

THE INSANITY DEFENSE IN OPERATION: A PRACTICING PSYCHIATRIST VIEWS DURHAM AND BRAWNER

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Unlike the other participants in this symposium, I am neither a scholar nor theoretician in the field of the insanity defense. Instead, I was a practitioner of forensic psychiatry for two years under the jurisdiction of the United States District Court for the District of Columbia while the *Durham* rule¹ was in effect. From 1968 to 1970 I was assigned by the United States Public Health Service to duty as a medical officer (psychiatry) in the John Howard Pavilion of St. Elizabeths Hospital. John Howard Pavilion is a 400-bed maximum security unit which is almost exclusively devoted to the evaluation and treatment of mentally ill felony suspects. Of John Howard's twelve wards, three during my stay were assigned to pretrial observations and nine handled post-trial treatment of patients found not guilty by reason of insanity. A smaller number of patients were committed as mentally incompetent to stand trial or as convicted prisoners who had become insane while serving sentence. Some patients were civilly committed or were voluntary admissions, but required maximum security. I was assigned to both evaluation and treatment wards, and often treated patients I had evaluated and found to be insane. Thus I was from time to time privileged to observe the miraculous recoveries of patients who had successfully malingered insanity. As for mistakes in the other direction: either I never found anyone sane who was in fact insane, or else the prison never sent any of these patients to the hospital. I think the latter explanation is more likely.

Not all of the patients at John Howard Pavilion were under the jurisdiction of the United States District Court for the District of Columbia. Some came from federal jurisdictions in which the American Law Institute sanity test was in effect. Thus, I had practical experience with both tests as an "expert witness."

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1. *Durham v. United States*, 214 F.2d 862 (D.C. Cir. 1954).

Actually "expert witnesses" usually do not think of themselves as being professional witnesses. Most think of themselves as psychiatrists who work in a hospital or ward for mentally ill legal offenders, for that is what most of them do. The purpose of this essay, then, is to describe the problems of the insanity defense and criminal commitment as they appear to a psychiatrist in a hospital for the criminally insane.² Viewed from this vantage point, the terrain seems to look quite different from the way it appeared to the Court of Appeals in *United States v. Brawner*.³ For example, I was surprised to find in the *Brawner* decision that the principle issue determining the court's preference of sanity tests seemed to be the "undue dominance by the experts giving testimony."⁴ In the *Brawner* decision the *Durham* test is replaced by the ALI test, chiefly to avoid dominance by experts. Judge Bazelon's concurring opinion favors the Wechsler test ("cannot justly be held responsible") over the ALI test, chiefly because he feels it would be still more effective in curbing dominance by the experts. Indeed, he now feels in retrospect that the *Durham* test was adopted in the first place because it was hoped that it would permit less dominance by experts than the test which had preceded it.

I must confess I am mystified by the court's use of the degree of expert dominance as the prime criterion for acceptability of a sanity test. It is not the sanity test that is responsible for expert dominance; it is the whole way the judicial process works in actual practice. The overall process for deciding insanity defense cases does not discourage domination by experts; it encourages it. Indeed, it insures it so certainly that the particular sanity test employed can influence matters only slightly.

THE JUDICIAL PROCEDURE FOR DETERMINATION OF SANITY

The following process describes how the question of insanity was decided in the District of Columbia when I was at St. Elizabeths Hospital. This is also how it is presently determined; *Brawner* has only changed the wording of some of the documents involved.

In a felony prosecution, if anyone raises the question of insanity and requests a psychiatric evaluation of the defendant, the judge is virtually

2. Since I have had little experience with pretrial evaluation of misdemeanants, and since misdemeanants are rarely found not guilty by reason of insanity, the subsequent discussion shall be concerned only with accused felons.

3. 471 F.2d 969 (D.C. Cir. 1972).

4. *Id.* at 981.

obligated to order the defendant committed to St. Elizabeths Hospital to be examined to determine whether he is competent to stand trial and whether he was sane at the time of the crime. The court order authorizing the examination quotes verbatim the language of the insanity test currently prevailing in the District in specifying the questions the hospital is to answer. The hospital's report to the court quotes the same language that was on the court order. Both the court order and the hospital report quoted *Durham* and *McDonald v. United States*⁵ before June 23, 1972, the date the *Browner* opinion was issued, but the essential information contained in the report to the court remains unchanged. The report states whether the patient 1) has a psychiatric diagnosis, 2) is competent to stand trial, and 3) was sane at the time of the alleged act. Those three pieces of information are the real substance of the report, though each piece may be couched in a paragraph of legal formula language. The three pieces of information contained in these reports are decided by a single psychiatrist, since the hospital—indeed the entire District of Columbia—can only rarely muster the psychiatric manpower for double or multiple independent examinations.

In the overwhelming majority of cases the hospital's report to the court is the sole determinant of the outcome of the insanity defense. If the hospital reports that the patient was sane at the time of the alleged act, the defense almost always abandons the insanity plea. Since over seventy-five percent of felons examined are reported as having been sane, the majority of insanity defenses are thus resolved before the case even comes to trial. If the hospital reports that the defendant was insane, the prosecution ceases to contest the issue. This results in a trial that would perhaps surprise the framers of *Washington v. United States*:⁶ it is a trial by judge with the verdict never in doubt. The defense stipulates that the crime cited in the indictment occurred and that the defendant committed it. Then the expert psychiatrist is put on the stand.

