

## FROM DURHAM TO BRAWNER, A FUTILE JOURNEY

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*Durham v. United States*,<sup>1</sup> in 1954, was the first major change in the law of criminal responsibility of the mentally ill in this century. I suspect *United States v. Brawner*<sup>2</sup> will be the last such major change. This is not because I believe *Brawner* is such a satisfactory solution to the problems of the mentally ill offender that no further legal progress need occur, but rather that the history of events between 1954 and 1972 demonstrates that these problems are not soluble through manipulation of the legal rules of responsibility.

I think it is fair to say that when Judge Bazelon revitalized the New Hampshire rule of 1869-1871<sup>3</sup> through *Durham*, he was hopeful of also revitalizing the cooperative, understanding, and progressive relationship between psychiatry and the law which those early New Hampshire decisions represented.<sup>4</sup> New Hampshire's Justice Doe, through extensive correspondence with Isaac Ray, the most knowledgeable forensic psychiatrist in the United States,<sup>5</sup> carefully planned both the substance and the strategy of the New Hampshire reform. Evidently Judge Bazelon, like Justice Doe, was convinced that revision of the legal rules of insanity made in accord with the best available psychiatric advice and offering encouragement to the more progressive psychiatric promises of the time would result in real change, change of benefit both to the mentally ill offender and to the society victimized by his irrational behavior.

The purpose of this article is to discuss why such benefits have not materialized from *Durham* and why they should not be expected from

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1. 214 F.2d 862 (D.C. Cir. 1954).

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

3. *State v. Jones*, 50 N.H. 369 (1871); *State v. Pike*, 49 N.H. 399 (1869).

4. Reik, *The Doe-Ray Correspondence: A Pioneer Collaboration In The Jurisprudence of Mental Disease*, 63 YALE L.J. 183 (1953).

5. See Diamond, *Isaac Ray and The Trial of Daniel M'Naghten*, 112 AM. J. PSYCHIATRY 651 (1956), for a description of the crucial role that Ray played in 19th century forensic psychiatry.

*Browner* or other recent modifications of the laws concerned with responsibility of mentally ill offenders.<sup>6</sup>

### THE CHALLENGE THAT WAS *Durham*

Legal reforms assume that either the affected individuals will rise to the challenge of the new law or that the law will, by the power of its authority alone, force the realization of the progress inherent in the legal change. Little of either has occurred as a consequence of *Durham* and there is no reason to believe that *Browner* will fare better.

In a certain sense the medical-psychological treatment of the criminal offender and the punitive-justice system are competing over the destiny of the individual offender. I have little doubt that if either method were clearly superior to the other the competition would have been decided by now and the successful method would have prevailed. To be sure, there are issues other than those of utility. Punishing the criminal is not only for the purpose of moral reform of the offender and to serve as a deterrent to the would-be offender, it also fulfills other needs. It furthers the mythology of justice, creating the illusion that the world is fair. By nurturing emotions of vengeance it furthers social solidarity and protects against the terrifying anxiety that the forces of good might not triumph against the forces of evil after all.

As powerful as these theological notions are, I do not think they would prevent the dominance of *any* system of treatment of the criminal offender, mentally ill or not, that really worked. The failure of *Durham* lay, not in the good intentions of the law, but rather in the inability of psychiatry, both as a body of scientific knowledge and as a profession, to meet the challenge set forth by the *Durham* court. If psychiatry could have fulfilled its promise to the law, there would be no hesitation today as to the appropriate legal rules to permit it to gain priority over the ancient rituals of punishment and revenge.

*Durham* anticipated that the psychiatric expert would be able to accurately differentiate the mentally ill offender who committed his crime as a result of his psychopathology from the mentally sound offender who committed his crime for more normal reasons such as greed, passion or other evil intent. Furthermore, *Durham* anticipated that the expert could communicate the basis for this differentiation with suffi-

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6. Such as *United States v. Wade*, 426 F.2d 64 (9th Cir. 1970); *United States v. Currens*, 290 F.2d 751 (3d Cir. 1961).

cient clarity to permit the trier of fact to make a rational decision, fully taking into consideration the psychiatric evidence, yet not blindly submitting to the authority of the expert.

