of the district attorneys, since both emphasized the necessity of introducing psychiatric resources into the sentencing and correctional processes. Chambers, for example, observes:

> The *Durham* experiment, however valuable it has been for sharpening the debate on criminal responsibility . . . may . . . have served to deflect attention from the necessity of creating—as California has created—extensive psychiatric facilities within the prison system. It may then be time for the court to undertake the ultimate experiment—abandoning the defense altogether and building a humane and effective system of criminal corrections.[22]

The American Psychiatric Association cited the 1929 joint position statement of the APA and the American Bar Association, advocating:

1. That there be available to every criminal and juvenile court a psychiatric service to assist the court in the disposition of offenders.
2. That no criminal be sentenced for any felony in any case in which the judge has any discretion as to the sentence until there be filed as a part of the record a psychiatric report.
3. That there be a psychiatric service available to each penal and correctional institution.
4. That there be a psychiatric report on every prisoner convicted of a felony before he is released.
5. That there be established in every state a complete system of administrative transfer and parole and that there be no decision for or against any parole or any transfer from one institution to another without a psychiatric report.[23]

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21. National Legal Aid and Defender Association also disapproved of all extant tests of criminal responsibility (on the ground that they discriminate against the poor), but did not expressly advocate abolition—or indeed any other alternative.

22. Brief of Prof. David L. Chambers, III, as Amicus Curiae at 35.

23. Brief for American Psychiatric Association as Amicus Curiae at 26.

Amicus added, somewhat wistfully, that it "hopes that these principles someday may be implemented."[24]

On Psychological Testimony

Another issue on appeal, closely related to that of the insanity defense, was the propriety of the prosecutor's efforts to discredit the testimony of a St. Elizabeths psychologist who had testified concerning the results of projective tests he had administered to the defendant, in part by doing a little testifying himself in cross-examination and in his closing argument. For example, he told the jury in summation:

> Ladies and gentlemen, then we come to that ink blot. . . . Fourteen responses and four of them turn out to be anatomical things—hearts or whatever it happened to be. Is there something unusual about that? Is a man crazy when he sees a heart or something else four times . . .? After all, they are just blots of ink. Is a man crazy when he sees them? And how about that last one, that rocket one. He says he sees a rocket going off. I asked him, doctor, was there any rocket fired during that period of time that might stick in a man's brain and might suggest it to him? The doctor doesn't know. But there is something explosive about a personality if he sees a rocket on a little ink blot.
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> Well, ladies and gentlemen, there is not much I can say about that; I am not an expert. . . . But I can say one thing; that it is a jury decision. It is your province. It is your function to take that evidence and weigh that evidence and decide whether what that doctor said as far as you are concerned made any sense at all.[25]

The American Psychological Association, as might have been expected, was most vehement in its denunciation of the prosecutor's tactics; William H. Dempsey, Jr., in his amicus brief, also criticized the prosecution:

> In the case at bar . . . the gravest damage to the defense was worked through the prosecutor's cross-examination of the clinical psychologist and his closing argument. The thrust of the questions and argument was that either the psychological tests were unreliable or that the expert did not know how to administer them, or both. But there is nothing in the record to support either point. Indeed, the government evidently employs such tests itself when the results are favorable . . . .[26]

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24. *Id.* at 27.
25. Record at 36, United States v. Brawner, 471 F.2d 969 (D.C. Cir. 1972).
26. Brief of William H. Dempsey, Jr., as Amicus Curiae at 8.

Among the other amici, only the American Psychiatric Association commented at length about the question of the psychologist's treatment at the hands of the prosecutor, but its remarks suggest that it was more interested in attacking the psychologist than in reproving the prosecutor:

> [P]sychologists are not trained in medicine, are not doctors of medicine, and on the basis of psychological testing alone should not be permitted to testify as to a specific diagnosis of a mental disease or defect and to relate the alleged criminal act to that disease or defect. The final diagnosis and the relation of the disease to productive acts is a complicated scientific medical and psychiatric problem. Laymen should not be permitted to testify as the final expert in diagnosing medical mental illnesses or defects, and certainly are not qualified to relate specific acts on a productivity basis to these medical problems.[27]

While some of the phrases in the paragraph quoted above are far from clear,[28] the Association's ultimate objective is quite clear: reversal of Judge Bazelon's decision in *Jenkins v. United States*,[29] which held that, assuming proper qualification,[30] a psychologist may state his clinical findings and opinions. In that case, too, the American Psychiatric Association had filed a brief amicus curiae, to very much the same effect as the quotation above, if in somewhat less sophisticated terms; viz.,