The nature of his testimony depends on the specific trial judge presiding. A few judges will take over the questioning of the psychiatrist and examine him closely in a sincere effort to assure themselves that justice is being done. Most feel that psychiatry is over their heads, and simply allow the prosecution and defense to formalize the deal

5. 312 F.2d 847 (D.C. Cir. 1962).

6. 390 F.2d 444 (D.C. Cir. 1967).

they have made. Approximately a quarter of the judges are in such a hurry to get the "trial" over with that they will not permit the questioning to deviate substantially from the following script:

Examiner: [May be either defense or prosecuting attorney, or in cases of extreme impatience, the judge.] Have you examined the defendant and arrived at a diagnosis?

Psychiatrist: Yes.

Examiner: What is the diagnosis?

Psychiatrist: Paranoid schizophrenia [or any other diagnosis].

Examiner: Do you find that the defendant has a rational as well as factual understanding of these proceedings against him and is he able to consult and cooperate with his attorney in his own defense?

Psychiatrist: Yes.

Judge: I declare the defendant competent to stand trial. Proceed.

Examiner: Did you find in your examination of the defendant that at the time of the crime he was suffering from a mental disease which substantially affected his mental or emotional processes and substantially impaired his behavioral controls?

Psychiatrist: Yes.

Examiner: What was that disease?

Psychiatrist: Paranoid schizophrenia.

Examiner: Did you find that the crime was the product of the defendant's schizophrenia? [I assume this question is now worded according to the ALI rule.]

Psychiatrist: Yes.

Judge: I declare the defendant not guilty by reason of insanity. Is the witness prepared to proceed with the *Bolton*⁷ hearing at this time?

Psychiatrist: Yes.

Judge: Proceed.

7. *Bolton v. Harris*, 395 F.2d 642 (D.C. Cir. 1968). After a defendant has been acquitted by reason of insanity in the District of Columbia, a judicial hearing must be held on the question of whether the defendant involved ought to be retained in custody on the basis of his current mental condition. The procedures at the hearing are substantially similar to those in proceedings for civil commitment of the dangerous mentally ill. For a fuller discussion of the development of this aspect of the insanity defense in the District of Columbia, see *United States v. Brawner*, 471 F.2d 969, 996-98 (D.C. Cir. 1972).

- Examiner: Do you find that the defendant is still suffering from paranoid schizophrenia?
- Psychiatrist: Yes.
- Examiner: Is he likely to be dangerous to himself or others in the foreseeable future because of his illness?
- Psychiatrist: Yes.
- Judge: I hereby commit the defendant to St. Elizabeths Hospital until such time as this court is satisfied that he is no longer likely to be a danger to himself or others in the foreseeable future by reason of mental illness. Adjourned.

Even when the judge allows questioning to expand beyond this script, the fact remains that in over ninety percent of trials involving the actual employment of the insanity defense dominance of the jury by the experts is *not* a valid issue because there is no jury. In such cases the judge seems bound by the experts' testimony even when he appears to have major reservations about it. (I remember one trial in which the judge was so outraged by the deal the prosecution and defense had made that he could not bring himself to declare the defendant not guilty by reason of insanity. It turned out that his only recourse was to transfer the trial to another judge whose feelings about the case were not so strong.) The prosecuting attorneys go along with the procedure even when they will confide to another psychiatrist on no uncertain terms that they feel the expert witness in the case is a fool and the defendant is obviously sane. It is virtually impossible for the prosecution to have the defendant examined by another psychiatrist. Thus, the expert witness dictates the verdict.

I trust this tour through the judicial process has illustrated how, by one means or another, the opinion of the psychiatrist who examines the defendant is almost certain to become the verdict of the court. Since this is so, I believe a sanity test is better judged by the effect it has on psychiatrists than by the effect it has on juries. I shall return to that matter shortly, but right now I would like to digress a bit, to point out that a sanity test may be viewed as a prognostic test and judged accordingly.

THE SANITY TEST AS A PROGNOSTIC TEST

In medicine a prognostic test is a procedure that predicts what will happen to a patient. For instance, an elevated blood urea nitrogen predicts that a patient will be found to have kidney disease. Conver-

sion of a tuberculin test from negative to positive predicts that a patient will be found to be infected with tuberculosis. These tests are often called diagnostic tests, but then a diagnosis is nothing but a technical term designed to briefly communicate a great deal of prognostic information.

I am sure legal theoreticians will object at this point and say that a sanity test predicts nothing; it is concerned with the past—the time of the crime—not the future. I am well aware of the theoretical function of a sanity test. The problem is that a sanity verdict not only determines criminal guilt, but also has other effects which are probably more important. If a finding of not guilty by reason of insanity had practical as well as theoretical value, the defendant would walk out of the courtroom a free man. Instead, he is almost always sent to a hospital for the criminally insane under a criminal commitment order.⁸ In a way, that is worse than going to prison, for in prison a man gets out when his time is up. A man in a hospital for the criminally insane is there under a triple lock: the first lock is his illness, which must remit before he can be released; the second lock is his doctor; and the third lock is the judge. Both doctor and judge must agree that the patient has recovered his sanity before he will be released. Each feels a strong responsibility for the safety of the community. The doctor must convince the judge of the patient's recovery; the judge must demand that the doctor convince him. The public hearings required may attract the attention of the press. In contrast, a patient civilly committed is released by a simple order in the ward order book when his doctor feels he would be better off at home. There is no doubt in my mind that criminal commitment is substantially more harmful to most patients' welfare than is civil commitment. Why shouldn't patients found not guilty by reason of insanity be civilly committed? Why should a criminal court retain jurisdiction over them after they have been found innocent? The only explanation I can see for these procedures is that the theory behind the insanity defense is almost totally divorced from its actual practical function. Frankly, it seems to me that the theory behind the defense is simply fallacious, and a verdict of not guilty by reason of insanity is not an acquittal at all, but a special type of conviction that leads to a special type of sentencing. I have

8. The *Bolton* decision in the District of Columbia, requiring a separate hearing for issuance of the commitment order, has really changed nothing. In two years' time I only heard of one defendant who was released at his *Bolton* hearing.

examined more than one defendant who feared that he might be found "guilty by reason of insanity," thus displaying the insight that often accompanies naiveté.