Neither *Durham* nor any rule of criminal responsibility directly deals with the issue of treatment. A grossly psychotic defendant is to be found not guilty by reason of insanity even if there is no prospect of his successful treatment. An insanity verdict which disregarded treatment prospects made good sense in the days of *M'Naghten* when the sane felon often went to the gallows and the insane were confined in an asylum for the rest of their lives. But with the near abolition of capital punishment and with the expectation that the offender, sane or insane, must someday be released back into the community, the efficacy of treatment becomes a matter of vital importance. It may not be addressed directly, either by the rule of responsibility or by the evidence presented to the jury, but it will surely be taken into account openly or covertly by the legislature or appellate court that is considering legal reform as well as by the trier of fact in rendering a verdict on the individual case.

In short, *Durham*, as does *Brawner* and every other modern rule of criminal responsibility of the mentally ill, expects that the expert can make a precise diagnostic formulation; that he can communicate the basis for that formulation to the trier of fact so that a decision can be made as to whether the defendant is "mad or bad"; and that for those defendants who are found to be "mad," effective treatment can be provided in some sort of non-punitive institution.

#### THE INCONSISTENCY OF PSYCHIATRIC PROGRESS WITH THE REQUIREMENTS OF THE LAW

I submit that today the psychiatrist is unable to perform effectively any of these tasks well; further, that he does them less well now than he did eighteen years ago when *Durham* was adopted; and still further, that he is not going to do better under any variant of the American Law Institute formulation, no matter how legally sophisticated it may be presented. My explanation for this dismal prognostication follows.

Consider first the matter of accurate diagnosis. Psychiatry, as a branch of medicine, shared a need for precision of diagnosis. In medicine, as the fruits of the scientific method became available to the practicing physician, it became imperative that the pathology of the individual patient be exactly defined, that causal agents be detected and

that remedies based upon rational scientific bases be prescribed. Such scientific medicine brought great triumphs such as the virtual eradication of polio and some other dread diseases. The scourge of cancer is yet to be conquered, but no one today doubts that when, and if, it is conquered it will be by scientific medicine and not by art or by faith.

Until relatively recently it was assumed that progress in psychiatry would be along similar lines: first the definition of pathology (that is, the diagnosis), then the discovery of the etiology, and then surely would come the remedy and the prevention. Since 1911, when Bleuler coined the term "schizophrenia" and so brilliantly defined the basic psychopathology of that psychosis,<sup>7</sup> exhaustive research has been conducted throughout the world to further delineate the precise nature of the mental changes underlying this dread illness, and many therapies have been proposed and tried out in practice. Much of value has been discovered by this research and clinical experience, but little of this is useful to the law. If anything, the modern research on schizophrenia adds confusion and uncertainty to questions about which the law demands clarity and definitive answers. The vast amount of information which has been accumulated about the condition called schizophrenia cannot be integrated in such a way as to be helpful, or even understandable, to the law in its dealings with the mentally ill. If anything, the lack of integration of our knowledge can only give the legal mind the impression that nothing is known about this mental disease, if it is a disease. It is not true, of course, that nothing about schizophrenia is known. The difficulty is that we do not know the kinds of facts about it which would be convenient to the determination of the legal definition of criminal responsibility.

Modern research raises doubts as to whether schizophrenia is one disease, or many diseases, or no disease. It may only be a condition, probably an abnormal condition, but conceivably a normal variation of human response to stress. There may be associated biochemical and physiological abnormalities which may or may not be significant. There certainly are profound abnormalities of thought and feeling process. Yet these abnormalities may fluctuate to such a degree that they elude clinical detection. Predictions of outcome are possible for statistical groups but have little reliability for the individual with whom the law is concerned.

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7. E. BLEULER, *DEMENTIA PRAECOX ODER GRUPPE DER SCHIZOPHRENEN* (1911) (4. Abteilung, 1 Hälfte).

Although the behavioral manifestations of schizophrenia can be grossly obvious, the disorders of thought and feeling behind those behavioral patterns may involve only the most subtle deviations from the normal, deviations which may be very difficult to describe convincingly to the layman. If the schizophrenic defendant is grossly psychotic with delusions and hallucinations, there will be agreement among the experts as to the diagnosis (but not necessarily as to his legal responsibility). But grossly psychotic persons are seldom the focus of legal controversy. The so-called "borderline schizophrenic" may be intuitively regarded by the experienced psychiatrist as the sickest of all. Yet the subtlety of the psychopathology and its seeming irrelevance to the legal issues at trial usually makes it impossible to convince the jury that the defendant is not mentally sound.

