THE DURHAM RULE IN ACTION

Judicial Psychiatry and Psychiatric Justice

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EXERCISING ITS RIGHT to frame a new standard of criminal responsibility,[1] the United States Court of Appeals for the District of Columbia declared in *Durham v. United States:* "An accused is not criminally responsible if his unlawful act was the product of mental disease or defect." [2]

AUTHOR'S NOTE: *The author is grateful to Professor Harold D. Lasswell of Yale University, Professor Jackwell Susman of George Washington University and Dean J. E. Richardson of the National University of Australia, who have read the manuscript and provided comment, criticism and suggestions. They are of course to be absolved from the limitations of the work.*

1. The United States Court of Appeals for the District of Columbia is entrusted with the formulation of a test of criminal responsibility to be applied in the District. Durham v. United States, 214 F. 2d 862, 874 (D.C. Cir. 1954); Fisher v. United States, 328 U.S. 463, 476–77 (1945).

2. Durham v. United States, *supra* at 874–75. In developing its basic theme the Court of Appeals further states:

> The legal and moral traditions of the western world require that those who, of their own free will and with evil intent (sometimes called *mens rea*), commit acts which violate the law, shall be criminally responsible for those acts. Our traditions also require that where such acts stem from and are the product of a mental disease or defect as those terms are used herein, moral blame shall not attach, and hence there will not be criminal responsibility. *Id.* at 876.

As stated, the Durham Rule does appear at first glance as "a peculiar mixture of Aristotelian Faculty Psychology, Metaphysics, Mysticism, and Medieval Theology." See C. Savage, *Discussion*, 116 AM. J. PSYCH. 295, 296 (1959).

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Mental disease or defect remained undefined by the court beyond the statement that disease connoted "a condition which . . . [was] capable of either improving or deteriorating" and that defect connoted "a condition which . . . [was] not considered capable of either improving or deteriorating." [3] The jury was thereafter no longer required to depend on artificial or arbitrarily selected symptoms derived from a more primitive age, but was to be guided instead by "wider horizons of knowledge." [4] As expressed by Judge Bazelon for the court: "The question will be simply whether the accused acted because of a *mental disorder,*

Until the Durham case, the District of Columbia was governed by the *M'Naghten Rules* and the "irresistible impulse" test.

The *M'Naghten Rules* provided that it "must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong." M'Naghten's case (1843), 8 E.R. 718. The *M'Naghten Rules* have been supplemented by the irresistible impulse test in the District of Columbia. That doctrine, as stated by the Court of Appeals, is that the degree of insanity which will relieve the accused of the consequences of a criminal act must be such as to create in his mind an uncontrollable impulse to commit the offense charged.

> This impulse must be such as to override the reason and judgment and obliterate the sense of right and wrong to the extent that the accused is deprived of the power to choose between right and wrong. . . . The accepted rule . . . is that the accused must be capable, not only of distinguishing between right and wrong, but that he was not impelled to do the act by an irresistible impulse, which means . . . that his reasoning powers were so far dethroned by his diseased mental condition as to deprive him of the will power to resist the insane impulse to perpetrate the deed, though knowing it to be wrong. Smith v. United States, 36 F. 2d 548, 549 (D.C. Cir. 1929).

Significantly, upon the introduction of "some evidence of insanity" the burden devolved upon the Government to prove sanity beyond reasonable doubt if it was to secure a conviction. See Davis v. United States, 160 U.S. 469 (1895).

3. Durham v. United States, *supra* at 876.

4. *Id.* at 875. It is questionable whether the Durham Rule, as thus stated, represents any significant innovation. Cognition need not be the only criterion of culpability under an enlightened interpretation of the rules of M'Naghten's case (1843), 8 E.R. 718.

See, *e.g.*, People v. Schmidt, 216 N.Y. 324, 110 N.E. 945 (1915); Stapleton v. The Queen, 86 Commw. L.R. 358 (Aug. 1, 1952). Dr. Frederic Wertham has made the point in these words:

> Judge Bazelon's . . . conclusion is . . . based on . . . psychiatric vagaries. . . . He substitutes a new test for the *M'Naghten* rules. In essence it requires that the plea of legal insanity must be based on a demonstration that the crime was the product of mental disease. If he had had better psychiatric advice, Judge Bazelon would have known that this is precisely how the *M'Naghten* rule has been interpreted in practice by experienced psychiatrists. F. Wertham, *Psycho-authoritarianism and the Law,* 22 U. CHI. L. REV. 336 (1955).

For a more recent demonstration of the susceptibility of the M'Naghten Rules to enlightened psychiatric usage see F. WERTHAM, A SIGN FOR CAIN 229–86 (1966).

and not whether he displayed particular symptoms which medical science has long recognized do not necessarily, or even typically, accompany the most serious *mental disorder.*" [5]

The manifest content of Durham jurisprudence has—since 1954—reflected a hodge-podge of purposes.[6] In the first flush of exuberance, Durham case law reflected the broadest possible expansion of the concept of exculpatory mental illness. The "right-wrong" test was viewed as inappropriate—at least as the sole determinant of criminal responsibility.[7] Reliance upon cognition was declared hazardous if not misleading. Traditional conceptions of insanity were derided as phrenological nonsense.[8] Impelled by "broader horizons of knowledge" the court later declared: "The assumption that psychosis is a legally sufficient mental disease and that other illnesses are not is erroneous." [9]

Dealing with the problem raised by the inherent ambiguity of what is or is not mental disease or defect productive of crime, the court declared that productivity need be judged solely in terms of a necessary or critical causal relationship between mental disease or defect on the one hand and criminal behavior on the other. This relationship did not, as seen by the court, mean that the act under scrutiny must be "a direct emission, or a proximate creation, or an immediate issue of the disease," but rather that the "relationship between the disease and the act, . . . *whatever it may be in degree,* . . . be . . . critical in respect to the act." [10]

In this process, the court evinced a partiality toward what appeared to be a psychoanalytically oriented account of human behavior. Label-pinning, suggestive of organic psychiatry, was to be avoided. As explained in *Carter v. United States:*[11]

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5. Durham v. United States, *supra* at 876 (emphasis supplied).

6. For a good description of evolving *Durham* doctrine see A. Krash, *The Durham Rule and Judicial Administration of the Insanity Defense in the District of Columbia,* 70 YALE L.J. 905 (1961).

7. See Durham v. United States, *supra* at 869–74.

8. *Id.* at 867.

9. Biscoe v. United States, 248 F. 2d 640, 641 n. 2 (D.C. Cir. 1957).

10. Carter v. United States, 252 F. 2d 608, 616, 617 (D.C. Cir. 1957) (emphasis supplied).

11. *Id.* at 617. Dr. Thomas Szasz observed that, absent a clear and objective finding of crime, not provided for under Durham jurisprudence, such "description and explanation" was not psychoanalytic but pseudo-psychoanalytic in character. He referred to Freud's strictures on the psychiatric mismanagement of testimony in the Halsman case. SZASZ, LAW, LIBERTY AND PSYCHIATRY 104–05 (1963). Cf. United States v. Arduini,

> Description and explanation of the origin, development and manifestations of the alleged diseases are the chief functions of the expert witness. The chief value of an expert's testimony in this field, as in all other fields, rests upon the material from which his opinion is fashioned and the reasoning by which he progresses from his material to his conclusion; in the explanation of the disease *and its dynamics*, that is, how it occurred, developed and affected the mental and emotional processes of the defendant . . .

The value of psychiatric testimony lay—in brief—in a mastery of the defendant's life history. Thus, the court expressed its dissatisfaction with the quality of psychiatric testimony in the case of two defendants in these terms: "We know nothing of their childhood, their emotional states, the major events of their lives, their day-to-day behavior, their personalities, their own explanations for their behavior." [12]

Notwithstanding these brave new insights, the court intended to provide treatment for the beneficiary of the insanity defense exclusively upon an intra-mural basis—and specifically within the confines of St. Elizabeths Hospital. It directed that the patient be detained until he had shed all manner of "abnormality" which suggested danger to society. In so doing it scrapped the rule enunciated by the Congress which permitted the detention of the patient only until such time as he had recovered his "sanity" and demonstrated his lack of dangerousness.[13]

In the day to day administration of the insanity defense, the submerged content of Durham jurisprudence was in many ways more significant than what seemed manifest. What transpired was that a court, conspicuous for its sophistication in the understanding of psychodynamics, declined every invitation to pass upon the credibility of psychiatric testimony.[14] As a practical matter this meant that the staff of St. Elizabeths, possessing, as it did, a virtual monopoly of critical

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Criminal No. U.S. 10749-66 (D.C. Gen. Sess. 1967) for a judicial opinion affirmatively holding that acquittal on the basis of a reasonable doubt of mental illness was in no way inconsistent with the finding that a defendant at the time of a crime may "very well [have been] . . . without mental disease or mental disorder . . . ."

12. Rollerson v. United States, 343 F. 2d 269 (D.C. Cir. 1964).

13. The beneficiary of the insanity defense who seeks release from St. Elizabeths Hospital must meet the Draconian requirements fashioned by the Court of Appeals. He must prove, beyond reasonable doubt, his freedom from "any abnormal condition" and that he is not likely to repeat the act which had resulted in his insanity acquittal. See R. Arens, *Due Process and the Rights of the Mentally Ill: The Strange Case of Frederick Lynch*, 13 CATHOLIC U.L. REV. 22–25 (1964), and statutes and cases cited therein.

14. In Horton v. United States, *Crim.* No. 59–62 (D.D.C., 1962) a conviction rested essentially upon the testimony of a St. Elizabeths physician that the appellant was

mental examinations, had carte blanche in the determination of mental disease or defect and hence of criminal responsibility.[15] The Court of Appeals would not interfere. Neither, it appears, would the American Psychiatric Association. A questionable latitude moreover was conceded by the Court of Appeals to the trial courts which on occasion adopted a predominantly cognitive criterion in their jury charges.[16]

Inevitably the insanity defense of the District of Columbia became dependent, as suggested by Judge Kaufman, on a psychiatric judgment which did not appear subject to any effective review.[17]

What, then, was the type of psychiatric justice obtainable under Durham? Between 1959 and 1963 a project, first financed by the Norman Foundation and then by the National Institute of Mental Health, surveyed the administration of this rule. Earlier reports have dealt with the attitudes of trial judges and juries in the administration of the insanity

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mentally and emotionally healthy. The Government conceded that the appellant was a chronic drug-addict involved in long-term criminality as a consequence of his addiction. It further conceded that the appellant had attempted suicide. On conviction, the appellant contended that the St. Elizabeths testimony as to his mental health was as credible as the assertion that the earth was flat. The Court of Appeals rejected this argument and declared that the St. Elizabeths testimony presented an issue to be resolved by the jury, *i.e.*, that it could be believed by reasonable men. Horton v. United States, 317 F. 2d 595 (D.C. Cir. 1963).

15. In the case of United States v. Vincent Gilleo, criminal case no. 583-59 (D.D.C. 1960), a Government psychiatrist declared with gay insouciance that it was his psychiatric opinion that the defendant was "criminally responsible."

16. See, *e.g.*, Simpson v. United States, 320 F. 2d 803 (D.C. Cir. 1963); see also generally R. Arens & J. Susman, *Judges, Jury Charges and Insanity* 21 How. L.J. 1 (1966).