When the insanity defense is raised, both the defendant and the prosecutor are more concerned about the future than about the past. The defendant's concerns are obvious. But prosecutors also consider whether prison or a hospital is more likely to rehabilitate the defendant and protect the public. It is true that the prosecutor's opinions are limited by what the psychiatrist has to say about the past, but in informal pretrial conferences prosecutors show by the questions they ask that they are very much concerned about the defendant's future. Conscientious judges show the same concern by their questions to the psychiatrist on the stand.

I think this covert concern about the defendant's future is entirely appropriate, since the *effect* of a sanity verdict is to send a defendant either to prison or to a hospital. This is an important decision, for I believe that it is a simple practical truth that some felons need to be in prison and others need to be in a hospital, and it is often a very bad thing for one of them to be sent to the wrong place. It so happens that the insanity defense is virtually the only mechanism the law has for deciding whether a felon will be sent to a hospital instead of prison.⁹ Since this is so, it is important that a sanity test be capable of predicting whether prison or a hospital would be a disastrous disposition for the defendant. This prediction is the least we can expect of a sanity test. As far as I am concerned, a sanity test is no good if it fiddles around with arcane matters such as trying to guess whether the defendant was capable of some sort of theoretical malice at the time of the crime, but still fails to make the crucial prediction.

Because I think prediction is the central function of the sanity test, I judge sanity tests by the twin criteria that determine the worth of any prognostic test: reliability and validity.

THE RELIABILITY OF SANITY TESTS

Reliability is much the same as reproducibility. If a test is given to

9. I am aware that defendants are sometimes "saved" from prison by a semi-permanent commitment as mentally incompetent to stand trial, but this is a desperate and highly regrettable course of action which is usually prompted by the defense attorney's fear that his insane defendant may not meet the technical criteria for a finding of not guilty by reason of insanity.

the same subject several times during an interval in which there should be no change in the subject, and the test results show little variance, the reliability of that test is good. If there is considerable variance, the reliability is poor. Ideally, reliability should not diminish if different evaluators are applying the test.

My opportunity to observe the reliability of the sanity tests arose in the minority of cases in which the defendant was given a staff conference in which two or more psychiatrists (evaluators) participated. The defendant's attending psychiatrist would present the history; then the patient would be interviewed in the conference. Following this, the psychiatrists would discuss the case and form their conclusions.

It was interesting to note that, in spite of the pressure for consensus implicit in the practice of sending a single report to the court, there frequently was disagreement among the doctors, and the report sent to the court represented the same sort of compromise that results when an appeals court sits en banc. If the doctors had each submitted individual reports the rate of agreement regarding sanity on a series of defendants would have been perhaps sixty to seventy percent.¹⁰ Since we performed examinations under both *Durham* and ALI, we could compare their effects. It seemed to me that most psychiatrists on the staff applied ALI fairly uniformly: they found a defendant insane only if he were so ill that he suffered a generalized destruction of judgment, or if the illness had, by an effect specific to that illness, led him to commit the specific crime in question.

The *Durham* rule was another matter. Psychiatrists varied widely in their notions of the circumstances which might permit a crime to be considered the product of a disease. Some psychiatrists essentially disregarded the *Durham* rule in favor of the more traditional approach: they only found the crime to be a product of the disease if the disease had destroyed the defendant's capacity to recognize the criminal nature of the

10. The question of the inter-rater reliability of psychiatric diagnosis has been systematically studied. Phillip Ash found that when a team of psychiatrists interviews a patient together in a staff conference setting, there is only fifty-seven to sixty-seven percent chance of any two of them agreeing even as to which broad diagnostic category (e.g., psychosis versus neurosis versus psychopathic personality) best fits the patient. Ash, *The Reliability of Psychiatric Diagnoses*, 44 J. ABNORMAL AND SOCIAL PSYCHOLOGY 272, 276 (1949). M.G. Sandifer, in a similar study, found fifty-seven percent agreement on specific diagnosis and seventy-one percent agreement as to whether the patient was psychotic or not. Sandifer, Pettus & Quade, *A Study of Psychiatric Diagnosis*, 139 J. NERVOUS AND MENTAL DISEASE 350, 355 (1964).

crime or had destroyed his capacity to conform his behavior to the requirements of the law. Others assumed productivity to be present in any defendant whose illness could cause impairment of judgment, no matter how slight. Thus, when a diagnosis of schizophrenia or personality disorder was made, productivity was usually assumed. After all, everything a man does is a product of his personality. And there is a personality diagnosis in the psychiatric nomenclature for almost everyone. Furthermore, those who were psychoanalytic in their orientation were confronted with the psychoanalytic doctrine that everyone is at least a little neurotic, and everyone's neurotic traits determine in part everything he thinks, feels or does. Free will is as alien to psychoanalysis as it is fundamental to legal theory.