What has been said about schizophrenia may be reiterated for other conditions, especially the character disorders. Here the clinical delineation of the disorder, if it be a disorder and not a normal variant, is even more blurred than in the case of schizophrenia. There is little expert agreement as to the nature of even the most flagrant cases. Some psychiatrists regard such conditions as moral problems having nothing to do with medicine or psychiatry<sup>8</sup> and others believe certain character disorders may be a serious mental illness allied to the major psychoses.<sup>9</sup> There is some evidence, which cannot be disregarded, that the poor impulse control and violent behavior associated with certain character disorders may be the consequence of abnormal brain rhythms and other brain pathology.<sup>10</sup>

As a general trend in psychiatric practice in the eighteen years between *Durham* and *Brawner*, there is much less interest in the definitive diagnosis of the mental patient. Many psychiatrists of recent training believe (incorrectly, I think) that the diagnosis doesn't matter, that efforts to classify and categorize dehumanizes the therapeutic process and obscures the "real" psychological events. Diagnoses may be regarded as merely labels and mental disease as existing only by virtue of the labels which are attached to persons who are then compelled to live up to the labels. The label may be applied not for the pur-

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8. T. SZASZ, *THE MYTH OF MENTAL ILLNESS* (1961).

9. H. CLECKLEY, *THE MASK OF SANITY* (4th ed. 1964).

10. V. MARK & F. ERVIN, *VIOLENCE AND THE BRAIN* (1972); Henry, *Positive Spike Discharges in the EEG and Behavior Abnormality*, in *EEG AND BEHAVIOR* 315 (G. Glaser ed. 1963).

poses of explaining or communicating the nature of the illness but rather for the purpose of manipulating the recipient of the label as an "instrument of social action."<sup>11</sup>

The above discussion of the modern uncertainties of psychiatric practice may be countered by the argument that the law is not concerned with diagnosis and with what is and what is not a mental disease by clinical standards. Because of the intense controversy over just these issues which developed out of *Durham*,<sup>12</sup> there evolved *McDonald v. United States*,<sup>13</sup> which provides a legal definition presumably independent of the vagaries of the individual psychiatric expert or of classification systems:

[A] mental disease or defect includes any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls.<sup>14</sup>

*Browner* makes it specifically clear that the *McDonald* definition is still applicable.<sup>15</sup> This is a good definition and I approve of it, not only for legal purposes but for clinical use as well. But it does not solve the problem of contemporary psychiatric confusion. Unless the psychiatric expert can testify as to exactly what condition the defendant suffers from and can give a particular description of the manner in which the abnormality affects those mental and emotional processes *relevant to the criminal act*, he will have no credibility before the jury. However, the psychiatric expert, if he is scrupulously honest, can seldom so testify. His evidence should rather sound something like this:

I think, but I am not certain, that the defendant has a mental disease, or an abnormality, or what merely may be a normal variation, which has substantially affected his mental or emotional processes in ways which I find difficult to understand and explain to you and this has possibly, but maybe not, substantially affected his behavior controls in ways which could be, but are not necessarily, relevant to the criminal act of which he is accused and which, as yet, I am not even sure he has committed.

If this is the true expert opinion, it will have little significance to the jury no matter how it is fleshed in with clinical details. I submit

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11. Regrettably, I have forgotten who originated this excellent phrase.

12. See *Blocker v. United States*, 288 F.2d 853, 857-62 (D.C. Cir. 1961) (Burger, J., concurring).

13. 312 F.2d 847 (D.C. Cir. 1962).

14. *Id.* at 851.

15. *United States v. Browner*, 471 F.2d 969, 983 (D.C. Cir. 1972).

that *Browner* does not remedy this difficulty even with its inclusion of the *McDonald* definition. The problem is psychiatric, not legal.