17. United States v. Freeman, 357 F. 2d 606, 621–22 (2d Cir. 1966). A strongly restrictive view of the insanity defense was manifested by the Court of Appeals since the turn of the decade. Trial judges who put the "right-wrong" gloss on an insanity charge could count on the support of a majority of the Court of Appeals for the District of Columbia. Thus, the court declined in Simpson v. United States, 320 F. 2d 803 (D.C. Cir. 1963) to find plain error in a jury charge which included this language:

> As an example of this causal connection or relation, if a person at the time of the commission of a crime is so deranged mentally that he cannot distinguish between right and wrong, or, being able to tell right from wrong, he is unable by virtue of his mental derangement to control his actions, then his act is the product of his mental derangement.

The Court of Appeals also held that an insanity acquittal had to be predicated on an "abnormal condition of the mind which substantially affect[ed] mental or emotional processes and substantially impair[ed] behavior controls." McDonald v. United States, 312 F. 2d 847, 851 (D.C. Cir. 1962).

The number of insanity acquittals has declined significantly since 1962 as shown by this table:

(footnote continued on next page)

defense in the District of Columbia.[18] These concluded that wide strata of the public—including both trial judges and jurors—held the belief, often quite strongly, that the "right-wrong" test, classically embodied in the M'Naghten Rules, was the only acceptable criterion of exculpatory mental illness. An assay of public psychiatric facilities in the District of Columbia, undertaken by the project, alongside of the study of the attitudes manifested by trial judges and juries, found the psychiatric opposition to an expanding insanity defense no whit less than that of the psychiatrically unsophisticated public. Psychiatric attitudes, particularly those encountered at St. Elizabeths Hospital, were marked by massive fears of the break-down of the already scarce resources of the public hospital and by the unexpectedly punitive orientation of public psychiatrists.

TABLE 1.—*Persons found not guilty by reason of insanity*

(U.S. District Court for the District of Columbia, fiscal years 1954–1966)

Fiscal Year	*Defendants in Cases Terminated**	*Defendants in Cases Tried**	*Defendants NGI†*	*NGI as Percent of Defendants in Cases Terminated*	*NGI as Percent of Defendants in Cases Tried*
1954‡	1,870	673	3	0.2	0.4
1955	1,384	453	8	.6	1.8
1956	1,595	456	16	1.0	3.5
1957	1,454	456	7	.5	1.5
1958	1,666	522	17	1.0	3.3
1959	1,642	528	32	1.9	6.1
1960	1,367	400	35	2.6	8.8
1961	1,337	457	66	4.9	14.4
1962	1,282	480	66	5.1	13.8
1963	1,183	398	53	4.5	13.3
1964	1,142	393	23	2.0	5.9
1965	1,286	372	35	2.7	9.4
1966	1,230	380	26	2.1	6.8
Totals	18,438	5,968	387	2.1	6.5

* Source: Administrative Office of the United States Courts. [Abstracted from President's Commission on Crime in the District of Columbia, Report 535 (1966)—ed.]

† "NGI" = not guilty by reason of insanity in this and subsequent tables.

‡ The fiscal year preceding the decision in *Durham* v. *United States*. Prior to this year, insanity patients were not recorded separately from all other prisoner patients at Saint Elizabeths Hospital.

18. R. Arens, D. Granfield & J. Susman, *Jurors, Jury Charges and Insanity*, 14 CATHOLIC U.L. REV., 1 (1965); R. Arens & J. Susman, *Judges, Jury Charges and Insanity*, 12 How. L.J. 1 (1966).

This is a report on the response of government physicians, largely drawn from St. Elizabeths Hospital, to the Durham rule, particularly as reflected in the day to day development of the insanity defense.

TESTIMONIAL PRACTICES

Most lawyers generally regard St. Elizabeths physicians as "good witnesses." These physicians gear their testimony to meet the psychological demands of the courtroom. In contrast to many private practitioners, they appear brief, succinct, and usually grammatical in courtroom testimony. Their testimony in fact often has the thrust of a good lawyer's argument on appeal. In this context, the striking fact is that St. Elizabeths physicians prefer to deliver their testimony in terms of the M'Naghten Rules, often with marked facility.[19]

The conception of partisanship, entertained by some of the St. Elizabeths staff, has been expressed by Dr. Mauris M. Platkin, a senior physician at the John Howard Pavilion of St. Elizabeths Hospital, in these words: "Whatever the testimony of the psychiatrist, he will have previously determined in his own mind whether the defendant is suffering from a mental illness, and his testimony will inevitably be 'slanted' to lead the jury to the same conclusions as his own." [20]

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19. This is known to any lawyer with significant experience in the conduct of the insanity defense in the District of Columbia. Prosecuting counsel frequently couch questions in terms of the "right-wrong" test and St. Elizabeths physicians have answered such questions without difficulty. The following is characteristic:

> Q. Doctor, in your opinion was the defendant Frank Horton able to distinguish right from wrong on December 15, 1961.
>
> A. Yes.
>
> Q. In your opinion, Doctor, could the defendant Frank Horton embrace the right and resist the wrong?
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> A. In my opinion I would say that he could. This is what I believe to be a temporary situation with him, that he could postpone his immediate act, a temporary postponement because drug addicts in general, if on drugs, they have a craving, a tremendous urge to obtain the medication that they are receiving and I think they can postpone temporarily this desire but they eventually have a tremendous urge and a desire to satisfy the need both physiological and psychological need to obtain the medication or narcotics.
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> MR. HANTMAN: Thank you, Doctor, no more questions.

United States v. Horton, *Crim.* No. 59–62 (D.D.C. 1962), Transcript of Proceedings.

20. M. Platkin, *A Decade of Durham,* 32 MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA, 317–319 (1963).

A major characteristic of such testimony is its conclusory form. Explanation of a given condition and how it arose, developed, and affected the mental and emotional processes of the defendant is minimal. Supporting data are predigested for the jury and the final conclusion of "with" or "without mental disorder" is stated with maximum emphasis.

Unlike most of the private psychiatrists encountered in the courtroom, St. Elizabeths physicians depend overtly and overwhelmingly upon the hospital record of the patient for their testimony. The hospital record is perused repeatedly in the course of their testimony both on direct and cross-examination. As one listens to their testimony one is clearly impressed with the legal virtuosity of the claim—usually of lack of mental disorder—which is propounded.

The flesh and blood individual who is asserted to be with or without mental disorder rarely emerges from such testimonial utterances. The testimony is nonetheless presented with an air of certitude which has an obvious appeal to the lay mind.[21]

On most occasions, St. Elizabeths physicians will stress reliance upon what they describe as elaborate diagnostic studies but the quantitative character of diagnostic contacts will remain unstated except for those relatively rare occasions when opposing counsel will seek to exact specific answers on cross-examination.[22]

Although background information as to the defendant will often be sketchy, the testimony of the typical testifying doctors drawn from the John Howard Pavilion (the maximum-security wing of St. Elizabeths) will tend to dwell upon the various phases of a seemingly elaborate diagnostic work-up, even if the testifying witness has not participated in every such phase. It is not infrequent for such a witness to devote one-third of his testimony to describing his professional qualifications and the balance of his testimony, save for the conclusion of "with" or

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21. See, *e.g.*, observation of C. J. Connolly & P. McKellar:

> When questions of testimony are involved, our legal informations have the strong impression that the Court—that is to say the jury, judge, etc.—tend to be more impressed by the witness who can give his evidence with "absolute certainty." The witness who qualified his statements and makes minor reservations for the sake of greater accuracy makes relatively less impact. This may not seem unreasonable but we know from many laboratory experiments that "certainty" is no absolute guarantee that the witness is correct or any more accurate.

C. J. Connolly & P. McKellar, FORENSIC PSYCHOLOGY, 16 Bulletin of the British Psychological Society (No. 51, reprint) 3 (1963).

22. See, *e.g.*, United States v. Horton, *Crim.* No. 59–62 (D.D.C. 1962), Transcript of Proceedings, pp. 441–43.

"without mental disorder," to describing each phase of the diagnostic work-up at St. Elizabeths Hospital—even to the mention of serology and X-rays.

The courtroom slant, as described by Dr. Platkin, is near hypnotic in impact. Hearing of X-ray studies in such a context, the average member of the courtroom audience thinks immediately of rationally relevant roentgenology—and assumes that skull X-rays have been taken. All too rarely does the bubble burst. When it does, impressive X-ray studies of the brain shrink to the standard chest X-ray of the routine "physical" on cross-examination.

The emerging legalistic virtuosity of St. Elizabeths psychiatrists' testimony is often coupled with unyielding and apparently irrational rigor. One example is provided by the Horton case. Disclosures by defense counsel of a suicidal attempt and the breaking of a window in the presence of police by the defendant—conceded to be a narcotics addict—in no way deflected a senior St. Elizabeths psychiatrist from his opinion that the defendant suffered from no mental disorder, and was in fact an "emotionally healthy" person.[23]

Another example is provided by the Ray case. There, a senior physician of St. Elizabeths Hospital testified that epilepsy was a mental disorder only when it was clearly attributable to a "chronic brain syndrome" and that idiopathic epilepsy was therefore no mental disorder at all.[24] He did not know that the defendant had or claimed to have a history of delusions. When asked to assume such a history on cross-examination, he refused to admit that it could raise a reasonable doubt as to the accuracy of his diagnosis of no mental disorder:

> Q. And you were unaware of the fact that . . . [an employer] describes him, his personality before he went to D.C. General Hospital, as one of the hardest workers she had, . . . that he got along well with everyone, and the guests, and then describes his personality after he returned from D.C. General Hospital, in March of 1960, in terms of, quote, "that the whole world was against him, and finally even me"; that God was telling him to do everything when he came back, and after she criticized him and told him to do something that he wasn't doing, he replied that God told me to do this; and on another occasion, when she reprimanded him, he replied that God and I are laughing at you; and that he often refused to go into the dining room because people were after him and some of the guests

23. Official Transcript of Proceedings, United States v. Horton, *Crim.* No. 59–62 (D.D.C. 1962), pp. 425–26.

24. United States v. Ray, *Crim.* No. 250–61, Official Transcript of Testimony of Dr. Platkin and Dr. Owens (D.D.C. 1962) p. 64.

were Russian spies; and that he would giggle and laugh at nothing; and that because of this, and because of her opinion that he was mentally ill, she had to let him go, despite the fact that she was sympathetic and had done what she could to help him. You were unaware that she says that all of this took place after he was released from D.C. General Hospital for a period up to about the last of April of 1960; is that correct?

A. DR. OWENS: That is correct.

Q. Now this information, had it been in your possession, would have had to have been evaluated for its psychiatric significance, wouldn't it?

A. Yes, I would have evaluated it.

Q. And it has some psychiatric significance, right?

A. Any information concerning a patient is of psychiatric significance.

Q. Well, Doctor, let me ask you this: Assuming that this information were given you, assuming you believe that information, and assuming there was nothing to suggest that this behavior was the result of alcoholism or any toxic condition making that assumption, would you have an opinion as to whether or not the man was suffering from a mental disease at the time this behavior was taking place?

A. Would you repeat the question? I am not clear. Leaving out—

Q. I will be glad to repeat it.

THE COURT: The reporter can read it.

(The pending question was read by the reporter.)