> Psychology basically deals with philosophy. Psychologists study philosophy, not medicine . . . and have Ph.D. degrees, i.e., Doctors of Philosophy . . . .[31]

Observing that ". . . there was neither testimony adduced on cross-examination, nor testimony of a prosecutor's witness, to support a dis-

27. Brief for American Psychiatric Association as Amicus Curiae at 20.

28. *E.g.*, what does "final expert" mean—would the American Psychiatric Association require that psychological evidence be admitted only as ancillary to psychiatric testimony, or would it bar psychological testimony as to diagnosis and "productivity" altogether? Also, what are "*medical* mental illnesses or defects," since both psychiatrists and psychologists—and, indeed, other mental health professionals and para-professionals—purport to treat functional mental illness.

29. 307 F.2d 637 (D.C. Cir. 1962).

30. *Id.* at 645. "The determination of a psychologist's competence to render an expert opinion based on his findings as to the presence or absence of mental disease or defect must depend upon the nature and extent of his knowledge. It does not depend upon his claim to the title 'psychologist.' "

31. The briefs of both the American Psychiatric Association and the American Psychological Association are excerpted in R. ALLEN, E. FERSTER & J. RUBIN, *supra* note 15, at 160-74.

paragement of the very concept of projective tests, as based on mere ink blots," the Court of Appeals in *Brawner* criticized the prosecutor's questioning and summation as a "know-nothing appeal to ignorance," adding the veiled threat that it is "an approach we do not expect to recur." However, it did not find it so persistent and aggravated as to result in reversible error (perhaps because of the judge's "clarifying questions," or the fact that defense counsel failed to object).[32] Interestingly, just two months prior to the decision in *Brawner*, the court had to deal with a somewhat similar judicial disparagement of psychological testing. In *United States v. Alexander & Murdock,*[33] the trial judge took over the questioning of the clinical psychologist testifying for the defense:

Witness: On the Minnesota Multiphasic Personality Inventory, it is a series of 500 or so true and false statements which have been standarized against people with known mental symptoms and complaints. There are various patterns, profiles we call them, based on the way an individual responds. Mr. Murdock's pattern of responses is very similar to standardized groups of people who are known to have—known to be sullen, known to be alienated, known to be a kind of loner, not being identified with any of the establishment's kinds of views.

The Court: That is an opinion.

Witness: No, I am telling you a fact.

The Court: I beg your pardon, Doctor. That is an opinion. Give them the facts on which you reached that opinion. What answers did he give you that led you to that opinion? Give us some examples of sullen answers to questions.

. . . .

Witness: I don't have the raw—the actual MMPI which I want to talk about. I have the summary sheet. I don't have the actual 568 questions. I have his responses, but I don't know what the actual questions were. . . . I do have the results of other tests which I perhaps. . . .

The Court: Mr. Witness, you are entitled to those opinions, but you are not the judge. The jury is the judge of the facts and, therefore, you are required to explain to the jury in factual

32. United States v. Brawner, 471 F.2d 969, 1003-04 (D.C. Cir. 1972). *Cf.* King v. United States, 372 F.2d 390 (D.C. Cir. 1967).

33. 471 F.2d 923 (D.C. Cir. 1972).

> terms . . . what the underlying material is from which you reach your opinion, because the jury is not required to accept the opinion of any expert and they have to weigh the testimony of experts and to do that they need to know what it is that the expert relied on to reach his conclusion.[34]

Concluding that the witness's answers were unsatisfactory, the court ruled that his testimony was entitled to no weight, and instructed the jury to disregard it, and Murdock's counsel moved for a mistrial. The Court of Appeals did not rule squarely on the propriety of the judge's questioning or on his instruction to the jury to disregard the psychologist's testimony, but affirmed the conviction and described the situation as a "failure of communication ending in evident mutual exasperation."[35] Judge Bazelon in his dissent observed:

> It would have been perfectly appropriate to question Dr. Blum further about the precision of his tests, the margin of error in their results, and the significance of his findings in this particular case. He might well have been asked how closely Murdock's responses matched the standard profile on which Dr. Blum based his evaluation—whether Murdock fit squarely in a standard category or whether the psychological evaluation was more tentative. By asking exclusively for specific test responses, which would add little to the jury's understanding of the expert's opinion, the trial judge may have inadvertently cut off the flow of information about the statistical nature of the tests, information without which the jury could not evaluate Dr. Blum's opinion testimony.[36]