I have written elsewhere about the law's quest for certainty and its dismay over the uncertainty of the psychiatrist, usually expressed in the pontification that psychiatry is not yet an "exact science."<sup>16</sup> Paradoxically, the present confusion of psychiatry in regard to some of its most basic tenets has resulted from the greatly accelerated increase of scientific knowledge about mental illness. In medicine, as in all science, certitude often reflects dogma and lack of valid information. The psychiatry of the 1970's is well advanced over that of the 1950's, but it is less usable by the law. I predict the evidentiary value of psychiatric testimony will become less, rather than more, credible in the coming decades as further increase in knowledge adds to the confusion.

#### THE RELUCTANT PSYCHIATRIST

Another problem not solved by *Browner* is the reluctance of competent, well-trained psychiatrists to involve themselves in the legal system. Those of us who write and talk a lot about law and psychiatry and who are directly related to the teaching of psychiatry in the law schools seldom go to court. Forensic psychiatry is much more interesting and less traumatic to the ego when practiced from the armchair rather than from the witness chair. In the period between *Durham* and *Browner* there has been no increase in the number of well-qualified psychiatrists who are willing to serve as experts, and there continues the widespread use of grossly incompetent pseudo-experts who are brought into the courtroom by cynical attorneys who have no faith in their witness's testimony but are quite willing to use them for whatever effect they may have on the jury. For example, in a certain jurisdiction in California, I know of a physician who is crudely incompetent in his willingness to make snap psychiatric judgments accommodating to the prosecution. The local district attorney is openly contemptuous of this pseudo-psychiatrist and privately gives his opinions no credibility. But, at the same time, he frequently employs him to examine a defendant immediately after apprehension, knowing that an opinion resulting from an examination as soon as possible after the commission of the crime carries greater weight with the jury.<sup>17</sup>

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16. Diamond, *The Scientific Method and the Law*, 19 HASTINGS L. REV. 179, 194 (1967).

17. The widely held belief that the sooner a defendant is examined after commis-

There are a number of reasons why the competent psychiatrist so willingly leaves forensic psychiatry to his more dubious colleagues. Service as an expert witness is often damaging to one's self-esteem, it is almost always poor public relations, it usually requires learning a whole new set of concepts and values, and it often does violence to the intimate therapist-patient relationship.

The law presumes that the expert witness is detached, impartial, objective and unconcerned with the outcome of the case at bar. To further such objectivity, *Washington v. United States*<sup>18</sup> prohibited the expert from giving an opinion as to the existence of mental disease or defect and whether the alleged criminal act was the "product" of such mental disease or defect since these are the ultimate issues which must be decided by the trier of fact without benefit of expert opinion. Fortunately, this unsound restriction on expert testimony has been alleviated by *Brawner*.<sup>19</sup> Such detachment is more appropriate to the forensic pathologist than to the psychiatrist. Most psychiatrists conceive their primary role as therapist, and their loyalty is to their patients. To have another human suffer as a consequence of one's objective testimony is not compatible with the healing function of the physician. Some of us, even though we do forensic work, feel so strongly about this that we will refuse to testify if our testimony will not aid the defendant in a criminal trial. This does not mean that we will testify for the defendant if the psychiatric findings do not warrant such testimony or that we are in any way dishonest in our testimony; we just do not wish to become involved if our testimony will be hurtful to another.

I have suggested the principle (which I know to be legally unsound, but which I believe to be medically correct) that psychiatric expert testimony should be reserved exclusively for the defense in criminal trials. Let the prosecutor prove sanity or other elements of the requisite mental state required by the definition of the crime by the use of

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sion of the crime, the more valid is the appraisal of his mental state is not necessarily true. In my experience, it often requires considerable distance in time from the criminal act to gather the information which is necessary to accurately evaluate the mental state of the defendant. Also, time lends perspectives which may be obscured by events surrounding apprehension of the defendant. His fear and distrust at the time of apprehension may prevent him from revealing much about his mental state. Opinions emphasizing the defendant's "objective" appearance may be incorrect and misleading.

18. 390 F.2d 444 (D.C. Cir. 1967).

19. *United States v. Brawner*, 471 F.2d 969, 1005-07 (D.C. Cir. 1972).



non-expert witnesses or by the circumstances of the crime. Such a procedure would eliminate the troublesome battle of the experts as well as being more compatible with the psychiatrist's role as healer. I have no expectation that this suggestion will be adopted by any court.