A. What my opinion would be, that this is not in itself diagnostic of mental illness. I think some of the things you described were rather bizarre. But I think you have to consider, in obtaining information, how it is obtained, the way that it is related to you, by whom is giving the information; other details that are going on within the patient at the time these symptoms were supposed to be present. So I don't think really on the information that you have given me, assuming that all of it is correct, that I would make a psychiatric opinion on the basis of the information that you gave me.[25]

Yet another example is provided by the fifth trial of Willie Lee Stewart on a charge of murder. Stewart had entered a grocery store at about closing time. After ordering a soda and a bag of potato chips which he ate in the store, he pointed a pistol at the proprietor who was standing behind the counter with his wife and daughter. The women pleaded with Stewart to "take the money" and offered him the register. He, however, "didn't step back, he didn't step forward, he didn't change

25. United States v. Ray, *Crim.* No. 250–61, Official Transcript of Testimony of Dr. M. Platkin and Dr. Owens (D.D.C. 1962) pp. 43–45.

expression, he 'just fired.'" Only then did he open the register "and emptied it very calmly, walked out the door and closed it behind him." [26]

Called as a government witness in that trial, Dr. Platkin testified that he had found the defendant without mental disorder. Upon cross-examination, he was informed by the defense counsel—clearly for the first time—that the defendant had engaged in various episodes of irrational violence, highlighted by an attempt at throwing his child into a blazing furnace. Part of the colloquy between defense counsel and Dr. Platkin went as follows:

Q. Suppose after that interview you had been told and believed that on two occasions in two different homes Stewart tried, actually tried, to put his little baby in a burning fire and was prevented only by physical intervention by at least one person, maybe two or three, and that on another occasion he gave every indication of wanting to throw his baby out the window and was again prevented only by physical force from doing so; suppose you believed he did those things, would you classify him as normal?

A. I would classify him as a person who has a vicious temper. I don't think on the basis of those two episodes only, and assuming—I am assuming that I had investigated those things, and I say this because whenever I receive a report like that, one of the things I am concerned about was: Was there alcohol involved; was he febrile, a person under a fever perhaps could behave somewhat irrationally; was there any other condition surrounding this event that might have caused him to behave this way. I don't think I could take it at face value and draw conclusions from that, but—

Q. Suppose—I'm sorry. Have you finished?

A. Yes; go ahead.

Q. Suppose you eliminate those possibilities? Suppose he wasn't drunk, nor anything else of the sort you have mentioned. Do you still say that is the action of a normal man who is angry?

A. I'd say it's the action of a person with an ungovernable temper, but I wouldn't necessarily conclude at all that this is a mentally ill person.

Q. What do you mean, an ungovernable temper?

A. Well, a person who might want to throw his child out of the window or put him in an oven shows an extreme—extremely vicious temper which flares up, perhaps, based on some provocation, but it's not in itself evidence of mental illness.

Q. Do you mean ungovernable in the same sense that the word uncontrollable is used?

A. Uncontrollable with respect to the incident, yes.

26. *Washington Post & Herald*, March 14, 1953, p. 11.

Q. That's right.

A. Yes.

Q. A person who cannot control his temper is said to have an uncontrollable temper; correct?

A. Yes, that's correct.

Q. He does not have normal control over his emotions; is that correct?

A. Well, I don't know what you mean by normal, Mr. Murray. Very frankly, I know that many people, and again I include myself among them, at times display very irrational temperamental outbursts, some of which we are ashamed of afterwards, and yet at the time it's ungovernable we listen to no reason, we stop at nothing. The incident might last five, ten minutes, a half hour. And after that we recognize what we had done or tried to do, we recognize that it was not proper or acceptable or tolerable behavior. But I don't think it amounts to mental illness.

Q. You were referring, apparently, to a quarrel you might have with somebody in the house where you offend them by words. I am referring now to a man who tries to put his own baby in a burning furnace. Is there any difference?

A. Well, I wasn't referring to a mere quarrel. I was referring to something even more vicious than that. We get into fights. I don't include myself in this category. But we know many people who get into fights or have serious arguments in which physical violence is concerned, and it's regrettable, but we don't necessarily class these people as being mentally ill. As I say, it's a relatively frequent thing that people displace their hostility from other sources to areas where they will be less controllable. It's a common phenomenon that people come home and display severe outbursts of temper against relatively innocent members of the family after they have been chastened or scolded by the boss or have had an argument downtown or given a ticket by the policeman, or something like that.

I think it's asking too much to make a diagnosis of mental illness even when the outbursts of temper are of such degree of severity as you describe.[27]

This treatment of testimonial practices, while illuminating, fails to provide an understanding of the constraints which the social structure of St. Elizabeths exercised on the administration of the Durham Rule. For such a treatment, we must turn to an examination of the facilities themselves.

27. Transcript of Proceedings, United States v. Willie Lee Stewart, *Crim.* No. 633–53, pp. 2049-2051-A. (D.D.C. 1962).

FACILITIES

The poor of Washington depend on public psychiatric facilities for exploration of such questions as competency to stand trial and responsibility as affected by mental disease or defect.

Almost invariably an order for a mental examination entered by the District Court commits the criminal defendant to the diagnostic care and custody of St. Elizabeths Hospital. Even in the rare case in which the defendant has sufficient means to secure independent psychiatric examination, an order for his examination by the St. Elizabeths staff will usually be handed down by the court, and the defendant may be explicitly directed to cooperate with the St. Elizabeths physicians with the intimation that his lawyers may be cited for contempt if he does not.[28]

Thus, St. Elizabeths is in all but the rarest of cases the ultimate arbiter of the existence of mental disease or defect for the people of the District of Columbia.

Home to approximately 7,000 mental patients in the nation's capital, St. Elizabeths is conspicuously understaffed and overcrowded. As described by one of its senior physicians, it was "designed principally for the treatment of persons suffering from acute and chronic psychosis." [29] It is in no way atypical of public mental institutions elsewhere which have been described as "unmanageably large . . . , economically depressed, running on a fraction of the costs of general hospitals, schools or jails, . . . chronically understaffed, and . . . usually cut off from the main stream of professional life." [30]

The minimal budgetary allocation St. Elizabeths receives per patient per day bespeaks the scarcity of its resources and rules out any meaningful attempt at individualized treatment. Total costs per patient per

28. In United States v. John S. Sweeney, criminal case no. 466–60 (D.D.C. 1960) transcript of proceedings on December 16, 1960, the Government secured a court order directing a defendant, charged with murder, to cooperate with St. Elizabeths physicians on the ground that "it would be an intolerable situation if the Government should be deprived of the opportunity to ascertain the truth . . . ." In this context—since contempt proceedings against the defendant would be fatuous—Government counsel suggested that the defendant's lawyers would seem proper targets of criminal prosecution if they persisted in advising their client not to talk to Government physicians. See *id.* at 4–6.

29. M. Platkin, *A Decade of Durham*, 32 MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA, 317, 318 (1963).

30. E. Cumming and J. Cumming, SOCIAL EQUILIBRIUM AND SOCIAL CHANGE IN THE LARGE MENTAL HOSPITAL; M. Greenblatt, D. Levinson & R. Williams, THE PATIENT AND THE MENTAL HOSPITAL, 49 (1957).

day have been reported as $8.88 for the fiscal year of 1962, $10.30 for the fiscal year of 1963, and $11.22 for the fiscal year of 1964. Of those costs, allocation for food per patient per day has been 84 cents for the fiscal year of 1962, 93 cents for the fiscal year of 1963, and 93 cents for the fiscal year of 1964.[31]

It is inevitable under these circumstances that St. Elizabeths should be incapable of meeting the standards of the American Psychiatric Association for public mental hospitals. It must be recalled in this connection that "these standards represent a compromise between what was thought to be adequate and what it was thought had some possi-

31. Another dimension is obtained by examining a summary of total annual budgetary authorizations for St. Elizabeths Hospital for the period of 1957 to 1967 which was forwarded to Dr. Robert G. Kvarnes of the Washington School of Psychiatry on April 13, 1967. The figures reflect some rise in appropriations for St. Elizabeths. Nothing in these figures, however, suggests the wholesale reorientation of the hospital to accommodate the vast numbers of non-psychotic as well as psychotic patients eligible for insanity acquittals at least until MacDonald v. United States, 312 F. 2d 847 (D.C. Cir. 1962).

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SAINT ELIZABETHS HOSPITAL

History of Authorizations

1957–1967

Fiscal Year	*Salaries and Expenses Appropriation*			*Buildings and Facilities*	*Total for*
	Direct Appropriations	*Reimbursements*	*Total Program*	*Appropriations*	*Hospital*
1957	$2,870,000	$11,886,782	$14,756,782	$7,764,000	$22,520,782
1958	3,165,800	12,857,801	16,023,601	235,000	16,258,601
1959	3,442,000	13,674,285	17,116,285	212,000	17,328,285
1960	3,805,000	14,682,725	18,487,725	330,000	18,817,725
1961	4,572,000	16,285,415	20,857,415	5,445,000	26,302,415
1962	5,105,000	17,392,801	22,497,801	645,209	23,143,010
1963	6,332,000	19,623,576	25,955,576	8,095,000	34,050,576
1964	7,852,172	20,056,828	27,909,000	627,000	28,536,000
1965	9,619,897	19,749,103	29,369,000	2,032,000	31,401,000
1966	10,289,591	20,323,409	30,613,000	1,977,000	32,590,000
1967	8,865,000[a]	22,693,000[a]	31,558,000	2,298,000	33,856,000
1967 Suppl.[b]	995,000	52,000	1,047,000	——	1,047,000

[a] Starting with 1964, the Hospital began operating with an indefinite appropriation, under which it receives, in appropriated funds, the difference between reimbursements and its total authorized operating program. Accordingly, the direct appropriation and reimbursement figures shown for 1967 should be regarded as estimates.

[b] Proposed supplemental appropriation to cover general schedule and wage board salary increases.

bility of being realized."[32] One encounters cases in which a patient is placed in a ward housing 1,000 patients and which provides two psychiatrists for their care and treatment.[33]

Contact with the hospital by the Project over a period of four years has confirmed the impression of others that as

> in many [other] mental hospitals there is a record [at St. Elizabeths] of disgruntled psychiatrists asserting they are leaving so they can do psychotherapy. Often a special psychiatric service, such as group psychotherapy, psychodrama or art therapy, is introduced with great support from high

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32. H. Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 AM. J. PSYCHIATRY 1, 7 (1958); for the standards themselves see AMERICAN PSYCHIATRIC ASSOCIATION STANDARDS FOR HOSPITALS AND CLINICS, 44–45 (1958).

The obvious failure of St. Elizabeths Hospital to meet the standards of the American Psychiatric Association is reflected essentially in the failure to meet the required ratio of psychiatrists to patients. These can be reflected in the following table:

PERSONNEL RATIOS FOR PUBLIC MENTAL HOSPITALS

	Admission & Intensive Treatment Service	*Continued Treatment Service*	*Geriatric Service*	*Medical & Surgical Service*	*Tuberculosis Service*
Physicians	1:30 Patients	1:150 Patients	1:150 Patients	1:50 Patients	1:50 Patients
Clinical Psychologists	1:100 Patients	1:500 Patients	——	——	——
Registered Nurses	1:5 Patients	1:40 Patients	1:20 Patients	1:5 Patients	1:5 Patients
Attendants	1:4 Patients	1:6 Patients	1:4 Patients	1:5 Patients	1:5 Patients
Hydrotherapists	1:50 Patients	1:250 Patients	——	——	——
Activity Therapy Workers:					
Registered OT's	1:100 Patients	1:300 Patients	1:250 Patients	——	1:100 Patients
Others*	1:40 Patients	1:100 Patients	1:150 Patients	——	1:100 Patients
Psychiatric Social Workers:		One to 80 new admissions per year. One to 60 patients on convalescent status or on family care. One supervisor to every 5 case workers.			
Dentists (reg.)		One to one thousand patients—all services.			
Dental Hygienists		One to five hundred patients—all services.			
Laboratory Technician		One technician to 7,500 procedures a year—all services.			