Operating without meaningful guidelines from the court as to what sort of concept of causation was really intended by the "product" formulation, doctors sometimes became immoderate in their views. A common experience was that a new doctor on the service would find virtually every defendant insane. Some would actually insist that *anyone* who would commit a felony must be insane. However, after being confronted with the task of trying to manage an unselected group of felons in the hospital following their criminal commitment, the new doctor would reverse tack and become very stringent about finding defendants insane. I found that the nonprofessional staff of the hospital had seen this pattern so often that they expected it of any new doctor. Under the *Durham* rule many doctors felt they could justify a finding of sanity only if they found the defendant to be free of mental illness, so the rate of finding "no mental disorder" would rise when they began finding less insanity in the defendants they examined.¹¹ The secretaries who typed the reports to the court in-

11. It is instructive to note that the service which examined felons found about seventy-five to eighty percent of defendants to have "no mental disorder," whereas the service which examined misdemeanants (who never raised the insanity defense or returned to haunt their examiners) found less than ten percent to have "no mental disorder." D. CHAMBERS, A REPORT ON JOHN HOWARD PAVILION AT ST. ELIZABETHS HOSPITAL 23 (June 4, 1969) (unpublished report submitted to St. Elizabeths Hospital and the National Institute of Mental Health). There probably were more psychotics among the misdemeanants, but the differences between the misdemeanants and felon populations were not nearly as extreme as the reports to the court would indicate. There was a real difference in diagnostic tradition on the two services. This was most clearly demonstrated whenever a misdemeanant was reported as insane and it was subsequently discovered that he was out on bond pending a felony trial. In such a case the district court would be bound to commit the defendant to John Howard Pavilion for a second pretrial examination with regard to the felony. I remember four or five such cases,

formed me that one doctor who had been there before I came had never adjusted to these pressures, and switched every few months from finding everyone insane to finding everyone sane and then back again.

Other extraneous factors also determined some doctors' decisions. Some doctors seemed to have the "policy" that anyone who committed a sex crime was insane. Some doctors tended to find a defendant insane if they felt the hospital could "help" him—or if they felt sorry for him. One psychologist had a racial quirk: though he might find black defendants either sane or insane, he invariably found any white defendant to be insane.

Often the patients committed for treatment filed writs of habeas corpus, alleging that their confinement was "arbitrary and capricious." The phrase stuck in my mind because it described so aptly the process for deciding a defendant's sanity status. When so many doctors had such arbitrary and idiosyncratic standards for determining sanity, the finding for a given defendant depended too greatly upon the specific doctor who was assigned to examine him. It was too much like drawing straws, for you will remember that the great majority of defendants were examined by only one psychiatrist, and his opinion became the verdict of the court.

Therefore, from what I have seen of the *Durham* and ALI sanity tests in action, poor reliability is a major problem with both of them, but it is a far worse problem with the *Durham* test—so much so that I am vastly pleased that it has been abandoned. I might also add that I am even more pleased that the court did not adopt the Wechsler test advocated by Judge Bazelon, for in the large majority of cases which are resolved without a jury trial, it would be one psychiatrist alone, with all his quirks and prejudices and all his brusque confidence in his own professional judgment who would decide whether the defendant could justly be held responsible for his act. Personally, I am appalled at the thought of any one man deciding the issue by such a broad and subjective guideline. The reliability of that test would be even less than that of *Durham*.

THE VALIDITY OF SANITY TESTS

The other criterion for judging a prognostic test is validity. A test has high validity if it predicts what it is supposed to predict. A test

and in all but one, the staff of John Howard Pavilion not only found the defendant sane, but also found no mental illness present.

may have high reliability but poor validity. Such a test would always make the same prediction when applied to the same subject in a brief interval, but the prediction would be wrong.

What is it that a sanity test is supposed to predict? As I stated above, I think that the least a sanity test should be expected to predict is whether it would be disastrous to send a defendant to prison on the one hand or to a hospital on the other. I cannot overemphasize the practical importance of keeping a given defendant out of an institution that is wrong for him. I am sure it takes no effort to imagine the effect of sending a psychotic to a contemporary prison. From time to time when I was at John Howard Pavilion we received prisoners in transfer who had been discovered to be mentally ill while serving time in Lorton Reformatory.¹² The suspicion that the prisoner might be insane usually resulted from a very serious suicide attempt or a series of less serious attempts, or the prisoner could not be made to accept prison discipline by even the most determined efforts of the prison. These latter prisoners were usually transferred directly from solitary confinement, so ravaged by their illness that they were scarcely aware of the punishments the prison had imposed. Furthermore, I have no way of guessing how many other mentally ill prisoners remained in prison in a state of quiet terror, subject to repeated abuse by other prisoners, convinced they would be killed if they ever tried to resist.