#### PSYCHIATRIC TREATMENT OF THE OFFENDER

The role of the psychiatrist in the treatment of the criminal offender, mentally ill or not, is still uncertain, and the progress which was anticipated by *Durham* and other reforms of the criminal law of responsibility has not materialized. Some institutions for the criminally insane remain like medieval dungeons, unfit for human habitation and degrading to inmate and staff alike.<sup>20</sup> Others appear clean and modern and less crowded, but the treatment programs tend to be superficial, routinized, and often administered by untrained, inexpert personnel with little consideration of the particular therapeutic needs of the individual. Poorly conceived treatments, such as psychosurgery, are sometimes recommended, which results in justifiable storms of protest over the ethical issues involved in such experimentation. Institutions may retreat in the face of such public protest and reduce what few appropriate treatment programs are in effect.<sup>21</sup>

There is as yet no thoroughly reliable psychiatric treatment method which can be applied to the mentally ill offender and which can ensure both his rehabilitation and the safety of society. Much additional research and experimentation with a diversity of potentially useful methods is required. But grave doubts arise as to the ethical propriety of applying experimental treatments to captive, coerced subjects who are in no position to give informed consent.<sup>22</sup>

Despite the great public concern over the rising crime rate there is not a corresponding interest in the research and development of psychiatric treatment programs for offenders. It is my impression that there is somewhat less tendency now than there was in 1954 to regard crime as a psychiatric problem, to be remedied by treatment methods. Much of the federal funding which has become available in recent

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20. See Wiseman's documentary movie, *Titticut Follies*. See *Wyatt v. Stickney*, 344 F. Supp. 73 (M.D. Ala. 1972); *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971).

21. *San Francisco Examiner and Chronicle*, March 12, 1972, at 16, col. 1.

22. NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, *THE INSTITUTIONAL GUIDE TO HEW POLICY ON PROTECTION OF HUMAN SUBJECTS 2* (1971).

years as a consequence of public alarm over crime has gone into hardware and is concerned only with apprehension and custody of the criminal, not his treatment.

A source of special difficulty is the problem of integrating treatment of the patient who requires legal custody with the more progressive treatment programs of the community mental health movement. These community programs emphasize voluntary participation, open door hospitals, out-patient clinics and avoidance of isolation of the patient from the community. A patient who is defined as dangerous and whose custody must be secured because of his legal status does not fit into such a community program. Hence, treatment of such patients is expected to take place in an old-fashioned maximum security hospital or in a prison. It is very difficult to adequately staff such institutions and many psychiatrists believe that the authoritarian atmosphere inherent in such organizations precludes successful treatment even if adequate staff were available. In any event, there is little in the United States to compare with the small, expensive, intensive treatment institutions which exist in some European countries.<sup>23</sup>

The day is long gone when the public saw psychiatry as the panacea for whatever ails the individual and humanity. The medical model of treatment has serious limitations when applied to social problems and whatever may be the future solutions to problems of crime and control of the criminal, I do not expect the psychiatrist to play the dominant role. Accordingly, the differentiation of the morally responsible sane offender from the nonresponsible mentally ill offender may not be the critical issue that it has been in the past.

#### THE LIBERTARIAN POSTURE

There are several different postures which one might take toward the failure of psychiatry to provide a viable program of treatment and rehabilitation for the mentally ill offender. There is the iconoclastic position psychiatrist Thomas Szasz has expressed in his many writings.<sup>24</sup> In Szasz's view mental illness (with some few exceptions) is not conceptualized as a disease in any medical sense of that term, but

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23. See, e.g., G. STÜRUP, *TREATING THE UNTREATABLE, CHRONIC CRIMINALS AT HERSTEDVESTER* (1968).

24. LAW, LIBERTY AND PSYCHIATRY (1963); PSYCHIATRIC JUSTICE (1965); THE MANUFACTURE OF MADNESS (1970); IDEOLOGY AND INSANITY (1970); and many journal and magazine articles.