* Includes such personnel as occupational and recreational therapy aides, physical education instructors, and music and dance instructors.

Id. at 61.

A document, almost suggestive of political compromise, the American Psychiatric Association manual, eschews firm figures wherever possible and avoids embarrassing comparisons between the hard realities of hospital practice and the identifiable standards of the most authoritative body of psychiatric practitioners.

33. Lynch v. Overholser, Habeas Corpus No. 171–60 (1960).

> hospital management; then slowly interest is transferred elsewhere and the professional in charge finds that gradually his job has been changed into a species of public relations work—his therapy given only token support except when visitors come to the institution and high management is concerned to show how modern and complete the facilities are.[34]

If the Durham Court had intended the accommodation of a significant number of non-psychotic patients on the premises of St. Elizabeths Hospital after an insanity acquittal, it had not made—and it is not likely that it had the power to make—any effective provision for their care.[35] It is clear, too, that Congress had not made a budgetary increase sufficient to permit accommodation of any significant number of non-psychotic patients. In the halcyon year of 1957, the court declared that "the assumption that psychosis is a legally sufficient mental disease and that other illnesses are not, . . . [was] erroneous."[36] Since that time, Congressional appropriations for St. Elizabeths have not been such as to suggest inclusion within the Hospital of the large number of offenders who could be regarded as victims of a non-psychotic mental disorder. It should be recalled in this connection that the incidence of moderate through severe symptom formation in a sampling of 1,660 midtown adults in a metropolitan community has been found to be 42.5 per cent.[37] The rise in appropriations—considering the increase in the cost of living—cannot, by any stretch of the imagination, be viewed as capable of encompassing a modest fraction of the influx suggested by such figures.

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34. E. GOFFMAN, ASYLUM 92 (1961).

35. Overholser v. O'Beirne, 302 F. 2d 852 (D.C. Cir. 1962).

36. Briscoe v. United States, 248 F. 2d 640, 641 n. 2 (D.C. Cir. 1957).

37. L. SROLE et al., MENTAL HEALTH IN THE METROPOLIS [The Mid-Town Manhattan Study].

T.A.C. RENNIE SERIES IN SOCIAL PSYCHIATRY (1962) reports as follows with regard to a sample of 1,660 mid-town adults:

Table 8–3. Home Survey Sample (Age 20–59), Respondents' Distribution on Symptom-formation Classification of Mental Health

Well	18.5%	
Mild symptom formation	36.3%	
Moderate symptom formation	21.8%	
Marked symptom formation	13.2%	
Severe symptom formation	7.5%	
Incapacitated	2.7%	
Impaired*		23.4%
N = 100%	(1,660)	

* Marked, Severe, and Incapacitated combined.
Id. at 138.

Designed "principally for the treatment of persons suffering from acute and chronic psychosis," St. Elizabeths Hospital clearly has not received sufficient funds to reconstitute itself as a treatment center for psychoneuroses and personality disorders as well.[38]

SOCIAL STRUCTURE AND IDEOLOGY

The authoritarian atmosphere at St. Elizabeths Hospital appeared to be consistent with recent research on the public mental hospital by Gilbert and Levinson. They describe two types of staff orientations, "custodial" and "humanistic":

> The model of the custodial orientation is the traditional prison and the "chronic" mental hospital which provide a highly controlled setting concerned mainly with the detention and safekeeping of its inmates. Patients are conceived of in stereotyped terms as categorically different from "normal" people, as totally irrational, insensitive to others, unpredictable and

38. One must further bear in mind that current psychiatric opinion holds that the treatment of many psychiatric disorders can best be accomplished outside of a hospital, and for those that do require hospitalization, return to the community should be as rapid as possible to prevent the debilitating effects of institutionalization. In this light, automatic confinement of all persons suffering from mental and/or emotional disorders to St. Elizabeths Hospital is a counter-therapeutic practice, even if one were to assume that the facilities at St. Elizabeths were ideal.

Dr. Raymond Prince, Member of Psychiatry Department of McGill University in letter to author, dated April 14, 1967.

The attitude of the Court of Appeals toward a constitutional right of adequate and humane treatment of those confined within St. Elizabeths Hospital has varied through a period of approximately two decades.

An early concern for the fate of those confined within St. Elizabeths Hospital was replaced by apparent callousness. Compare Miller v. Overholser, 206 F. 2d 415 (D.C. Cir. 1953) with Overholser v. O'Beirne, 302 F. 2d 852, 854 (D.C. Cir. 1962).

In a path-breaking decision in 1966 the Court of Appeals declared that there was a right to treatment for those committed to a mental hospital, that "involuntary confinement without treatment [was] 'shocking'" and that a patient acquitted by reason of insanity and confined in St. Elizabeths Hospital was entitled to a hearing upon the allegation that he was denied adequate and humane medical care. The decision, however, provides no indication as to whether St. Elizabeths physicians will succeed in establishing the adequacy of their treatment facilities by testifying that what they administer is "environmental" or "milieu" therapy, *i.e.*, in lay language, that the privilege of breathing in the air of St. Elizabeths Hospital is treatment enough. Rouse v. Cameron, 373 F. 2d 451 (D.C. Cir. 1966).

For a psychiatric reaction to the case, suggestive of this very possibility, see the news story in *Washington Post and Herald*, January 10, 1967 p. B1 entitled "Holtzoff Fights Back in Insanity Case Appeal" which includes this paragraph: "Dale C. Cameron, superintendent of St. Elizabeths Hospital and Rouse's ward psychiatrist, Stray H. Economon, testified that Rouse's treatment is 'adequate, if not ideal'. They described

> dangerous. Mental illness is attributed primarily to poor heredity, organic lesion, and the like. In consequence, the staff cannot expect to understand the patients, to engage in meaningful relationships with them, nor in most cases to do them much good. Custodialism is saturated with pessimism, impersonalness, and watchful mistrust. The custodial conception of the hospital is autocratic, involving as it does a rigid status hierarchy, a unilateral downward flow of power, and a minimizing of communication within and across status lines. . . .
>
> The humanistic orientations, on the other hand, conceive of the hospital as a therapeutic community rather than a custodial institution. They emphasize interpersonal and intrapsychic sources of mental illness, often to the neglect of possible hereditary and somatic sources. They view patients in more psychological and less moralistic terms. They are optimistic, sometimes to an unrealistic degree, about the possibilities of patient recovery in a maximally therapeutic environment. They attempt in varying degrees to democratize the hospital, to maximize the therapeutic functions of nonmedical personnel, to increase patient self-determination . . . and to open up communication wherever possible.[39]

Staff members of the John Howard Pavilion appeared characteristically deferential to standard symbols of authority. A leader of the Bar representing an indigent client by appointment of the court could count on a greater show of deference on the part of staff members than the recently admitted member of the Bar performing an identical function.

Although nominal self-government for patients including those of the maximum security John Howard Pavilion has been secured, the respect relations between patients and physicians appeared far removed from those prevailing at the institution for criminal psychopaths near Copenhagen where the medical staff joins the patients for their meals in the same dining room.[40]

Rouse as a sociopath who does not respond well to treatment and is aloof and uncooperative."

A hearing in District Court, following the Court of Appeals decision, resulted in the dismissal of the habeas corpus petition.

Significantly, in an order handed down *sua sponte* on April 4, 1967, the Court of Appeals declared that the right of treatment applied independently of any legislative history which appeared to support it. Rouse v. Cameron, 373 F. 2d 451 (D.C. Cir. 1966).

As this article goes to press the Court of Appeals still remains to be heard from on the adequacy of Rouse's treatment at St. Elizabeths.

39. M. Gilbert & P. Levinson, *"Custodialism" and "Humanism"* in MENTAL HOSPITAL STRUCTURE AND STAFF IDEOLOGY. Greenblatt, Levinson and Williams (eds.) THE PATIENT AND THE MENTAL HOSPITAL 22 (1957).

40. The Institution for Criminal Psychopaths at Herstedvester, under the supervision of Dr. George Sturup, was visited by the author. For one of numerous published

Only minimal weight was accorded to the diagnostic opinions of junior psychiatric members at staff conferences preliminary to the certification of a given patient in a criminal case as with or without mental disorder, notwithstanding the fact that the senior physicians who seemed dominant spent half of their time in court and had clearly less contact with patients than the junior staff.[41]

It was commonplace for findings of psychopathology by St. Elizabeths psychologists to be rejected by the medical staff on the assumption that psychologists, like laboratory technicians, were only qualified to convey data, the true meaning of which could be detected only by the medical staff.[42]

Ward visits by senior members of the staff had an aura of military inspections in which subordinate attendants reported on their charges and presented the appropriate front of cleanliness and decorum.[43]

Asked as to the presence of odors of human excrement on a ward in which an individual beneficiary of the insanity defense had been confined, a St. Elizabeths physician denied having ever personally detected such odors but declared that hospital procedures were such as to make it likely that the ward would "get itself cleaned up" preliminary to a visit by a senior staff member.[44]

Preoccupation With Security

Regardless of staff intentions, the policies of a public hospital are affected to a greater or lesser degree by public pressures. It is obvious that a significant segment of the public expects the hospital to give security priority over treatment.

Whether willingly or unwillingly, a public hospital under these circumstances tends to yield to such demands to greater or lesser degrees.

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descriptions of the Danish treatment of the psychopathic offender, see S. HURWITZ, CRIMINOLOGY 412–14 (1952).

41. Junior staff members and psychologists at St. Elizabeths encountered by Project staff members have frequently manifested a humane concern for the patient as an individual and a sense of optimism about his therapeutic potential, much at variance from the attitude frequently conveyed by senior staff members.

42. See Transcript of Proceedings, United States v. Oscar M. Ray, Jr., *Crim.* No. 250–61 (D.D.C. 1962) pp. 24–25.

43. See I. Belknap, *Human Problems of a State Mental Hospital*, 65 (1956).

44. Testimony of Dr. David W. Harris, Transcript of Proceedings, Tremblay v. Overholser, Habeas Corpus No. 288–61 (D.D.C. 1961), p. 16.

The maximum security John Howard Pavilion has "steel bars and bullet proof glass."[45] The hypothesis that the "authoritarian personality" is more likely to be attracted to such an institutional framework on a permanent basis does not seem implausible.