This is, of course, a more charitable characterization than the "know-nothing appeal to ignorance" charge leveled against the prosecutor in *Brawner*, but it may amount to very much the same thing.[37]

Judge Bazelon concluded his dissent in *Murdock* with this appraisal of psychological testimony:

> The problem of dealing effectively with testimony based on psychological tests is not a new one for this court. We have frequently seen attorneys and judges elicit from a psychologist a series of test questions and answers, thereby setting up an easy target for ridicule. It would be inappropriate to shield these tests from scrutiny by prohibiting such questions. . . . Indeed, it may be that the validity of the tests is so

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34. *Id.* at 953-54.
35. *Id.* at 967.
36. *Id.* at 955.
37. *See* the instructive monograph by David Silber, Ph.D., *Clinical Psychology—Its Role and Methods*, in R. ALLEN, E. FERSTER & J. RUBIN, *supra* note 15, at 83-92.

doubtful that they should be excluded from evidence as a matter of law. But if courts are willing to accept the tests as legitimate diagnostic tools, it is troublesome to see counsel or the court attempting to discredit them in a particular case by ridicule, rather than exploring their acknowledged strengths and weaknesses.[38]

On Psychiatric Testimony—and the Role of the Public Mental Hospital

The brief of Professor David L. Chambers, III, of the University of Michigan School of Law, was devoted almost exclusively to St. Elizabeths Hospital, the principal public mental hospital in the District of Columbia, and its staff psychiatrists, who testify in nearly all cases in which the insanity defense is raised. Chambers insisted that:

> Several versions of the insanity defense are under consideration in this case. The purpose of this brief is to suggest that much more is needed than a reformulation of the test before the defense can operate in this jurisdiction in a manner that will provide a fair hearing to defendants raising the defense and that will serve satisfactorily the functions we envision for the insanity defense, specifically, the diagnostic process at St. Elizabeths Hospital needs to be greatly improved. . . . If, however, the Court fails to take such steps or help to see that they are taken, I fear that it will make little difference which version of the insanity defense it chooses to adopt.[39]

Professor Chambers conducted an empirical study at St. Elizabeths Hospital's John Howard Pavilion (the ward for criminally committed patients) for the National Institute of Mental Health in 1969, and at various points in the brief he drew upon the findings of that study. It is a brief that deserves wider circulation, for much of what is said of St. Elizabeths Hospital is equally applicable to any large state facility for the "criminally insane."

Among the points made by Professor Chambers are the following:

1. There are too many patients and too few psychiatrists (in 1969, John Howard Pavilion had 370 patients and four psychiatrists, with referrals of 450 defendants charged with felonies each year on sixty-day observation orders), with little in the way of real "observation" since the average patient stays over sixty days and sees a doctor only twice.

2. There is a diagnostic "conflict of interest," in that defendants raising the insanity defense are examined at John Howard Pavilion, and

38. United States v. Alexander & Murdock, 471 F.2d 923 (D.C. Cir. 1972).

39. Brief of Prof. David L. Chambers, III, as Amicus Curiae at 3.

if found not guilty by reason of insanity, are returned to John Howard Pavilion for treatment. "The doctors at St. Elizabeths, knowing that a decision that a man is mentally ill may lead to his return to the hospital, may, consciously or unconsciously, decide a man is not mentally ill simply to insure that he is not returned to the hospital."[40] The brief argues that due process requires that the hospital be barred from one or the other of these functions.

3. These possibly conflicting roles of the hospital staff may also affect decision-making by the judge or jury, who, even if opposing testimony (that the defendant is "insane") is believed, may hesitate to acquit by reason of insanity, fearing that the hospital will promptly release one whom its staff do not believe belongs there.

4. Because of the shortage of professional personnel, and the heavy inroads on their time necessitated by frequent testifying in court, both diagnostic evaluations and treatment suffer.

5. A significant number of those whom the St. Elizabeths staff diagnoses as mentally ill and who are found not guilty by reason of insanity have problems with which John Howard Pavilion is ill-equipped to deal (*e.g.*, the anti-social personality—formerly termed the psychopath or sociopath); and, conversely, many criminal defendants who could profit from hospitalization are never referred to the hospital for examination or treatment.