rather as maladaptations often reflecting deficiencies in character and moral responsibility. Particularly, he believes justice should be blind, making no distinction between the mentally ill or defective and the normal—all should be held to the same standard of responsibility. According to Szasz, psychiatric treatment in any form other than purely voluntary, privately sought therapy engaged in solely for the benefit of the individual represents an intolerable tyranny of the “therapeutic state.”<sup>25</sup> This is a very seductive solution, appealing alike to the liberal who is concerned about individual liberties and to the ultra-conservative who sees psychiatry as mitigating the strictness of the criminal law, a law which he believes is already too indulgent to the offender. Further, Szasz’s scheme should be easy to put in operation: psychiatrists should withdraw completely from participation in any aspect of the criminal justice system, and the law should abandon all recognition of mental or emotional disorder as relevant to the determination of responsibility and the subsequent disposition of the offender. Although I believe Szasz’s “myth of mental illness” thesis to be scientifically and professionally unsound,<sup>26</sup> Szasz has, nevertheless, raised such serious questions relevant to the use of psychiatry by the law that one can never retreat back to the hopeful and somewhat naive days of *Durham*. I had hoped that *Browner* would give particular attention to these libertarian issues. However, the court makes it clear that any truly radical solutions, such as abolition of the insanity defense altogether, is a matter for legislative rather than judicial action, and does not consider the related questions further.<sup>27</sup>

#### SOCIAL FACTORS AS EXCULPATING

Another possible response to the limitations of psychiatry, as experienced by the criminal justice system, would be to broaden the perspective of the law, yet still retain the concept of exculpation and mitigation toward those who are less capable than the normal person to exercise the free will which the law insists is the basis of all criminal justice. Thus, the law could be “demedicalized” (to coin a word) by extending legal exculpation to all those persons who *for any reason* lack the ability to make a free, rational, responsible decision when faced

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25. T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY* 216 (1963).

26. Diamond, Book Review, 52 CALIF. L. REV. 899 (1964) (review of T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY*).

27. *United States v. Browner*, 471 F.2d 969, 985 (D.C. Cir. 1972).

with the temptation or impulse to commit a crime. Such exculpatory reasons might well include poverty, continued unemployment, chaotic living conditions, such as that associated with ghettos, and other social and environmental detrimental factors which could impair an individual's powers of free will without necessarily resulting in a disease or mental abnormality. Thus, proper attention could directly be given by the law to cultural deprivation and other external factors which override the individual's capacity for free choice.

*Brawner* does acknowledge that social and cultural determinants are relevant to the issues of criminal responsibility, but only insofar as they result in an "abnormal condition of the mind."<sup>28</sup> Thus, all such evidence of social and cultural abnormality must be filtered through the medical funnel of mental abnormality (at best a synthetic construct and statistical abstraction), regardless of the *McDonald* definition.<sup>29</sup> The court asserts:

Our recognition of an insanity defense for those who lack the essential, threshold free will possessed by those in the normal range is not to be twisted, directly or indirectly, into a device for exculpation of those without an abnormal condition of the mind.<sup>30</sup>

Such a statement is an open invitation to indulge in the invidious semantic quibbling that has characterized so much forensic psychiatry in the past. The expert may simply assert that, in his view, lack of the power of free will by the defendant is proof in itself of mental abnormality; that mentally normal persons are presumed to have the power of free will, *ergo*, this defendant who has been shown to lack free will because of, let us say, cultural deprivation, is by definition mentally abnormal, for he is deficient in one of the essential elements of mental normality. This is simply not a good way to deal with such a fundamental and controversial issue. When the court states

Finally, we have not accepted suggestions to adopt a rule that disentangles the insanity defense from a medical model, and announces a standard exculpating anyone whose capacity for control is insubstantial, for whatever cause or reason.<sup>31</sup>

it has not clarified the role of social, cultural and environmental factors in exculpating from responsibility. But it does thwart the further

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28. *Id.* at 995.

29. See text accompanying note 13 *supra*.

30. *United States v. Brawner*, 471 F.2d 969, 995 (D.C. Cir. 1972).

31. *Id.*

“demedicalization” of the whole issue of criminal responsibility and so deprives the law of one possibly satisfactory direction for reform.

#### VETERANS OF THE WAR AGAINST CRIME

Another possible response to the limitations of the medical-psychiatric approach to the offender, especially to the problem of the probable incompatibilities of custodial confinement with its inevitable punitive implications and the rehabilitative needs of the offender, is to drop all pretense that rehabilitation can be accomplished within a custodial institution. Instead, a system of sequential, rather than simultaneous, custody, punishment and reformatory treatment could be introduced.