It is perhaps more difficult to imagine the disasters that result from sending a sane man to a hospital. I shall attempt to describe some of the disasters I witnessed at John Howard. The patients committed to John Howard Pavilion as not guilty by reason of insanity sorted out into three categories. The first group were psychotic and were not much different from patients in any mental hospital. They did not need to be in a maximum security facility, and I do not believe they needed a criminal court to review their treatment. The second group of patients seemed no different from convicts in prison; indeed, many had long criminal records. Many were "ideological outlaws": professional drug dealers, car thieves, and armed robbers. A few were even involved in organized crime. Many simply lacked the common sense to stay out of trouble though they were not "ideological outlaws." This group of patients had none of the psychiatric diagnoses we usually associate with "insanity." For the most part, they were drug addicts or

12. Lorton Reformatory is the prison facility for convicted felons in the District of Columbia.

problem drinkers, or simply had deviant personalities. They had been found not guilty by reason of insanity as a result of successful malingering or as a result of a quirk in judgment of the psychiatrist who examined them. I honestly do not believe any jury given full information concerning such defendants would find them insane. Finally, the third group of patients were habitual criminals who had coincidentally become psychotic. Their criminal records antedated the onset of their psychoses, and certainly the psychoses were not responsible for their criminal careers. These patients had been found not guilty by reason of insanity because under *Durham* it was almost impossible to say that the crime was not the product of the illness if that illness was of psychotic proportions at the time of the crime. However, in the course of treating such patients it often became apparent that there was a reciprocal relationship between their psychoses and their criminality: recovery from the psychosis might restore full viciousness and cunning to a patient who had been perplexed and docile while psychotic. I particularly remember the case of one young robber who became hallucinated and catatonic while in jail awaiting trial. His cell-mates took advantage of his helplessness by gang-raping him, and when he was transferred to John Howard Pavilion, he was terrified and grieving about having lost his "manhood." After a few weeks of medical treatment his hallucinations, catatonia and helplessness were gone, and a few weeks after that it was discovered that he had taken to initiating new admissions to the ward who were helplessly psychotic by brutalizing and forcibly raping *them*. It struck me as ironic that recovery from psychosis often made such patients into more effective criminals, who would be released when there was finally no illness remaining to inhibit their dangerousness.

If all of this sounds like a perversion of the theory of "productivity" intended in *Durham*, I can only agree, while still pointing out that this was an effect that the *Durham* rule had in actual practice. And in all fairness I suspect such defendants would be handled much the same way under ALI, for the special problem posed by these defendants cannot be dealt with in the narrow context of the relationship between the illness and the single crime currently being prosecuted. The problem only becomes apparent when you examine the relationship between the illness and the defendant's whole criminal career.

From this point on I will artificially simplify the patient population into two groups. For the sake of brevity those patients who resemble ordinary psychiatric patients without criminal involvement will be termed "psychotic" and those patients resembling ordinary convicts in

prison will be referred to as "habitual criminals." (Hospital attendants referred to the same two groups as "sick" and "slick" respectively.)

Now let us return to the disasters that result if a sane man is sent to the hospital. From the above description you may see that in John Howard Pavilion there was no separation of "habitual criminals" from "psychotics," a policy which John Howard himself had advocated as an essential element of humanitarian penal reform. The effect of locking up these two groups together seems much the same in a hospital as in a prison. The "criminals" prey upon the "psychotics": they shake them down for money; they take away their possessions; they frighten them for the fun of it; they force sodomy on them; they give them illegal drugs to watch the antics that result. More indirectly, they force the psychotics to live in a prison atmosphere. Before working in John Howard Pavilion I had been inclined to think that much of the brutality of prison life was imposed upon prisoners by prison staff as part of their punishment. While working at John Howard Pavilion I was surprised to see how much brutality is imposed by the inmates themselves upon each other.

The average ward at John Howard Pavilion had thirty-five patients, who were supervised by three unarmed attendants. Clearly, the attendants were in no position to oppress the patients in any way. Indeed, they had their hands full trying to nip trouble between patients in the bud: negotiating compromises; manipulating collective opinion on the ward into prudent directions; and maintaining a shaky peace. But three attendants cannot keep a constant eye on thirty-five patients, and the "criminal" faction carried on its activities out of sight. It was rumored that the drug traffic in the hospital had a liquid capital of \$1000, and this money did not just lie around. Much of it was employed in gambling, which led to temper outbursts, debts, grudges, and pressure to pay up. Ward inspections regularly revealed that a high percentage of patients had weapons: knives, clubs, brass knuckles, garottes and even occasional firearms. Clearly, the peace of the wards was being maintained in part by a balance of terror, and one might imagine that a new admission would feel pretty panicky until he had obtained a weapon of his own. Indeed, we sometimes discovered worried relatives trying to smuggle weapons in for patients.

With all this illicit activity the need for secrecy was high, and the "psychotic" patients saw and heard things from time to time which they feared they could be killed for repeating. One patient had his

eye put out as a warning to keep quiet about what he knew about the dope traffic on his ward.

Contraband money was also put to good use in the shylocking trade. The going interest rate was said to be twenty-five percent per week. Shylocking had a fringe benefit in that it could function as the "camel's nose" in the process of corrupting an attendant. A one-week loan might tide an attendant over until his next paycheck, especially if, as a special favor, there were little or no interest. If the attendant were called upon for a few little favors in return, he might suddenly find himself in a situation where a group of patients could get together and have him fired by reporting some of the favors he had done for them. And the process could lead from there into frank felony. It was a generally accepted fact that the John Howard Pavilion dope and gambling traffic could not have existed without the assistance of some of the attendants. Although no attendant was caught while I was there, many of them talked quite freely of the corruption problem. One of them objected to a proposed policy of frisking attendants as they came into and out of the building on this basis: "If they did that, the corrupt ones would all quit, and if that happened there would be so few of us left that it wouldn't be safe, and we'd all have to quit." Indeed, the grapevine would sometimes report that the corruption on a given ward had reached such a point that the attendant staff as a body was "owned" by a clique of patients, and for all intents and purposes the "mafia" was running the ward.

