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## MEN IN STATE PRISON

FRANK T. RAFFERTY

The author is Assistant Professor of Psychiatry in the University of Utah and Director of Psychiatric services in the state prison. Prior to 1955 he served as a psychiatrist in the U. S. regular army in the Korean campaigns. His special interest in the relationship of law and psychiatry—more generally in the field of social psychiatry—began in that campaign. He is active in the study of group processes in the treatment of adolescents.—EDITOR.

In October, 1955, a psychiatric service was inaugurated at the Utah State Prison as a result of a long-standing administrative problem in the management of the psychotic inmate. A part-time psychiatrist-director, half-time psychologist, full-time social worker and secretarial staff were selected to serve this institution which receives all male felons convicted within the state. Total population averages 560, with a monthly intake of approximately 20. This psychiatric team directed its attention not only to the psychotic inmate, but acted in a consultant role to prison management; the operation of custody; classification; parole; and has functioned as a general mental health service. This function has been quite imperfect and handicapped by many factors such as the informal prison organization, lack of treatment orientation in prison officials, poorly trained personnel, etc. Despite many problems, considerable progress has been made in developing a treatment program. Rigorous research has not been possible, yet this experience has been significant in influencing the orientation and philosophy of the psychiatrist director. The primary objective of this paper is to communicate the perspective achieved from this experience with reference to the tests of criminal responsibility.

These tests have rested on the assumption that an insane individual should not be subjected to the punitive-deterrent treatment of criminal law and the correctional system. Insanity has been defined in terms of disruption of the cognitive functions of the ability to know and appreciate the significance of a given act. To this was added the ability to control actions by the knowledge of right and wrong. Over the years these tests have been severely criticized by most psychiatrists and it has been stated that scientific criteria of legal responsibility are logically impossible.<sup>1, 2</sup> Legal

authorities have responded to psychiatric criticism by attempting various modifications of the tests. Perhaps the modification recently adopted in the District of Columbia is to be considered the most advanced of these. It is referred to as the Durham decision, which holds that the accused is not to be held criminally responsible for an act which was the product of a mental disease or defect. Legal reaction to this test has been considerably less than enthusiastic. Substantially, this rule amounts to abandonment of any legal definition of insanity and the judge is instructed to find the defendant not guilty by reason of insanity if the jury accepts the evidence of the psychiatrist that the defendant is mentally ill. To be sure, it is theoretically necessary that the act be a product of the mental illness. But interpretation by the court has been to state that an act shall be a product of the mental illness if the facts of the act are such as to justify reasonably the conclusion that but for this disease, the act would not have been committed.

Psychiatrists will have equal difficulty giving a precise meaning to mental illness as they have to a concept of responsibility. One of the greatest difficulties in epidemiological studies has been the absence of a satisfactory definition of mental illness. Applying the concept to the prison population, I find that it either includes a very few of the inmates or includes most of them. In the first instance the concept of mental illness implies a determination of the intactness of cognitive function. In the latter, mental illness is equivalent to the psychodynamic determinants of behavior. Prison clinical experience demonstrates that diagnostic classification is a special complicated type of value judgment and as Szasz has pointed out, this special case of category formation depends on the psychological characteristics of the person engaged in forming categories and the

<sup>1</sup> ZILBOORG, G., *THE PSYCHOLOGY OF THE CRIMINAL ACT AND PUNISHMENT*—New York, Harcourt Brace, 1954.

<sup>2</sup> BOARD, RICHARD G., *An Operational Conception of Criminal Responsibility*, *AM. J. PSYCH.*, 113: 332-336, Oct., 1956.

social situation in which he participates.<sup>3</sup> It is apparent that psychiatry has become considerably more than a medical specialty dealing with a limited number of individuals who are suffering from a disease process. In effect, the psychiatrist has become a student of all behavior and turns to an integration of the biological and social sciences for explanatory concepts. Psychiatric nosology has not developed a classification that adequately represents our dependence on the Social Sciences.