I have long been convinced that one of the major obstacles to the success of treatment programs within maximum security institutions, for both the mentally ill and the mentally sound, is the prevailing attitude of hypocritical cynicism, shared by inmate and staff alike. The official posture of such an institution is that the institutional mission is therapy. To the inmate the impact of the institutional experience may be solely that of deprivation and punishment. Yet the inmate quickly learns that he must give lip service to the therapeutic process if he is ever to be released. And so a complex confidence game results, in which the staff administers treatments which they know full well to be ineffective and inadequate to inmates who are quite aware that they are not being treated but are undergoing punishment. If either staff or inmates protest or otherwise acknowledge this hypocritical, phony situation, there may be severe consequences. The staff member may find himself in a more difficult, less rewarding position, and the inmate may be labeled as uncooperative or even incorrigible and untreatable.

A simple solution could be devised: the offender, sane or insane, would be confined, under as humane conditions as possible, for whatever fixed term is deemed appropriate to protect society against his potential danger and which meets the public standards of elementary fairness. Having served his term, the former offender could then be regarded as a veteran of the war against crime, and like other veterans would be entitled to benefits for the purpose of making restitution for the damage done to him by his involuntary institutionalization and to facilitate his restoration back into the community as a functioning citizen. Such benefits might include monetary compensation, educational

and vocational training, and job placement, as well as medical and psychiatric treatment. Such benefits would be very real, and not just hypocritical gestures, for the recipient would be free from custody and punishment, living in his own community, and participating voluntarily. I believe that such a system of benefits might become acceptable to the public conscience if there were also comparable, or greater, restitutive benefits to the victims of crime.

Such radical solutions as here discussed are, of course, not properly subject to judicial decision of the nature of *Browner*. However, such imaginative possibilities should be studied by all those who might have some influence on the future course of the laws concerned with criminal responsibility.

#### THE AMERICAN LAW INSTITUTE CAVEAT

I am totally bewildered by the *Browner* court's attitude towards the caveat paragraph of the ALI rule, the notorious section 4.01 of the Model Penal Code.<sup>32</sup> Intended to exclude the "psychopathic personality" from the benefits of a liberalized rule of insanity,<sup>33</sup> repudiated by the three psychiatrists who participated in the formulation of the ALI rule,<sup>34</sup> and recently rejected by two federal circuits,<sup>35</sup> *Browner* indulges in the most extraordinary quibbling about this. The logic of the court's "pragmatic solution"<sup>36</sup> to include the caveat paragraph as a rule for application by the judge, but not for inclusion in instructions for the jury, escapes me. The court requires that:

The introduction or proffer of past criminal and anti-social actions is not admissible as evidence of mental disease unless accompanied by expert testimony, supported by a showing of the concordance of a responsible segment of professional opinion, that the particular characteristics of these actions constitute convincing evidence of an underlying mental disease that substantially impairs behavioral controls.<sup>37</sup>

This requirement seems to mean that not only must there be expert testimony at the trial, but there must be additional expert testimony

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32. *Id.* at 992-94.

33. *Id.* at 993.

34. Freedman, Guttmacher & Overholser, *Mental Disease or Defect Excluding Responsibility, a Psychiatric View of the American Law Institute: Model Penal Code Proposal*, 118 AM. J. PSYCHIATRY 32 (1961).

35. *Wade v. United States*, 426 F.2d 64 (9th Cir. 1970); *United States v. Smith*, 404 F.2d 720 (6th Cir. 1968).

36. *United States v. Browner*, 471 F.2d 969, 994 (D.C. Cir. 1972).

37. *Id.*

as to the "expertness" of the original expert testimony. Or does this requirement mean that the psychiatric expert must bring into court volumes of psychiatric journals and textbooks verifying that a "responsible segment" of his colleagues agree with him?