Like Judges Leventhal and Bazelon (see the quotes with which this article was begun), Professor Chambers believes that the wording of the insanity defense rule will make little difference for most defendants —not only because of the institutional problems summarized above, but also because in the majority of cases where the defense is raised the issue (and hence the rule) is never submitted to a jury. A system of bargained insanity pleas has developed, under which, if the hospital reports that the defendant is mentally ill and that the crime was a product of that illness, and if the defendant agrees not to contest indeterminate commitment to the hospital, a perfunctory hearing is held, with a stipulation of facts and brief testimony by a single psychiatrist, and a verdict of not guilty by reason of insanity is entered by the judge. Chambers observes that changing the wording of the insanity rule is hardly likely to alter a practice which offers so many advantages to the participants:

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40. *Id.* at 1.

> For both the judge and the prosecutor, the bargained defense serves to conclude a case with a minimal cost in time and with a reasonable assurance of long-term incarceration. For the defendant, it provides an alternative to prison. . . . For defense counsel, especially appointed counsel, it is attractive in reducing trial time and in providing the appearance of victory.[41]

Before leaving the Chambers brief, one further observation should be noted—and it is sufficiently important to warrant quoting extensively from the brief:

> Defense counsel and attorneys from the United States Attorney's office often appear confused and ill-informed about this Court's decisions regarding the insanity defense, about the examination process at St. Elizabeths, and, not surprisingly, about the whole subject of mental illness. . . .[42]
>
> During the period that I worked at the Hospital, one fact that was particularly painful to me was how little most trial counsel appeared to understand about the insanity defense and its operation. Many appeared to regard a verdict of not guilty by reason of insanity as a great victory without regard to the probable length of time their client would spend in the Hospital and without regard to the probable effect of long-term hospitalization on their client. Few provided any information to the Hospital during their client's stay despite the fact that the information that had led them to move for their client's examination might have proved helpful to their client if conveyed to the doctors. Many failed to interview Hospital doctors whom they planned to call at trial until the morning of the trial. This fact was doubly tragic because the Hospital staff, within the confines of their schedules, seemed to me uniformly willing to give freely of their time to explain to counsel what they were prepared to say, and help counsel understand their client's problem . . . .[43]

On the basis of more than a dozen years of practice, teaching and research in this bizarre, left-field business of law and psychiatry, the author of the present article must regretfully note that the same observations could have been made of any jurisdiction in the country.

ABOLITION OF THE INSANITY DEFENSE

Over a hundred years ago, a distinguished lawyer declared that the legislatures should "amend the law so as to require the question of in-

41. *Id.* at 31.
42. *Id.* at 2.
43. *Id.* at 25.

sanity to be determined by a competent tribunal after a conviction of the fact of guilt." He urged that the instruction to the jury should not be "'was the defendant capable of judging between right and wrong,' a proposition which no jury can determine, but 'did he . . . commit the specific act charged,' for whether he committed it sane or insane, the result is . . . that the safety of society requires that he should be placed in seclusion for such a period as will promote the joint ends of personal reformation and the preservation of the well being of the community at large."[44]

How modern and enlightened the words sound, even today! How eminently sensible to bring to an end the labeling process that has occupied nearly all the attention of specialists in both law and the behavioral sciences, and get to the potentially far more fruitful business of protection of society and reformation of the offender, which is, of course, the *raison d'être* of the criminal law. The idea sounds new even today, because, except for three abortive efforts several decades ago,[45] it has never been tried. The author recalls that when Dr. Cameron—then Superintendent of St. Elizabeths Hospital—propounded it in testimony before Senator Ervin's Subcommittee on Constitutional Rights of the Senate Judiciary Committee in the early 1960's, it was headline news in the *Washington Post,* which described it as "daringly innovative."

In the last few years, the proposal has gained powerful adherents: Karl Menninger,[46] Sheldon Glueck,[47] Seymour Halleck,[48] and Norval Morris,[49] to name a few.[50] The author's colleague at the National Law Center, Professor David Robinson, in his *Consultant's Report to the National Commission on Reform of Federal Criminal Laws,* offered sev-

44. F. WHARTON & M. STILLÉ, MEDICAL JURISPRUDENCE § 277, at 290 (2d ed. 1860).

45. Washington, Louisiana and Mississippi. In all three, the highest court of the state declared abolition of the insanity defense unconstitutional. State v. Lange, 168 La. 958, 123 So. 639 (1929); Sinclair v. State, 161 Miss. 142, 132 So. 581 (1931); State v. Strasburg, 60 Wash. 106, 110 P. 1020 (1910). This prompted both the American Psychiatric Association and Dempsey to declare in their briefs amici that a constitutional amendment would be required; the Court in *Brawner* observed that in any event abolition could not be accomplished by "judicial fiat."