I think it is significant that the term "mafia" was sometimes used by the ward attendants to describe the hoodlum element of the patient population, for there was a tendency of the "habitual criminals" on each ward and throughout the hospital to organize. Organization depended on the presence of a "boss": a hoodlum who by ambition and ability would attain a position of leadership over the other "habitual criminals" on the ward and thus direct and coordinate their activities.¹³ A boss' authority over his following was based on personal loyalty, and a certain quality of charisma was an absolute necessity for a boss. The bosses I knew of were all quite intelligent, charming, likeable people who not only made friends easily among the patients,

13. In the narcotics trade for instance, a boss' retinue might include a "bagman" who handled all the money and narcotics, a "corpsman" who administered injections, some "goons" to lean on people, and some "flunkies" for odd jobs. The boss himself might not have to handle either money or drugs or personally resort to violence.

but had also so completely won over at least one member of the professional staff that he was blind to the boss' faults. If a ward had no "criminal" with enough charisma to be a boss, its hoodlum element remained unorganized, and there seemed to be much less illicit activity. However, some bosses were able to utilize the period in the exercise yard to organize or at least penetrate more than one ward. Clearly the hospital would have been much better off without any such bosses, and clearly they had no business in the hospital. Far from being insane by any test, they were not even mentally ill (except for one who was a heroin addict). Indeed, they were highly competent people who were quite successful in their chosen profession of crime.

I have no reason to suspect that the prison atmosphere of endemic brutality that existed in John Howard Pavilion was any different from that in other hospitals for the criminally insane, for it did not result from laxness or incompetence in the hospital staff. It was simply the inevitable result of locking up a group of ideological outlaws in a facility in which the inmates far outnumber their attendants. We all know that such endemic brutality is customary in prisons, though I do not think we ought to condone it. Undesirable as such features are in a prison, they are downright intolerable in a hospital. It is as inhumane to confine hoodlums and psychotics together now as it was in John Howard's day, and I feel there can be no excuse in any legal theory for the perpetuation of this practice.

Still another disaster may occur when a sane man is found not guilty by reason of insanity: he may view himself as being able to escape from justice, and nothing that happens in the hospital is likely to make him less dangerous. He is most likely to be released within two years to resume his career in crime. Statistics tell us that he will probably commit many crimes before being again subjected to an earnest felony prosecution. And when that happens he will have a record of being "criminally insane." The original mistake is likely to be repeated. We had a few such "revolving door" case histories at John Howard Pavilion. One of them used to gloat that the doctor who had originally discovered his "schizophrenia" had handed him a "license to do burglaries" which he had made good use of ever since. He referred to St. Elizabeths Hospital as the "headquarters for my operation." John Howard Pavilion was often characterized by the hoodlums spending time there as "a good camp."

Having reviewed the practical effects of poor validity in a sanity test, let us finally judge the three tests reviewed in *Browner* with regard

to validity. First of all, we should note that the differences in reliability in the tests *will* affect their respective validity. Poor reliability takes precedence over good validity in determining the practical usefulness of a test. Therefore the *Durham* test has probably sent a higher percentage of defendants to the wrong place than the ALI will, *assuming* that the two tests both have good validity.

However, I do not think we can make that assumption. I doubt that these tests are even much good for determining the state of the defendant's mind at the time of the crime, let alone for predicting the best disposition of the case. For there is a basic source of error we have not even considered yet, and that is malingering.

The Problem of Malingering

In all sanity tests presently employed, a crucial step is the examination of the patient by a psychiatrist. The examination he performs is not much different from an ordinary psychiatric evaluation. Now in any medical evaluation the history is by far the most important part. The physical and laboratory examinations taken together are not nearly as likely to contain important findings as is the history alone. In psychiatry the history virtually dominates the evaluation; probably less than five percent of the facts on which psychiatric diagnoses are based come from sources other than the history. However, in the ordinary doctor-patient relationship the history is generally obtained from a patient who in some sense understands that his own interests are best served by trying to report his experiences to the doctor exactly as he remembers them. On the other hand, a defendant receiving a pretrial psychiatric examination in connection with a felony charge generally understands that as a result of that examination he will either be sent to prison for a definite and possibly lengthy period of time, or else he will be sent to a hospital for the criminally insane for an unknown and potentially unlimited period of confinement. He may have a strong preference for one of these two fates. He may have his own theories about how he can get the psychiatrist to send him where he wants to go. The psychiatrist does not necessarily know where the defendant wants to go and he certainly does not know the defendant's theories about insanity. He only knows what the defendant actually has told him. Even if he suspects that a defendant may be malingering, there is not much he can do about it. If a man says he hears voices, who is to say he does not? No one else is supposed to hear them. If a man says he believes

the Communists are taking over the country by replacing people with lookalike robots, who is to say he does not believe it? Likewise, a defendant may deny or simply not mention symptoms that really are present. And the only account the psychiatrist has of what was going on in the defendant's mind when he committed the crime is the account the defendant has provided.

Now I am sure that these objections to the accuracy of pretrial examinations are as old as the insanity defense itself, but let me assure you that I think this problem is very real. The psychiatric histories obtained in pretrial evaluations are quite different from those obtained in "civilian" psychiatry, and I would guess that in perhaps a quarter of the cases I reported to the court, my conclusions were based on significant false data. I believe that malingering *is* done in both directions, and I suspect that mentally ill defendants reporting a negative psychiatric history usually succeed in being found sane. I believe that most forensic psychiatrists have at some point in their careers confronted this general theoretical problem and have resolved it by deciding that the only malingering that exists is that which they detect, and having thus reassured themselves, they proceed to reassure the courts as well. But I myself have seen so much successful malingering that I cannot reassure myself or anyone else on this point.