Overt acknowledgment of the custodial role of the hospital has appeared at the highest level of formal authority within the hospital. As expressed by Dr. Winfred Overholser, as Superintendent:

> The notion that a verdict of not guilty by reason of insanity means an easy way out is far from the truth. Indeed the odds favor such a person spending a longer period of confinement in the hospital than if the sentence was being served in jail.
>
> As a matter of fact, only about one in four who have been sent to the hospital under this rule have been released. Some may never be released.
>
> If the patient is treatable he will be treated; if he is not, society is thoroughly protected.[46]

As previously noted, St. Elizabeths Hospital requests the transfer of those it has certified as mentally ill to the District Jail pending the disposition of their charges. Patients who have been transferred at the request of the hospital administration have—within the experience of the Project—included certified schizophrenics and psychoneurotics. Thus, a senior physician at the John Howard Pavilion declared in an affidavit, furnished to the prosecution, that a patient suffering from "psychoneurosis, anxiety reaction with obsessive features" would not be harmed in the least by a few months imprisonment in the District Jail.[47] Attempts by defense lawyers to resist such transfers have generally met with failure in the face of the judicial assumption that the courts should not interfere with internal hospital administration.

Rigid Ordering of Rank and Prestige Among Patients

Rank and prestige differences among members of the staff seem matched by rank and prestige differences among patients. Clearly the favorite group among patients is that against whom no criminal charges are pending.

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45. *Washington Post & Herald,* Oct. 24, 1963, p. A-3.

46. Statement by Dr. Overholser in the American Weekly, *Washington Post & Herald,* June 18, 1961, p. 4.

47. See Clerk's File, Sutherland v. United States, No. 16, 160 (D.C. Cir. 1961).

It would thus be inconceivable for, say, the Dix Pavilion of St. Elizabeths Hospital, housing civil patients exclusively, to recommend the transfer of a schizophrenic into an overtly disciplinary and predominantly punitive environment—not geared to the therapeutic needs of such a patient—on the ground that he would not be harmed by such a measure. It is commonplace, however, for the John Howard Pavilion —largely housing patients under criminal charges—to recommend the transfer of a schizophrenic to the District Jail to await disposition of his charges if regarded as "competent to stand trial" by the staff psychiatrists upon the explicitly stated assumption that he would not be harmed by a few months imprisonment.[48]

Defense attorneys who have occasionally inquired about the transfer of clients from the maximum security pavilion to a less restricted ward have often been met with the argument that the *pendency* of criminal charges required greater caution in the administrative disposition of the patient than would be indicated otherwise.

There appears to be little reason, moreover, to question the conclusion of a former United States Attorney for the District of Columbia that the attitude of the senior psychiatrists at the John Howard Pavilion is one of skepticism whenever faced with a claim of mental disorder by a patient subject to criminal prosecution.[49] Perhaps it is this type of skepticism which is mirrored in this colloquy between a senior staff member of the John Howard Pavilion and defense counsel in the course of cross-examination in the District Court:

> Q. Doctor, I suppose in your experience you have had numerous—well, thousands of interviews and have you been at all times alert to the possibility that the subject was malingering?
>
> A. In my particular work this is very much the case because practically all of the patients I deal with are those who are involved in some kind of criminal activity, so that I have to be aware of the fact that they may try to present a picture of themselves which would be self-serving. So, this is very much in my mind.
>
> Q. And the very fact that they are involved in a serious criminal offense, like Stewart here, charged with murder, would form a very strong motive for him to malinger?
>
> A. It might, yes, very definitely.

48. See Hearings before Judge Walsh in United States v. Walter Johnson, *Crim.* No. 381–59, July 13, 1961.

49. D. Acheson, *McDonald v. United States: The Durham Rule Redefined,* 51 GEO. L.J. 580, 588 (1963).

Q. Not merely you, but all psychiatrists are aware of that possibility, are they not?

A. Well, as I say, particularly in the work that we do. Those who see patients, for example, who come to the hospital voluntarily, are obviously less concerned with this problem than those who are sent to the hospital in connection with a criminal charge.[50]

The acknowledgment, in the words of a senior physician of St. Elizabeths Hospital, that the hospital has "been designed principally for the treatment of persons suffering from acute and chronic psychoses" would suggest without more that the non-psychotic mental disorder was neglected to a greater or lesser extent.

In a word, all available data tended to reinforce the impression of the hospital and its administration as "custodial" in every sense of the word.

This, then, was the context which gave life to decisions affecting the insanity defense in the District of Columbia. What emerged during the period of the project study was a national problem in microcosm.[51]

Diagnostic Procedures Dictated by Understaffing and Overcrowding

Commitments to St. Elizabeths for mental examination and observation are made routinely for a period of 90 days,[52] an extension of an

50. Transcript of Proceedings, United States v. Willie Lee Stewart, *Crim.* No. 633–53 (D.D.C. 1962), pp. 2043–2044. Goffman observed that demeaning and discrediting statements about patients in general are a commonplace characteristic of descriptions of a patient's history and general appearance in the records kept at St. Elizabeths Hospital. See E. GOFFMAN, ASYLUM 156–58 (1961).

51. There is no reason to believe that the St. Elizabeths scene is significantly different from that obtaining elsewhere. The impoverished public mental hospital has, in fact, been a national blight. See A. DEUTSCH, THE SHAME OF THE STATES (1948). See also materials cited regarding the inadequacy of the national mental hospital picture in R. Arens, *Due Process and the Rights of the Mentally Ill: The Strange Case of Frederick Lynch*, 13 CATHOLIC U. L. REV. 3 (1964).

52. This applies to District Court cases only. The Court of General Sessions (dealing with misdemeanors exclusively) commits defendants to D.C. General Hospital —usually for a period of one month. In isolated instances there are District Court commitments to the D.C. General Hospital as well. Those acquitted by reason of insanity are invariably committed to St. Elizabeths Hospital under D.C. Code Ann. §24–301 (1955). Unlike the D.C. General Hospital, St. Elizabeths is thus both the examining—and, ultimately treatment or custodial center—for those claiming the benefits of the insanity defense. The interest of St. Elizabeths in preventing the intensification of already existing overcrowding of its facilities is therefore obvious. It is

earlier 60-day period. As expressed by a District Court judge: "Unfortunately, mental examinations take at least 90 days under the present system. I do not know why they should take that long, but psychiatrists claim they need 90 days. . . . " [53]

St. Elizabeths has, since 1959, requested a minimal period of 90 days to afford its staff the time it deems essential for court-ordered mental examinations. In view of what is set forth below as to the scarcity of contact between St. Elizabeths physicians and their patients, it is problematic whether the 90-day period of observation requested by the Hospital was motivated as much by a desire to enhance diagnostic intensity as by that of adding to the testimonial effectiveness of St. Elizabeths physicians.

St. Elizabeths records do not reflect the precise number of times that a given patient has been seen by a member of the hospital staff.[54] Omissions in the records, one must note in this connection, reflect either a lack of contact with the patient or an attitude of skepticism leading, significantly, to underreporting.

In a Project case in which the defendant had been certified by St. Elizabeths Hospital as without mental disorder, the defendant's mother informed counsel that the defendant had been subject to unusual forms of mistreatment by his father. She told of whippings, of threats to assault the boy with an axe and of punishment of the boy by sticking wires in his penis.

The medical staff conference concerning the patient, held on April 25, 1960, did not have the benefit of this information. The hospital record reported the defendant as describing auditory and visual hallucinations at the staff conference, with this comment as to the reaction of the staff: "The patient is not very convincing in discussing these alleged hallucinations nor are the members of the conference very much impressed with his belief of mental illness at certain definite periods of his life."

The information gleaned from the defendant's mother was communicated to the superintendent of the hospital after the staff conference.

noteworthy too that the senior physicians in charge of court ordered examinations at St. Elizabeths—unlike those of the D.C. General Hospital who perform the same function—are usually older men with apparently limited professional mobility.

53. Official Transcript of Proceedings before Judge Holtzoff in United States v. Gilleo, *Crim.* No. 583–59, March 25, 1960, p. 3.

54. Testimony of Dr. Owens, Official Trancript of Proceedings, United States v. Frank Horton, *Crim.* No. 59–62 (D.D.C. 1962) p. 445.

The hospital record thereafter showed that two weeks *after* the staff conference the social service branch of the John Howard Pavilion conducted an interview with the defendant's mother which provided the details referred to above. Two days later, without any further review of the defendant's record at another staff conference, the defendant was turned over to the marshal for return to the District Jail—with an unaltered diagnosis of "no mental disorder." [55]

When appointed to represent John W. Jackson, Jr.,[56] upon a charge of murder at a somewhat later stage of the proceedings, counsel was confronted with the fact that St. Elizabeths had already certified the defendant as without mental disorder.

In an interview with counsel at the District Jail, the defendant seemed unable to engage in rational discussion of the charges. He repeated insistently that he wished to be tried, sentenced, and executed on the same day. The trial, which was subsequently continued, was at that time scheduled to be held within a week, and the defendant asked whether he could be introduced to his executioner on that occasion.

Upon discussion of the case with a senior psychologist of the St. Elizabeths Hospital staff, counsel was informed that the psychological test results suggested a significant possibility that the defendant was a victim of organic brain damage. The history of the defendant included a recorded instance of a skull injury and some fugue-type states of purposeless activity. Since the defendant had not been subjected to examination by a neurologist and had not received the benefit of such specialized neurological procedures as an electroencephalogram, a pneumoencephalogram, or routine skull X-rays in the course of his examination at St. Elizabeths Hospital, counsel considered it essential to secure further information on that score. At that stage the defendant was subjected to psychological examination by a privately retained psychologist. An affirmative finding of organic brain damage was presented as the result of the new series of tests. Private psychiatric examination revealed a "borderline schizophrenic"—leaving the question of brain damage open. A private psychiatrist declared in an affidavit filed in the District Court that the defendant required "extensive neurological testing" which had not been carried out at St. Elizabeths Hospital.

55. A criminal case tried in the District of Columbia in 1961 and not identified in the interests of the defendant.

56. United States v. John W. Jackson, Jr., *Crim.* No. 980–61 (D.D.C. 1962) p. 445.

When the St. Elizabeths staff was informed of these findings it responded in this manner as summarized in counsel's diary:

> At approximately 4 o'clock, on Thursday afternoon, May 17, 1962, I spoke by telephone with Dr. X of St. Elizabeths Hospital. I mentioned to him that several non-institutional psychiatrists had reached a conclusion, differing from that of the St. Elizabeths Hospital staff, regarding John W. Jackson's mental condition. Dr. X told me that he was aware of this fact.
>
> He added that he did not see any point in having Mr. Jackson returned to St. Elizabeths Hospital, since he was satisfied that no different diagnosis would be made upon re-examination.

In one case, in which the defendant was charged with murder, mayhem, and rape, a motion for a mental examination was supported by affidavits. The affiants asserted, among other things, that the defendant had tried to kill himself with an axe, that he had laughed hysterically when alone, and that he had committed acts of bestiality. St. Elizabeths never contacted the affiants but certified that the defendant was "not suffering from mental disease at the present time" and that there was no "evidence of a mental disease" at the time of the alleged offenses. The defendant did not attempt to interpose an insanity defense and was convicted of second-degree murder. St. Elizabeths doctors told the court-appointed counsel that they had observed no behavior such as that described in the affidavit and that they could only report on what they had observed at the hospital.