46. K. MENNINGER, THE CRIME OF PUNISHMENT (1969).

47. S. GLUECK, LAW AND PSYCHIATRY: COLD WAR OR ENTENTE CORDIALE? (1962).

48. S. HALLECK, PSYCHIATRY AND THE DILEMMAS OF CRIME (1967).

49. Morris, *Psychiatry and the Dangerous Criminal,* 41 S. CAL. L. REV. 514 (1968).

50. *See also* Goldstein & Katz, *Abolish the Insanity Defense—Why Not?,* 72 YALE L.J. 873 (1963).

eral cogent arguments for abolition, which may be summarized as follows:[51]

1. Trained mental health personnel—especially psychiatrists—are in critically short supply. Devoting their services to assistance in disposition and in treatment of people who need treatment, "seems far more sensible than encouraging their presence in courthouses so that they will be available to engage in retrospective reconstructions of criminal responsibility."
2. All of the prevailing insanity tests are vague, and perhaps meaningless, inviting "semantic jousting, metaphysical speculations, [and] intuitive moral judgments in the guise of factual determinations."
3. None of them offers much in the way of a guide to determining either "blameworthiness" or the infinitely more important question whether an offender ought to be institutionalized, and if so where and with what rehabilitative program.
4. The criteria for release of persons committed after a verdict of not guilty by reason of insanity are imprecise, and their application is erratic and often oppressive.
5. It makes good therapeutic sense to treat deviants as responsible for their conduct rather than as helpless victims of their "sickness."
6. The insanity defense fails to recognize the influences of social factors in restricting behavioral choices (*e.g.*, the offender suffering from delusions is exculpated, but the offender suffering from a ghetto environment and a delinquent sub-culture is not).
7. The defense overlaps with the mens rea requirement, and neither can be used effectively to determine dangerousness or need for treatment.

His recommendation was rejected by the Commission—as the idea has nearly always been rejected—with reluctance. And although it was rejected again in *Brawner*, the Court of Appeals has indicated that it is still under consideration. In *Washington* the court observed:

> [I]t may be that psychiatry and the other social and behavioral sciences cannot provide sufficient data relevant to a determination of criminal responsibility no matter what our rules of evidence are. If so, we may be forced to eliminate the insanity defense altogether, or refashion it in a way which is not tied so tightly to the medical model.[52]

And in *Murdock*:

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51. 1 WORKING PAPERS OF THE NATIONAL COMMISSION ON REFORM OF FEDERAL CRIMINAL LAWS 229 *et seq.* (1970).
52. Washington v. United States, 390 F.2d 444, 457 n.33 (D.C. Cir. 1967).

> Under each of the prevailing tests of criminal responsibility, the operation of the defense has been haphazard, perfunctory, and virtually inexplicable. If we cannot overcome the irrational operation of the defense, we may have no honest choice but to abandon it and hold all persons criminally responsible for their action.[53]

The defense of insanity is perhaps the most overwritten area in the law. It is really difficult to say anything new about it. As has been indicated, the proposal for abolition—novel as it may sound—has been around for a hundred years, and the arguments for and against have been so often stated that one has a feeling of *déjà vu* in discussing contemporary writings on the subject. But let us review the principal arguments *against* abolition:

1. The behavioral sciences have not advanced far enough to provide answers to such questions as moral culpability, dangerousness and treatability.[54] But if we are awaiting a scientific breakthrough on questions of moral blameworthiness, we will doubtless still be waiting on Judgment Day (when, presumably, the only authoritative decision on that score will be issued). And surely the treatment and release decision can more appropriately be made—despite the primitive state of our knowledge—after expert study and diagnosis of the offender, rather than by a legislature's prospective judgment, based on a description of a piece of behavior ("anybody who does this . . . gets that"), or through our present system of sentencing, prison and parole (which, as indicated by the statistics on recidivism, often works against both protection and rehabilitation).