The *Browner* court's equivocation, as exemplified by its comments on the ALI caveat, typifies to some extent the quality of the entire decision. Granted, a remodeling of *Durham* was long overdue, but when the Court of Appeals could have responded with bold, incisive strokes, it produced only indecisive, equivocal and timid changes which will not make any practical difference and will only add to the general confusion surrounding the insanity defense. This is well summarized by Chief Judge Bazelon, in his concurring opinion:

I fear that it can fairly be said of *Browner*, just as it should be said of *Durham*, that while the generals are designing an inspiring new insignia for the standard, the battle is being lost in the trenches.<sup>38</sup>

#### DIMINISHED RESPONSIBILITY (CAPACITY)

For the first time in the District of Columbia, recognition is given to the so-called "diminished responsibility" defense.<sup>39</sup> The inadequacies of *Fisher v. United States*<sup>40</sup> are acknowledged and the *Browner* court thoroughly disposes of the misconceived idea that the Supreme Court's affirmation of *Fisher* prohibited the adoption of the diminished responsibility defense.<sup>41</sup>

But here too, the Court of Appeals was unable to avoid its tendency to equivocate. It accepts the relevance of psychiatric evidence of impairment of capacity to premeditate and deliberate and so reduce what would otherwise be first degree to second degree murder, but it does not apply the same principle to capacity for malice, reducing murder to manslaughter. Here, as elsewhere in the *Browner* decision, the court does not come to grips with the real issues, and much of the extensive discussion which permeates this decision seems strangely irrelevant to the critical problems to which the court addresses itself. Surely, if the D.C. Circuit Court wished to adopt a doctrine with such far-reaching consequences as the diminished responsibility (or capacity) defense, it should have approached that subject in a more sophisticated

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38. *Id.* at 1012 (Bazelon, C.J., concurring).

39. In California this is usually referred to as the diminished capacity defense.

40. 149 F.2d 28 (D.C. Cir. 1946).

41. *United States v. Browner*, 471 F.2d 969, 998-1002 (D.C. Cir. 1972).

manner, rather than dismissing it as "a matter that requires further analysis and reflection."<sup>42</sup>

Experience with the diminished responsibility (or capacity) defense has been extensive in England and in California,<sup>43</sup> and indicates that this defense does not just supplement the insanity defense, but tends to supersede it, since it offers what may well be a much more rational solution to the problem of the mentally ill offender.<sup>44</sup>

### CONCLUSION

*Brawner* is proof, in itself, of the failure of *Durham*. But Judge Bazelon is entirely correct when he says:

*Durham* was designed to throw open the windows of the defense and ventilate a musty doctrine with all of the information acquired during a century's study of the intricacies of human behavior. It fueled a long and instructive debate which uncovered a vast range of perplexing and previously hidden questions. And the decision helped to move the question of responsibility from the realm of esoterica into the forefront of the critical issues of the criminal law.<sup>45</sup>

As such it will long remain as one of the great milestone decisions of the criminal law.

I fail to see that *Brawner* will have much historical significance other than marking the end of *Durham*. It adds nothing that is truly new to the law, it blazes no new paths, it perpetuates much that is uninspired and mediocre. It is full of compromise and equivocation, and fails to remedy the problems which *Durham* valiantly, if unsuccessfully, struggled to resolve. It seems likely that these problems are not soluble by such simplistic devices as reformulations of the rules of criminal responsibility. But it required eighteen years experience with *Durham* to demonstrate fully that this is so. *Brawner* does not

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42. *Id.* at 1002 n.75.

43. See *People v. Conley*, 64 Cal. 2d 310, 411 P.2d 911 (1966); *People v. Wolff*, 61 Cal. 2d 795, 394 P.2d 959 (1964); *People v. Gorshen*, 51 Cal. 2d 716, 336 P.2d 492 (1959); *People v. Wells*, 33 Cal. 2d 330, 202 P.2d 53 (1949); English Homicide Act, 5 & 6 Eliz. 2, c.11, § 2(1) (1957).

44. See Cooper, *Diminished Capacity*, 4 LOYOLA U.L. REV. 308 (1971); Diamond, *Criminal Responsibility of the Mentally Ill*, 14 STAN. L. REV. 59 (1961); Hasse, *Keeping Wolff from the Door: California's Diminished Capacity Concept*, 60 CALIF. L. REV. 1641 (1972).

45. *United States v. Brawner*, 471 F.2d 969, 1010 (D.C. Cir. 1972) (Bazelon, C.J. concurring).



seem to give proper recognition to the lessons to be learned from this experience, and it fails to address the real problems of the criminal law: how to combine compassionate attitudes towards the mentally ill with the urgencies of societal protection; how to respect and enhance the rights of the individual, protecting him against the unrestricted authority of the state as well as from the call for vengeance by the inflamed and fearful public, yet still enunciate a principle of fairness and justice.