On occasion, however, a patient in the John Howard Pavilion receives observation and examination which approximates the ideal in the light of contemporary knowledge. For example, Bernard Goldfine, the financier, was seen by doctors at St. Elizabeths nearly every day, often for lengthy periods, after he had been adjudged incompetent to stand trial by the District Court of Massachusetts. The doctors also spent considerable time with members of the patient's family.[57] Another example is provided by the case of John Sweeney, in which an unusual combination of circumstances, including the entry of private psychiatrists into the case, paid for by wealthy parents, resulted in a diagnostic study on the part of St. Elizabeths Hospital of far greater intensity than that which was carried out in the average case.[58]

57. Transcript of Proceedings, In matter of Bernard Goldfine, Habeas Corpus No. 246–90 (D.D.C. 1960) pp. 36–37.

58. United States v. John Sweeney, *Crim.* No. 466–60 (D.D.C. 1961).

Such cases tend to support findings by Hollingshead and Redlich that the kind of treatment administered to patients by psychiatrists depends to a significant degree upon the class and status of the patients under scrutiny.[59]

While this is in no way designed to suggest that class is critical in determining the quality of diagnostic studies done at St. Elizabeths, one is bound to record one's recollection of only a handful of cases of capital crime and/or insistent legal demands for diagnostic intensity as in any way approximating the quality of psychiatric study carried out for Goldfine or Sweeney. Murder cases do in fact come to mind in which such intensity was absent.[60]

Operative Conceptions of Mental Illness

Consistently with its basic predispositions, the St. Elizabeths staff has rejected a significant number of personality and neurotic disorders as not rising to the dignity of mental illnesses.[61]

An examination of all criminal files in District Court throughout the calendar year 1961 indicates that St. Elizabeths certifications of mental illness rarely include non-psychotic disorders. It is fair to state that psychiatric literature points to a clear professional consensus as to the psychopathology of two types of offenders—often encountered in criminal practice—the chronic narcotics addict and the person persistently

59. A. HOLLINGSHEAD & F. REDLICH, SOCIAL CLASS AND MENTAL ILLNESS *passim* (1958).

60. See United States v. John W. Jackson, Jr., *Crim.* No. 980–61 (D.D.C. 1961).

61. The "official" view of St. Elizabeths Hospital—propounded in terms of abstract theory and applied to the isolated case—has been in line with the AMERICAN PSYCHIATRIC ASSOCIATION'S DIAGNOSTIC AND STATISTICAL MANUAL. Thus, both "sociopathic" and "emotionally unstable" personalities have been officially proclaimed to conform to the hospital's conception of mental illness, in one case in mid-trial following a weekend conference by the hospital staff. See, *e.g.*, In re Rosenfield, 157 F. Supp. 18 (D.D.C. 1957) and Campbell v. United States, 307 F. 2d 597 (D.C. Cir. 1962). The evidence however suggests the practical repudiation of this view in numerous court cases, particularly as the full implications of the acceptance by St. Elizabeths Hospital of all non-psychotic sufferers of mental disorder hit home. It has been suggested—and it is borne out in terms of initial impressions that "[w]hat seemed to be emerging under the Durham rule was that neither legal principles nor medical concepts determined the defendant's fate so much as did administrative label changing by the hospital's staff." Reid, *The Bell Tolls for Durham*, 6 J. OF OFFENDER THERAPY 58 (1962).

involved in the sexual molestation of a child.[62] This consensus, however, has not bound St. Elizabeths Hospital.

At a time when a presidential commission was urging understanding of narcotics addicts as medically handicapped, St. Elizabeths Hospital blithely certified a significant number of chronic narcotics addicts as without mental disorder. In so doing, St. Elizabeths physicians occasionally described such offenders as "mentally healthy."[63] In fiscal year 1962 nine narcotic addicts were pronounced free of any manner of mental disorder by St. Elizabeths. Another thirteen of such addicts were diagnosed as suffering from mental disorders "not specifying use of drugs" and only two were diagnosed as suffering from a "mental disorder specifying use of drugs."

The following table as to the handling of narcotic addicts upon mental examination by the John Howard Pavilion upon court order was furnished by the present superintendent of St. Elizabeths to Professor Harold D. Lasswell of Yale University:

TABLE 1

Admission to John Howard Pavilion for Examination by Use of Drugs and Psychological Diagnosis, Fiscal Year 1962

PSYCHOLOGICAL DIAGNOSIS	TOTAL	NOT ADDICT	ADDICT-NARCOTIC	ADDICT OTHER	DRUG USE UNKNOWN
Total	183	144	24	1	14
Mental disorder specifying use of drugs	2	0	2	0	0
Mental disorder not specifying use of drugs	90	69	13	1	7
Without mental disorder	86	73	9	0	4
Diagnosis deferred or none given	5	2	0	0	3

62. See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL (1952).

63. See the testimony of Dr. David Owens in United States v. Horton, *Crim.* No. 59–62 (D.D.C. 1962). Transcript of Proceedings 425–426. Cf. White House Conference on Narcotic and Drug Abuse, Proceedings (1962); *President's Advisory Commission on Narcotic and Drug Abuse*, Final Report (1963).

For an example of a statutory scheme designed to substitute medical treatment for conventional punishment in the case of drug addicts, see, *New York Mental Hygiene Law* §§211–213 (1963).

In the same fiscal year, St. Elizabeths similarly certified a significant number of child molesters as without mental disorder. The following information was provided in reply to an inquiry as to the psychiatric diagnosis of sexual child molesters upon the premises of St. Elizabeths Hospital by its Superintendent:

1. There were 208 mental examinations given to prisoner patients admitted to Saint Elizabeths Hospital during fiscal year 1962.
2. Fifteen patients were charged with crimes involving sexual molestation and/or carnal knowledge of children.
3. Of these, six were diagnosed as With Mental Disorder; nine were diagnosed as Without Mental Disorder.[64]

It is not facetious to observe under the circumstances that in addition to the mentally healthy chronic drug addict, St. Elizabeths appears to have discovered the mentally healthy sexual child molester.

It would not be accurate to assume, however, that a victim of personality or neurotic disorder would never secure a certification as mentally ill by St. Elizabeths Hospital. Cases of such certification do exist.

It is impossible to provide meaningful criteria to enable an outsider to determine when a victim of a personality or neurotic disorder would secure St. Elizabeths certification as mentally ill. The availability of space coupled with the adjustment potential of the individual on a given ward may be significant factors. It may not be altogether accidental, therefore, that an individual diagnosed by St. Elizabeths as mentally ill by virtue of a sociopathic personality disorder[65] was viewed, on examination by a project psychiatrist, as "a quiet-spoken, friendly

64. Letter by St. Elizabeths' staff member to Axel W. Oxholm, Esq. in Washington, D.C., dated 1963.

65. See, *e.g.*, United States v. Marocco, *Crim.* No. 208–62 (D.D.C. 1962). St. Elizabeths Hospital has furnished the following breakdown of diagnoses of those admitted to St. Elizabeths by reason of insanity acquittals:

(Table, part of footnote continued on next page)

TABLE 6.—*Psychiatric diagnoses of NGI admissions to Saint Elizabeths Hospital, by crime charged*
[U.S. District Court, fiscal years 1954–1965]

		Psychiatric Diagnosis													
		Organic Disorder		*Schizophrenic*		*Other Psychoses*		*Mental Deficiency*		*Psychoneurotic*		*Personality Disorder*		*Without Mental Disorder*	
Crime Charged	*Total*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Murder	53	10	18.9	25	47.2	2	3.8	—	—	7	13.2	6	11.3	3	5.7
Rape	16	2	12.5	6	37.5	—	—	—	—	6	37.5	2	12.5	—	—
Other sex offenses	25	4	16.0	8	32.0	—	—	1	4.0	8	32.0	3	12.0	1	4.0
Manslaughter	6	1	16.7	2	33.3	—	—	2	33.3	—	—	1	16.7	—	—
Robbery	49	3	6.1	25	51.0	—	—	—	—	8	16.3	10	20.4	3	6.1
Aggravated assault	38	5	13.2	14	36.8	1	2.6	1	2.6	4	10.5	8	21.1	5	13.2
Housebreaking	49	2	4.1	23	46.9	1	2.0	—	—	9	18.4	13	26.5	1	2.0
Grand larceny	16	1	6.3	4	25.0	1	6.3	—	—	5	31.3	3	18.8	2	12.5
Forgery	31	2	6.5	6	19.4	—	—	—	—	7	22.6	15	48.4	1	3.2
Auto theft	28	3	10.7	12	42.9	—	—	1	3.6	5	17.9	4	14.3	3	10.7
Narcotics	30	2	6.7	8	26.7	—	—	—	—	3	10.0	16	53.3	1	3.3
Other felonies	20	2	10.0	8	40.0	—	—	1	5.0	3	15.0	6	30.0	—	—
Total	361	37	10.2	141	39.1	5	1.4	6	1.7	65	18.0	87	24.1	20	5.5

Source: Saint Elizabeths Hospital. [Abstracted from President's Commission on Crime in the District of Columbia, Report 541 (1966)—ed.]

and charming" individual, whose adjustment potential in a prison or hospital environment appeared optimal.[66]

It is difficult to assess the philosophy underlying the rejection of most personality disorders by St. Elizabeths Hospital. Available evidence points to the probability that staff doctors balance the demands of pure medical judgment against the needs of hospital economics and administrative policy.

The matter has been aptly put in these terms by a senior staff member of the John Howard Pavilion:

> In clinical practice, private or institutional, the nosologic category of a patient is of secondary importance to the question of whether he needs help, whether he requires occasional, supportive therapy or intensive, investigative therapy. Not so with the psychiatrist in court, since he is there required to answer squarely and categorically whether, in his opinion, the defendant is or is not suffering from "mental disease" . . . .[67]

It appears as though the senior members of the St. Elizabeths staff have assumed that this attitude enjoys the imprimatur of the Court of Appeals. This may explain why Dr. Julian, a staff psychiatrist at St. Elizabeths, testified that a man may be mentally sick, but not sick enough to warrant a certification of mental disorder for courtroom purposes.[68]

As expressed by a former United States attorney, "there is reason to believe that the more experienced doctors [at St. Elizabeths] are reluctant to make a finding of mental disease without some evidence of its effect on conduct. They tend to look for behavior consequences, as one element of mental disease . . . ." [69]

As expressed by an institutional psychiatrist, when asked to discuss a particular case in terms of mental illness and its causal relationship to crime:

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66. Report to Counsel, subsequently the basis of testimony by Dr. Leon Salzman, dated April 10, 1962, in United States v. Marocco, *supra.*

67. M. Platkin, *A Decade of Durham,* 32 MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA, 317–319 (1963).

68. United States v. Watson, *Crim.* No. 907–60 (D.D.C. 1961). Transcript of Proceedings, p. 246.

69. D. Acheson, *McDonald v. United States: The Durham Rule Redefined,* GEO. L.J. 580, 588 (1963).

> Sure, the man is sick. Under the Carter case, moreover, I would say that his crime is the product of mental illness. But I choose to accept a stricter legal standard because if I did not, we would be flooded with undesirables, who are not acutely ill and who would clutter up our facilities which are already strained to the breaking point.[70]

Contacts With the Prosecution and Suspicion of the Defense

Upon commencement of court ordered mental examination, St. Elizabeths "routinely" requests background information on its patient from the office of the public prosecutor. Moreover, hospital records seem obtainable by members of the U.S. Attorney's office, whether by subpoena, court order or otherwise—well in advance of trial—often when the records do not appear available to the defense. In at least two instances defense counsel discovered hospital records of his clients in the possession of a member of the prosecution staff in advance of trial and was permitted to inspect them only in the prosecutor's office. This experience does not seem to be unique.