2. The deterrent impact of the criminal law would be weakened.[55] But the reverse is true. It is the present haphazard and discriminatory insanity defense, postponing punishment for some, and avoiding it for others (who "couldn't help" what they did), which weakens the deterrent value of law.

3. It would obscure the "real issues." In a recent article a psychiatrist observes:

> Prosecutors often distort the real issues involved in the determination of criminal responsibility. In each case in which the author has testified, for example, she has been asked on cross-examination by the pros-

53. United States v. Alexander & Murdock, 471 F.2d 923 (D.C. Cir. 1972).

54. *See, e.g.*, Judge Haynesworth's opinion in United States v. Chandler, 393 F.2d 920 (4th Cir. 1968).

55. *See* Erickson, *Psychiatry and the Law: An Attempt at Synthesis*, 1961 DUKE L.J. 30.

> ecution (or directly by the court) some question about "treatability," that is, what disposition could be made of the allegedly insane defendant.[56]

But is not prognosis a "real issue"? Have we become so wrapped up in the game of labeling defendants "sane" or "insane" that we have lost sight of its purposes? Or perhaps it is indeed a game: "Do not pass go, do not collect $200."

4. "[E]liminating the insanity defense would remove from the criminal law and the public conscience the vitally important distinction between illness and evil . . . ."[57] To which the author can only comment: "Right on!" The dichotomy which the law has tried to maintain between the "mad" and the "bad" is a patent absurdity, whose loss will be little missed, save by professional testifiers and psychiatrist-baiting cross-examiners.

Perhaps the most telling objection to continuation of the quest for separation of the "sane" from the "insane" is that humanity just is not divisible into such discrete categories. If the elusive group we are seeking to define with our reformulations of rules are those without "free will"—without the capacity to choose to obey the rules of society —then where are they to be found? And how? The "sickest" of us, in the most remote back ward of a primitive state hospital, have some capacity to respond to rules, some consciousness of moral accountability (indeed, for some it is inability to deal with an overwhelming sense of guilt and unworthiness which has resulted in their need for hospitalization). And the "wellest" of us have areas of ego weakness, in which our range of behavioral choices is narrowed by our hereditary equipment and our experiences. If those we are trying to identify are the "treatables"—those who can benefit from mental health care—then we are simply not asking the right questions. How in any event can a lay jury be expected, on the basis of a few days or weeks of trial, to make a diagnosis and prescription of treatment—especially when the information on which it must act is filtered through the mechanisms of adversary inquiry, often focused on moral blameworthiness?

Once the label is applied—"sick" or "well," "responsible" or "insane"—who is benefited? A dear friend of the author, Dr. Seymour

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56. Gray, *The Insanity Defense: Historical Development and Contemporary Relevance*, 10 AM. CRIM. L.Q. 559 (1972).

57. A. GOLDSTEIN, THE INSANITY DEFENSE 223 (1967).

Pollack, appeared last year as a guest speaker in the author's Criminal Law and Procedure class, and told us about his experience in the Sirhan Sirhan case. Pollack appeared as a witness for the prosecution, and Dr. Bernard Diamond, also an eminent California forensic psychiatrist, appeared for the defense. Both made heroic investments of time—literally hundreds of hours of clinical interviewing, examination of reports and documents, conference with counsel, and testifying in court. To what end? Was society one whit better protected by it all? Was Sirhan Sirhan's condition—whatever it may be—improved in the slightest degree? We enjoyed the discussion of the case, and I think the students learned something from our analysis of the direct and cross-examination of these extraordinarily well-qualified experts. But I for one could not help but think how much more productive would have been the devotion of their considerable talents to something like providing consultation services to probation officers, setting up group therapy programs in correctional institutions, or establishing halfway houses for the vast majority of offenders, who cannot profit from—and indeed will be harmed by—incarceration in a prison. The author's first collaborator in teaching law and psychiatry at the Menninger School of Psychiatry, Dr. Joseph Satten, put it this way:

> [T]he psychiatrist can make his greatest contribution in legal situations if he enters after the question of guilt and innocence has been resolved and when the only question is what to do with the individual in his own and society's best interest. In other words, the psychiatrist can do the most good when he remains in his clinical, treatment-oriented role.[58]