Despite my conclusion that the psychiatrist as an expert witness is attempting a scientific and semantic impossibility in defining criminal responsibility or mental illness, I do not advocate the abandonment of tests of responsibility. I believe they serve important and practical functions in our criminal law. Such functions may not be exactly what we intend them to be, and indeed we may not know all the latent functions. For example, Dr. Szasz has suggested that the psychiatric testimony may be one of the many ways that criminal procedure has to protect the sentencing authorities from guilt feelings for hurting a fellow human being.<sup>4</sup>

Two more obvious functions served are: (1) the determination of the appropriateness of capital punishment and (2) the determination whether an individual should be confined in a prison or a hospital. As long as these functions are necessary, the tests of responsibility are necessary in some form.

It has not been sufficiently emphasized that these tests are intimately bound to the concept of capital punishment. An estimated 25 percent of new admissions could have legitimately made a strong plea of not guilty by reason of insanity under Utah's strict adherence to the M'Naghten Rules and the irresistible impulse. These men are confined on such charges as carnal knowledge, forgery, second degree burglary, failure to provide, etc. For the most part, the defense of insanity was not employed. Several different hypotheses to explain this phenomenon have been considered. It is possible that this represents an artifact of the practice of law and psychiatry in Utah and is not found in other states. It is possible that this is a product of the practice of allowing offenders to plead guilty to a lesser offense than the one

charged. It is possible that court appointed attorneys have had neither the interest, time nor financial resources to attempt to establish the defense of insanity.

The most probable explanation seems to be that attorneys turn to insanity as a defense in a desperate attempt to save their client from capital punishment. If lesser punishment is threatened, the attorney is inclined to advise his client to take his chances on serving a short term in prison as opposed to an indefinite confinement in the State Hospital. From the psychiatric point of view, this represents a shortsighted view of the client's interests. But it does underline a very real concern on the part of lawyers that commitment procedures do not protect the rights of the individual, particularly if commitment is for treatment following a criminal offense.

The tests of responsibility function in a practical way to determine whether a given individual should be confined in a prison or a hospital. The distinction between prison and hospital implies different things to different people. The prison implies punishment and the hospital, treatment. The responsible management of a prison is in the hands of non-medical personnel. Hospital patients have mental illnesses. Prison inmates have behavior disorders. Psychiatrists know how to treat the mental illnesses in hospitals, but do not know how to treat behavior disorders in prisons. The confinement in a hospital is different than confinement in prisons. The confinement in prison is punishment. Confinement in hospitals is ego supportive.

Each of these points deserve more attention than is possible here. My essential thesis is that hospitals and prisons are analogous social institutions developed to serve similar functions but in different stages of development. Historically, it would seem that prisons and hospitals have not always been so distinct. Mental illness has only recently escaped being considered morally evil and the result of supernatural punishment. Without medical supervision the correctional institutions have developed probation and parole, the pre-sentence investigation, the indeterminate sentence and penal treatment programs which are analogous to outpatient therapy, diagnostic studies and hospital treatment programs. Probably the extent to which prisons have developed into treatment institutions is not fully appreciated by those not in correctional work. At Utah State Prison, up to five percent of the population has

<sup>3</sup> SZASZ, THOMAS, *The Problem of Psychiatric Nosology: A Contribution to a Situational Analysis of Psychiatric Operations*, AM. J. OF PSYCH., 114: 405, 1957.

<sup>4</sup> SZASZ, THOMAS, *Psychiatry, Ethics and Criminal Law*, COLUMBIA L. REV., 58: 194, Feb., 1958.

been on tranquilizing medication. Over one-third of the population is involved in group therapy. Many individuals have at least short term access to individual therapy and milieu therapy is a general goal of the entire institution. Educational, recreational and vocational programs are equal or superior to those of the State Hospital. As more psychiatric energy, interest and research is directed to prisons, I am convinced that the distinction between prisons and hospitals will become increasingly blurred.

In summary, clinical psychiatric experience in prison supports the general psychiatric position that criteria of criminal responsibility are scientifically impossible. Definition of criminal behavior as a product of mental illness will probably be equally unsatisfactory. If, however, the tests of criminal responsibility are conceived as an expedient and pragmatic means of serving important social functions rather than as a search for scientific truth, psychiatrists should have less objection to their use in criminal law.