Lawyers engaged in tort litigation obtain hospital records of their clients upon the basis of a written authorization by the clients as a matter of course. A written authorization by the client will, however, fail to secure the necessary hospital records from St. Elizabeths Hospital in a criminal case in the District of Columbia. Nothing short of a court order will succeed in obtaining the hospital records for the defense and the attempt to secure such an order may well meet with opposition and dilatory tactics of the hospital staff.

Attempts by defense counsel to secure supplementary information, beyond the conclusory statement of "with" or "without mental disorder" transmitted in the hospital official certifications, have met with differing degrees of cooperation and non-cooperation by the hospital staff. While there have been occasions when explanatory statements concerning a given diagnosis were promptly and courteously provided, there have been other occasions when cooperation was utterly wanting on the part of senior members of the hospital staff. On one occasion, when defense counsel telephoned to inquire as to the specific diagnosis in the case of a defendant who had been certified as incompetent to stand trial, he was told by a senior physician of the John Howard Pavilion: "The

70. Interview conducted by Project staff member with staff physician of St. Elizabeths Hospital, Aug. 21, 1960.

District Attorney's office does not like us to engage in discussions of this kind with defense counsel." [71]

A lawyer who expresses his dissatisfaction to a St. Elizabeths physician with existing hospital procedures may be startled to discover that the prosecutor's office has been notified of his misconduct. A lawyer who had the temerity to suggest, at the conclusion of a case, that the testimonial assertion that there are "mentally healthy drug addicts" was questionable and that the matter would be best verified by transmitting a transcript of such testimony to the American Psychiatric Association, was formally accused of "intimidation" on complaint of an outraged St. Elizabeths staff.[72]

Communication of Diagnosis

Preliminary to trial, St. Elizabeths communicates its findings in criminal cases in a form letter.

As late as 1960, the Hospital provided a modicum of background information on a patient within the form letter. When such explanations were provided, one would frequently encounter statements such as this:

> Although the patient is not well integrated, he does not show clinical evidence of overt psychosis or any other type of mental disease at the present . . . . Our findings and information are not sufficient to warrant the formation of an opinion that the patient was suffering from mental disease between February 29 and June 27, 1960. However, in view of the patient's personality organization and rather poor integration, the possibility of his being mentally ill during the specified period cannot be definitely excluded.[73]

Or this:

> Available information indicates that . . . [the patient] has been a poorly adjusted individual, showing schizoid tendencies, a poor marital adjustment, an unstable occupational adjustment, and a long-standing tendency to over-indulgence in alcohol. However, in our opinion, he does not deviate sufficiently from normal to warrant a diagnosis of mental disease,

71. Telephone conversation between Project staff member and St. Elizabeths physician, Sept. 21, 1961.

72. United States v. Horton, *Crim.* No. 59–62 (D.D.C. 1962). Transcript of Proceedings, pp. 521–534.

73. St. Elizabeths certification in United States v. Aloysius Hart, *Crim.* No. 661–60 (D.D.C. 1961).

nor do we find evidence of mental disease existing on or about June 29, 1960. He is at best of dull normal intelligence, although he does not suffer from mental defect.[74]

At no time did the St. Elizabeths certification, however, provide the detail or the attempt at dynamic understanding of the individual exemplified by the certification of the D.C. General Hospital staff in the days when the latter still received cases from the District Court.[75] Significantly, during the last six years, the form letter sent by St. Elizabeths has changed: no longer is any information given which might suggest doubts concerning the diagnosis of "with" or "without" mental disorder which is transmitted to the court. The letter is barren of all information except that contained in the conclusory statement. Although the certification may not reflect unanimous staff opinion, it never includes a reference to any dissenting view. Instead it conveys the impression of intensive studies, suggestive of numerous and detailed diagnostic contacts and private interviews.

A characteristic form letter from St. Elizabeths, communicating a finding of mental disease and its causal relationship with the crime in issue,[76] is brief:

Mr. Morris Allen Kent, Jr. (Criminal Number 798-61), was committed to Saint Elizabeths Hospital on January 8, 1962, for a period not to exceed ninety days, upon an order signed by Judge Matthew F. McGuire, to be examined by the psychiatric staff of this hospital. It was further ordered that a written report be submitted to the Court regarding the patient's mental condition; mental competency for trial; mental condition on or about June 5 and 12, and September 2, 1961; and causal connection between the mental disease or defect, if present, and the alleged criminal acts.

Mr. Kent's case has been studied since the date of his admission to Saint Elizabeths Hospital and he has been examined by qualified psychiatrists of the medical staff of this hospital as to this mental condition. On April 4, 1962, Mr. Kent was examined and his case reviewed in detail at a medical staff conference. We conclude, as the result of our examinations and observation, that Mr. Kent is mentally competent to understand the nature of the proceedings against him and to consult properly with counsel in his own defense. It is our opinion that he is suffering from mental disease at the present time, Schizophrenic Reaction, Chronic Undifferen-

74. United States v. Pee, Jr., *Crim.* No. 701–60 (D.D.C. 1961).

75. A cut-off point around 1960 resulted in the routine referral of all mental examinations to St. Elizabeths Hospital.

76. United States v. Kent, *Crim.* No. 798–61 (D.D.C. 1963).

> tiated Type; that he was suffering from this mental disease on or about June 6 and 12, and September 2, 1961; and the criminal acts with which he is charged if committed by him, were the product of this disease. He is not suffering from mental deficiency. It is therefore requested that arrangements be made to have Mr. Kent transferred to the District of Columbia Jail to await disposition of the charges pending against him.
>
> Cordially yours,
>
> /s/ WINFRED OVERHOLSER, M.D.
> Superintendent

How does this analysis compare with the certifications made by the District of Columbia General Hospital psychiatric staff in the past and in those isolated instances in the present in which it is asked to pass upon a patient's mental condition for the District Court? D.C. General Hospital does not use a form letter. Frequently, a report by the D.C. General Hospital staff to the Court does not provide a definitive opinion as to whether a given individual has suffered from a mental disease productive of a crime. In such letters there may be, however, a significant amount of background information susceptible to the development of an insanity defense. Such information most frequently highlights significant aspects of the patient's history. This in turn may be related to the current diagnostic view. What emerges may give rise to further defense contacts with D.C. General Hospital doctors and the possible assertion of an insanity defense on new grounds.

Perhaps the contrast between the D.C. General Hospital certification in District Court cases and that provided by St. Elizabeths Hospital at this time is best appreciated by juxtaposing the St. Elizabeths Hospital finding of mental illness in the *Kent* case, reproduced above, with that of the D.C. General Hospital in the same case. The letter of the D.C. General Hospital reads as follows:

> On October 17, 1961, Morris Kent, a sixteen year old, light skinned, negro boy was admitted to the District of Columbia General Hospital for mental observation. He was accused of taking part in a series of housebreaking and rape episodes. The question was raised as to the competency of this boy or the presence of mental illness that might have led to the crimes.
>
> Morris has been here for almost 60 days. During that time he has been seen by many psychiatrists, has taken part in a diagnostic study, including psychologicals, electroencephalogram, and projective tests involving art materials. In addition there has been constant supervision of his activities

by nurses, attendants, and students all of whom are trained observers. There have been a series of staff conferences concerning all of the issues.

It is the consensus of the staff that Morris is emotionally ill and severely so. In view of the many facets of his behavior we feel that he is incompetent to stand trial and to participate in a mature way in his own defense. His illness has interfered with his judgment and reasoning ability, and when faced with situations unfamiliar to him, his anxiety occasionally becomes so great he becomes disorganized. There are many examples of this including his inability to report blood on his penis, the fact that occasionally his clothes have been stained by a bowel movement and particularly the disorganized and almost incoherent way that he has presented the details of his life and the trouble he has had. In some ways he can appreciate the predicament he is in while in other ways his attitude contains disregard for what he has done.

Indeed he has a mental illness of the schizophrenic type. At times this illness allows him to react within the bounds of normality, while at other times he reacts abnormally. During the time he committed the crimes his condition seemed to be a psychotic one but I am unable to arrive at a definite opinion on this matter. His life has been troubled for a number of years and has brought him great pain. Whether or not he can make use of psychotherapy is another issue, but it is our opinion long term treatment should be offered to him.

We would particularly stress the idea that this is a dangerous boy. His behavior has become more pressured from within, and has included activities that can result in destruction to himself and/or others. Certainly close and constant supervision must be, it seems to us, the outcome of the interest in this boy. We would recommend that such placement take place in an institution allowing some treatment of his mental condition rather than incarceration in a jail. We cannot, however, ignore our responsibility in underlining the danger and potential damage to himself and others that lies within him.

Sincerely yours,

MARY V. MCINDOO, M.D.
Chief Psychiatrist

WILLIAM J. NOVAK, M.D.
Clinical Director in Psychiatry

CONCLUSION

Durham jurisprudence began with a sonorous disclaimer of cognition as the exclusive criterion of criminal responsibility. Years have passed. It is ironic that today the tolerance of Durham jurisprudence for intellectual awareness as a criterion of criminal responsibility should exceed that of enlightened interpretations of M'Naghten.[77]

77. See R. Arens and J. Susman, *Judges, Jury Charges and Insanity*, 12 How. L.J. 1 (1966) and the cases cited therein. Cf. People v. Schmidt, 216 N.Y. 324, 110 N.E. 945 (1915); Stapleton v. The Queen, 86 Commw. L.R. 358 (Aug. 1, 1952) and F. Wertham, *Psychoauthoritarianism and the Law*, 22 U. CHI. L. REV. 336 (1955).

And indeed today's judicial psychiatry in the District of Columbia is passing strange.

The Court's support of the widest possible spectrum of exculpatory mental illnesses, consistent with accepted psychiatric usage, has withered on affirmances of convictions resting on the testimony of St. Elizabeths physicians that drug addicts, epileptics, sex-perverts and victims of delusionary and hallucinatory experiences are without mental disease or defect.[78]

The individual suffering from a psychoneurotic "check-writing proclivity" continues to be consigned by the Court to treatment within the walls of a mental hospital "designed principally for the treatment of persons suffering from acute and chronic psychosis." [79]

And what of the quality of psychiatric justice? Any survey of the scene makes it plain that the St. Elizabeths staff has engaged in no less than the usurpation of juroral and judicial roles by extra-diagnostic decision-making.[80]

The statement of a private practitioner aptly portrays the situation in these terms:

> . . . It appears to me that the Government psychiatrists have been operating from the stand-point of *post-hoc* logic. That is to say—the determination of "mental illness" in a particular case is derived from two

78. The doctrine of "inherent implausibility" often invoked against complaining witnesses in rape cases, did not seem to be applied to St. Elizabeths physicians on judicial review. See, *e.g.*, State v. Morrison, 189 Iowa 1027, 179 N.W. 321 (1920); Brown v. Commonwealth, 82 Va. 653 (1886); Cf. People v. Carey, 223 N.Y. 519, 119 N.E. 83 (1918). See also generally MILLER, CRIMINAL LAW 294 (1934).

79. Overholser v. Russel, 283 F. 2d 195 (D.C. Cir. 1960). Beyond this, it may be observed that the development of a doctrine of diminished responsibility as affected by mental impairment has been inhibited by extant Durham jurisprudence. See Stewart v. United States, 275 F. 2d 617, 623-24 (D.C. Cir. 1960). So has a sophisticated exploration of intent. Nothing in the District of Columbia reflects the resourceful and humane treatment of intent as affected by organic and functional disorder exemplified by Rex v. Charlson (1955) 1 All E.R. 859 and People v. Jones, 42 Cal. 2d 219, 266 P. 2d 38 (1954).