Finally, the defense of insanity works directly against both the goals of protection of society and reformation of the offender. As to the former, since the defense is just that—an affirmative defense—it may be raised or not raised at the option of the defendant. Should not treatment, when treatment is needed to effect behavioral change, be a part of the armamentarium of society, along with incarceration, vocational training, probation, and the other correctional tools? As to the latter, the whole process leading to an adjudication of non-responsibility may be counter-therapeutic. Is not the whole objective of therapy to help the patient accept the fact that he is responsible for what he does, and that he must take control of his life and make choices of behavior on reality-oriented grounds and not on fantasies? For the

58. Satten, *The Concept of Responsibility in Psychiatry and Its Relationship to the Legal Problems of "Criminal Responsibility,"* 4 U. KAN. L. REV. 361, 363 (1956).

psychopath-sociopath-antisocial personality, an acquittal "by reason of insanity" provides the one, irrefutable defense against any efforts at behavioral change: "I can't help myself; I'm sick!" Shades of "Dear Officer Krupke!"

This section of the article has been, perhaps, more polemical than specific. There are problems in effecting abolition of the insanity defense which demand fuller exposition. There is the problem of constitutionality if the change is made by the courts or the legislatures[59] (which the author is happy to leave to other scholars). And there is the problem of mens rea. Many of the substantive offenses are statutorily defined in terms of mental state (like malice aforethought, deliberately and premeditatedly, willfully, maliciously, with intent to . . . , etc.), and each may well involve the kind of intra-psychic foray now conducted under the rubric of the insanity rule (as California has discovered under its bifurcated trial system). And there is also the problem of the stigma and deprivation of civil and jural rights which now follows a criminal conviction. Perhaps the only way effectively to abolish the insanity defense is to abolish as well the moral condemnation of the criminal law, substituting for it a simple process of adjudicating the operative facts of guilt.

But, most important of all, if the defense of insanity is removed, something must be put in its place. And it is on this point that the brief of the National District Attorneys Association is deficient. The essential *quid pro quo*, in the author's opinion, is establishment of a real system of corrections, with differential treatment modalities geared to individual needs and capabilities, and not to reified labels. A system primarily community-based is needed, instead of the fortress-like prisons and "hospitals" (often differing from prisons only in that the guards wear white coats) of the present criminal justice system.

There is, of course, a danger in all this—that of developing a *Clockwork Orange*-like therapeutic state. The author recognizes the problem—it is real, but not insoluble. If the present system of determining "insanity" is to be abandoned for one in which triers of fact decide only the factual questions of who did what to whom, and whether the thing done is proscribed by law, and whether the whole process of proof conforms to due process safeguards, and in which the disposition decision is made after trial, by a more expert tribunal, after

59. *See* note 45 *supra*.

more intensive study than can be provided via the trial process, then that decision too must accord that elemental fairness subsumed in the phrase "due process of law." There must be provision for notice, representation, a right to independent evaluation, hearing, and judicial review. And perhaps there should also be membership on the dispositional panel of judges and lawyers as well as behavioral scientists, for their decisions involve social and legal, as well as medical and psychological, considerations.

A society must decide where it will spend its limited chips. If the optimal treatment for a given offender is one-to-one psychotherapy three times a week for a period of years, society has, it would seem, the right to say that it would prefer to devote its resources to other things (say, school mental health programs), and to take its chances with more traditional handling of the offender. Again, if "dangerousness," or the likelihood of repetition of the offense were the only criteria for release, most first degree murderers would be back on the streets within a few months, and most exhibitionists would be incarcerated (in hospital or prison) for life. But there is a social interest at stake, and perhaps the deterrence objective of the criminal law makes necessary some period of punitive custody for an offense as serious as murder; and perhaps society must accept the risk that the exhibitionist will repeat his offense under some future stress, if the only alternative is life imprisonment.

POSTLUDE

This article was subtitled: "New Lyrics for an Old Tune." The words of the *Brawner* rule are somewhat less ambiguous than those of *Durham-McDonald*—somewhat more in accord with what we know about human personality, but the tune is still the same and it is discordant, out of harmony with the objectives of the criminal law. Psychiatrists used to be called "alienists," and those whom they treated were regarded as "alien"—to be identified, separated from the "sane" and shuttled off to some remote, secure place. Whatever ultimately happens to the insanity rule—whether it is refined, substituted for, or scrapped—what happens to the mentally impaired offender is of infinitely greater importance. The Roman poet Terence said it simply and well: "I am a human being . . . and nothing that is human is alien to me."