The Problem of Defining "Mental Disease"

A second major source of impaired validity that affects both *Durham* and ALI is the requirement that to be insane a defendant must have a mental disease. Now you would not think that such a commonsense policy as that could make much mischief, but it certainly does when you try to apply it in practice. The second edition of the *Diagnostic and Statistical Manual*,¹⁴ which is the standard for American psychiatric nomenclature, tries to be comprehensive and provide a diagnostic label to fit anyone a psychiatrist might ever see in his office.¹⁵

14. AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS* (2d ed. 1968).

15. For instance, there are ten different personality disorders, an example of which is "obsessive-compulsive personality," defined as: "This behavior pattern is characterized by excessive concern with conformity and adherence to standards of conscience. Consequently, individuals in this group may be rigid, over-inhibited, over-conscientious, over-dutiful, and unable to relax easily." AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 14, at 43. The diagnosis of "transient situational disturbance" is defined as follows: "This major category is reserved for more or less transient dis-

This is very convenient for filling out insurance forms on patients who are not really sick but just have problems.

But real disputes arise in sanity determinations over the question of whether a particular diagnosis is or is not a "mental disease." As a general rule a court will accept a diagnosis as a "mental disease" if the expert witness says it is. But psychiatrists do not agree at all among themselves as to which of these diagnoses are diseases. Psychiatrists are even less in agreement as to the general definition of what constitutes mental disease, although many psychiatric theorists have opinions on this point. But it sometimes happens in a trial that the psychiatrists agree on the defendant's symptoms and diagnosis, but they disagree as to whether the diagnosis in question is a mental illness. Such cases are not rare, and they would be far more frequent if every defendant were examined by more than one psychiatrist. Since most defendants *are* examined by only one psychiatrist, this issue is usually resolved invisibly by the luck of the draw. Now, to have a sanity verdict be determined by the examining psychiatrist's views on a rather arcane area of abstract psychiatric theory, rather than by the facts (poorly as they may be known) of the defendant's psychiatric history, seems ridiculous to me. And yet the problem appears to have no solution. The following two attempts at solutions have failed:

1) The *McDonald* definition of "mental disease"¹⁶ is far too broad to be of any help with this problem. Indeed, its only purpose seems to have been to broaden the range of testimony about the defendant deemed to be admissible to the jury. But look what happens if we try to apply *McDonald* to the problem of specific diagnoses: Is heroin addiction a "mental disease" under *Durham-McDonald*? I must confess I cannot think of a psychiatric illness that better fits the *Durham-McDonald* definition of insanity. It is the only psychiatric disease that has as one of its typical manifestations an irresistible compulsion to commit crimes. It is the only psychiatric disease in which the impairment of behavior control can be measured: less than five percent of addicts who have been withdrawn and returned to the community are

orders of any severity (including those of psychotic proportions) that occur in individuals without any apparent underlying mental disorders and that represent an acute reaction to overwhelming environmental stress." *Id.* at 48. The Manual cites resentment associated with an unwanted pregnancy as an example of this latter diagnosis.

16. *McDonald v. United States* defines a mental disease or defect to include "any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls." 312 F.2d at 851.

able to avoid readdiction within a year. Voluntary withdrawal from heroin by persons with access to the drug is virtually unknown. Although the disease has little effect on cognitive processes, there is no psychiatric disease that has a greater effect on emotional processes. But in spite of all this, the United States Court of Appeals for the District of Columbia has refused to rule that heroin addiction is a mental disease that could constitute a basis for the insanity defense under *Durham-McDonald*.¹⁷ Each time the court makes a new ruling on this point, the opinion becomes more lengthy, obscure, and the reasoning of the court appears more tortuous and artificial. In the meantime, the trial judges are very straightforward when this issue arises in a trial: "In the District of Columbia heroin addiction is not a 'mental disease' on which an insanity defense may be based." I shall return to the problem of heroin addiction and sanity tests shortly, for I think it helps to show that the problems inherent in the insanity defense are a Gordian knot that cannot be unravelled, but must be split open by radical reforms in the law.

Let me merely add at this point that I do not think the law ought to decide which diagnoses are valid "mental diseases" by any definitional rule or list of permissible or impermissible diagnoses. If the psychiatric profession has not solved this problem yet, the law should also leave it open for dispute.

2) The Court of Appeals seems to feel it has solved the problem by giving the jury overriding authority to decide in the individual case whether a given diagnosis is a "mental illness" or not. I do not agree that this is a satisfactory solution because the vast majority of cases are decided by the examining psychiatrist alone: there is no jury, and the court never asks the psychiatrist about his reasoning in deciding that the diagnosis he made was a valid mental disease.

SHOULD THERE BE AN INSANITY DEFENSE?