80. This has been observed by such distinguished critics of the Durham Rule as Judge Kaufman who declared that in the District of Columbia "psychiatrists when testifying that a defendant suffered from a 'mental disease or defect' in effect usurped the jury's functions." Judge Kaufman noted in this connection:

> This problem was strikingly illustrated in 1957, when a staff conference at Washington's St. Elizabeths Hospital reversed its previous determination and reclassified 'psychopathic personality' as a 'mental disease'. Because this single hospital provides most of the psychiatric witnesses in the District of Columbia courts, juries were abruptly informed that certain defendants who had previously been considered responsible were now to be acquitted. United States v. Freeman, 357 F 2d 606, 621–622 (2d Cir. 1966).

> factors, (a) the available space, and (b) the treatability of the disorder recognized. I received the most significant part of my psychiatric training at St. Elizabeths Hospital, and can therefore see that side of the question. But it seems illogical for me that the fate of a man, standing accused, should be determined by logistic factors irrelevant to the life of this man . . . .[81]

The pattern of psychiatric testimonial practices produced by a commitment to such ends suggests the atmosphere of *Alice in Wonderland.*

Reform: Legal Doctrine and Practices

The pressing tasks of judicial reform can be stated succinctly. Judicial recognition of man as an integrated personality must be restated in terms more meaningful and binding than before. Repudiation of cognition as the exclusive criterion of criminal responsibility must be made crystal-clear. Psychiatrists and trial judges should not be permitted to accomplish by indirection what they may not do directly. The hold of a mechanically administered and cognitively oriented right-wrong test still remains to be broken by the Court of Appeals.[82]

And it is high time for meticulous assessment by the Court of Appeals of the credibility of St. Elizabeths testimony as reflected in the trial transcripts. One should not have to point out at this stage that a concern for the victim of mental disease or defect is not readily squared with the refusal of the Court to analyze the merits of the testimonial assertions of the Hospital as to the mentally healthy epileptic, drug-addict, sex-pervert and homicidal Willie.

To be sure, the Court of Appeals has at long last indicated a healthy degree of skepticism concerning the "conclusory testimony" of St. Elizabeths physicians in some of the matters referred to above. Only recently, the court declared that it had reservations about the validity of testimonial assertions by St. Elizabeths physicians that a "paranoid personality" disorder was not a mental disease.[83] Further steps in the scrutiny of psychiatric testimony, however, are overdue.

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81. Letter to author, July 2, 1963. The identity of the psychiatrist who wrote it is kept confidential at his request.

82. Earlier studies of jury charges have made it plain that the classical Durham view has made a minimal impact upon District of Columbia trial courts and trial juries. See R. Arens and J. Susman, *supra* and R. Arens, D. Granfield and J. Susman, *supra.* One may further suggest that the court may wish to reconsider the requirements governing the release of those acquitted by reason of insanity insofar as they have tended to discourage the assertion of the insanity defense. Cf. dissenting opinion of Mr. Justice Clark in Lynch v. Overholser, 369 U.S. 705, 720 (1962).

83. Rollerson v. United States, 343 F. 2d 269, 272, n. 6 (D.C. Cir. 1964). The court pointed out that the St. Elizabeths view appeared to be directly opposed to the

Reform: Existing Material and Human Resources

A disturbing question must be raised as to the role of St. Elizabeths in the administration of the insanity defense under any rule of criminal responsibility. Does the chronic housing and staff shortage of the hospital, to say nothing of the custodial and authoritarian orientation demonstrated by its staff, disqualify the hospital as an impartial arbiter of the existence of mental disease or defect in criminal cases? The question has been asked by no less formidable a protagonist of government psychiatry than Dr. Winfred Overholser while Superintendent of St. Elizabeths Hospital. Dr. Overholser had been ordered to assist in the psychiatric determination of the presence or absence of sexual psychopathy, as defined by District law. The findings of such psychopathy would have resulted in the indefinite confinement of the individual patient at St. Elizabeths. Writing to the District Court about his misgivings as to the demand upon the time of his staff members in the execution of such a study and the possible conflict of interests arising under such circumstances, Dr. Overholser declared:

> The order directs me to appoint two qualified psychiatrists to examine him, presumably at a place and time of their choosing. I shall arrange to have this done, but there are one or two points to which I wish to invite your attention. Obviously, I have no right to appoint anyone who is not on the staff of the Hospital. Our doctors are all extremely busy taking care of the patients who are already here and I shall somewhat reluctantly comply with your instructions.
>
> Another point of propriety is one that I should like to raise, namely, whether it is proper that physicians on the staff of St. Elizabeths Hospital should be called upon to determine whether a person not now in the Hospital as a patient should be examined by them to determine whether he should be sent to the Hospital. In civil cases I am sure that a question of this sort would be raised and I wonder whether it is entirely proper, whether legal or not, to make such an arrangement in a criminal case. The points which are raised are perhaps moot. Nevertheless, I should be remiss if I did not invite your attention to them in the hope that this apparent conflict of interest may not arise again.[84]

An equally disturbing question which must be raised is whether the available pool of psychiatric personnel is in fact sufficiently skilled and appropriately committed to the ideology of a democratic social order to

views reflected in the DIAGNOSTIC AND STATISTICAL MANUAL of the American Psychiatric Association and in standard psychiatric texts. *Ibid.*

84. United States v. Harry J. Allen, *Crim.* No. 438-60 (D.D.C. 1961).

permit constructive legal-psychiatric teamwork on any level in the reasonably foreseeable future.[85]

Beyond that it is safe to conclude that the repercussions of the Durham Rule call for studies of resistance to change, not too unlike those encountered in surveys of Southern Justice. It will certainly do no good to engage in another of the seemingly endless series of studies on the on-going dialogue between representatives of the legal and psychiatric professions.[86] It is clear at least that unless the problem of resistance to

85. Whatever misgivings may arise on this score vis-à-vis government psychiatrists are fully matched by similar misgivings vis-à-vis significant numbers of private psychiatrists engaged in legal-psychiatric work and observed in the District of Columbia. The interviewing of private psychiatrists in the nation's capital to determine their attitudes toward the insanity defense conducted by project staff members between 1959 and 1960 revealed a startling frequency in "custodial" and punitive orientation. Observation of such psychiatrists in court-work further revealed an equally startling appearance of indifference to the fate of the defendant and a disconcerting carelessness in the organization and presentation of testimonial materials. There were, of course, conspicuous exceptions.

86. The change from coercion to rehabilitation by mental hospitals and prisons has been the subject of a number of recent studies. M. GREENBLATT, D. LEVINSON & R. WILLIAMS, THE PATIENT AND THE MENTAL HOSPITAL (1957); MCCLEERY, POLICY CHANGE IN PRISON MANAGEMENT (1957); D. Cressey, *Contrary Directives in Complex Organizations: The Case of the Prison*, 4 ADMIN. SCI. Q. 1 (1959); D. Cressey, *Achievement of Unstated Organizational Goals: An Observation on Prisons*, 1 PACIFIC SOC. R. 43 (1958); O. Grusky, *Role Conflict in Organizations: A Study of Prison Camp Officials*, 3 ADMIN. SCI. Q. 452 (1959).

Two points are often repeated: (1) The ideal goals of mental hospitals, correctional institutions, and prisons are therapeutic. "The basic function of the hospital for the mentally ill is the same as the basic function of general hospitals . . . that function is the utilization of every form of treatment available for restoring the patients to health." M. GREENBLATT, R. YORK & D. BROWN, FROM CUSTODIAL TO THERAPEUTIC PATIENT CARE 3 (1955). (2) Despite large efforts to transform these organizations from custodial to therapeutic institutions, little change has taken place. Custodial patterns of behavior still dominate policy decisions and actions in most of these organizations. "In the very act of trying to operate these institutions their *raison d' etre* has often been neglected or forgotten." M. Greenblatt, D. Levinson & R. Williams, *op. cit., supra* at 3. Two sociologists stated explicitly:

> Custody and care of delinquent youth continue to be the goals of correctional agencies, but these are growing aspirations for remedial treatment. The public expects juvenile correctional institutions to serve a strategic role in changing the behavior of delinquents. Contrary to expectations, persistent problems have been encountered in attempting to move correctional institutions beyond mere custodialism . . . . Despite strenuous efforts and real innovations, significant advances beyond custody have not been achieved.

R. Vintner & M. Janowitz, *Effective Institutions for Juvenile Delinquents*, 33 SOCIAL SERVICE R. 118 (1959).

One reason for this failure has been found in the external environment. Organizations have to adapt to the environment in which they function. When the relative

change is met—and it is maximal in the field of the psychiatric defense—no rule of criminal responsibility, however rational and idealistic, can avoid the frustration and distortion of Durham.

Barely a year ago a new group of "patients" became eligible for the ministrations of available government psychiatry. Sitting en banc, the U.S. Court of Appeals for the District of Columbia held in 1966 in *Easter v. United States* that a chronic alcoholic was a victim of an illness and that he could not be prosecuted for the manifestation of such symptoms as public drunkenness although he could be subjected to compulsory treatment for his condition.[87]

The chronic alcoholic, it may be observed in conclusion, may pay dearly for such judicial largesse. For barring a change in public and psychiatric attitudes and the creation of meaningful facilities for humane and effective treatment, the history of *Easter* is likely to approximate the history of *Durham*, a disaster whose lessons have yet to be learned.

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power of the various elements in the environment are carefully examined, it becomes clear that, in general, the subpublics (*e.g.*, professionals, universities) which support therapeutic goals are less powerful than those which support the custodial or segregating activities of these organizations. E. CUMMING AND J. CUMMING, CLOSED RANKS (1957). Under such circumstances, most mental hospitals and prisons must be more or less custodial.

The present study suggests that the internal environment also imposes constraints. Even assuming that through the introduction of mental health perspectives and personnel, especially psychiatrists, St. Elizabeths' operating policies became oriented to therapy, it appears that Vintner's and Janowitz's observation would still be valid. St. Elizabeths would not be very effective serving therapy goals. Supportive of this conclusion is the small number of professionals available as compared to the large number of patients, the low effectiveness of the present techniques of therapy, the limitations of knowledge, and so on.

87. Easter v. District of Columbia, 361 F. 2d 50 (D.C. Cir. 1966). See the similar holding by the Fourth Circuit in Driver v. Hinnant, 356 F. 2d 761 (4th Cir. 1966). The United States Supreme Court has so far declined to decide the issues raised by these cases. See the dissent by Mr. Justice Fortas in Budd v. California, *cert. denied* 385 U.S. 909 (1966).

The inadequacies in existing treatment facilities for the alcoholics in the District of Columbia are highlighted in REPORT OF THE PRESIDENT'S COMMISSION ON CRIME IN THE DISTRICT OF COLUMBIA 474–490 (1966). The courts, in turn, have been erratic in the handling of alcoholic patients. As observed by a news reporter, "[o]ne judge's chronic alcoholics are another judge's drunks, or so it seemed yesterday after General Sessions Judge Milton S. Kronheim sentenced a man previously adjudged a chronic alcoholic to 30 days in jail for public intoxication." *Washington Post & Herald*, July 6, 1966, p. B1.