Nettlesome as the problems of malingering and of defining "mental illness" are, they constitute only superficial flaws in the practical application of sanity tests. However, there is a more basic flaw that invalidates every conceivable sanity test. It will be remembered that a prognostic test is only valid if it predicts what it is supposed to predict. That means that a sanity test could only fulfill its unique function in deciding the defendant's fate if it were some variant of the following theme: "A

17. See *Gaskins v. United States*, 410 F.2d 987 (D.C. Cir. 1967).

defendant is to be found not guilty by reason of insanity if the court determines that it would be disastrous to send him to prison and furthermore determines that commitment to a psychiatric hospital would be a preferable disposition." Now there never has been and never shall be any sanity test remotely resembling that example, for traditional legal theory requires that a court can only make the decision whether to send the defendant to a hospital or a prison by determining whether, in some theoretical sense, the crime he committed was not *really* a crime. But it is not the crime that is sent to prison; it is the criminal. And the theoretical state of his mind at one single point of time in the past may well be water over the dam by the time the court is faced with the question of where to send him. I can only conclude that the whole traditional theory of the insanity defense (and of criminal commitment as well) is fundamentally invalid.

I do not think there is any way to patch up the insanity defense to make it work well. Instead, another mechanism should be devised to decide whether the defendant should go to a hospital. Speaking as a simple-minded legal layman, it seems to me that a decision about where to send a defendant is properly a part of the presentencing evaluation and ought not to precede the verdict. Suppose a guilty verdict could be taken to mean only that the court had determined that a prohibited deed had been done and the defendant was the one who did it. Then the insanity defense could be abolished. Suppose the theories and procedures of criminal sentencing could be basically revised so that the main purpose of a sentence would be to prevent future crimes rather than to take vengeance for those already committed. Then it could be a simple matter for a court, having found a defendant guilty and in need of psychiatric care, to "sentence" the defendant to a psychiatric hospital. I think it would be much easier to design sentencing statutes and procedures that would keep a defendant from going to the wrong place than to try to solve all the dilemmas inherent in the insanity defense. Furthermore, sentencing reform might better allow us to cope with all of the mistakes that inevitably are made in psychiatric evaluations of legal offenders. Just as parole can be revoked or restored, provision might be made for a "convict" to be transferred from a hospital to a prison, or vice versa, if it became clear that he had been sent to the wrong place. Another unnecessarily restrictive tradition might also be broken down: prison sentences are usually set for a specified period of time whereas hospital commitments are usually indeterminate. I can see potential advantages to a hospital being given

a predetermined period of time in which to rehabilitate a "convict" to the point that he would no longer need supervision by a criminal court. I can also see potential advantages to indeterminate prison sentences.

I might also mention the advantages that might be gained by supplementing sentencing reform with actual prison reform. Unlike sentencing reform, prison reform would cost a lot of money and would require a real commitment on the part of the community. But if prisons were as dedicated to the rehabilitation of their inmates as hospitals are, and if they received as much community support and review as hospitals do, the stark differences between these two types of institutions would begin to fade, and the similarity of their social missions would become more apparent. A "convict" sent by mistake to the wrong institution would suffer much less harm, and intermediary facilities might then arise for those "convicts" who need both prison and a hospital.

The following are examples of two types of defendants that demonstrate the way in which agonizing dilemmas might disappear if the insanity defense were replaced by sentencing reform.

Heroin Addiction: This is clearly a mental illness, but the data now available indicate that psychiatric treatment is ineffective in treating this disease. On the other hand, probation and parole have a very favorable effect on the attainment of stable abstinence.¹⁸ If the contemporary sanity tests were used honestly in actual practice, they would all find heroin addicts insane and deprive them of the experience which would help them the most. Under sentencing reform, addicts could be given probation precisely because that is what works best. If, as now appears likely, methadone maintenance proves still better than parole alone, addicts could be resentenced to require that they participate in such a program.

Sex Offenders: It is often highly debatable whether any given sex offender is mentally ill. Certainly few sex offenders meet the usual criteria for being found not guilty by reason of insanity.¹⁹ Yet the very inadequacy of the prisons for rehabilitation of sex offenders (coupled

18. Vaillant, *A Twelve-Year Followup of New York Narcotic Addicts: The Relation of Treatment to Outcome*, 122 AM. J. PSYCHIATRY 727 (1966).

19. The sexual deviations may determine what kind of offense a deviant commits, but just because an individual's libidinal orientation is deviant does not mean he is powerless to control his sexual impulses. It probably makes no more sense to excuse a homosexual pedophile of molesting a little boy than it does to excuse a rapist of molesting a grown woman.

with the hope that hospital commitment might be a better disposition for them) has led many jurisdictions to pass criminal sexual psychopath statutes to allow for commitment of those offenders who cannot be committed as insane. Sentencing reform could accomplish the same purpose and eliminate the need for special, discriminatory, and somewhat awkward laws to deal with this one type of legal offender.

I would like to conclude by suggesting that the origin of the insanity defense as well as the increasing complexity and unwieldiness it has developed over the years may both be results of the same trend of moral change in our society that could in the end retire the insanity defense altogether. The insanity defense arose out of an unwillingness to punish a man whose offense resulted from a medical affliction. The defense has expanded and raised many problems as our society has developed more and more scruples about punitive sentencing and has become more oriented toward non-punitive rehabilitation. In the course of this trend the death penalty, which was once routine, has become cruel and unusual punishment and has finally been largely abandoned.

It is my hope that this trend will lead to reforms that will allow criminal sentencing to be concerned only with protection of the public and rehabilitation of the offender. As such reforms progress and sentencing begins to offer offenders hope for the future, we will reach a point at which the idea of a criminal sentence as a punishment for the past will seem as cruel and unusual as the death penalty seems now. It will be at that point that the trend which gave rise to the insanity defense will have rendered it obsolete.