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Psychiatry and Colorado Criminal Law

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PSYCHIATRY AND COLORADO CRIMINAL LAW*

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"Law and legal procedures have always been a mystery to the uninitiated, a snare to the unwary and a red rag to the unhappy man possessed of reforming zeal."—Lord Buckmaster

The incidence of serious crime, a matter of profound public concern, shows the need for searching inquiry in many areas including the adequacy of present criminal legislation. When the crime is that of murder and when the defendant's guilt is not in doubt, a plea of not guilty by reason of insanity is almost inevitable. Equally inevitable is the battle of psychiatric witnesses whenever the state psychiatrists find the accused to be legally sane. The public is puzzled by this disagreement within the medical profession. Opinions differ; some persons believe that the offender must be crazy to commit such a brutal crime; others are alarmed at the possible abuse of the insanity plea and demand the death penalty, while reformers insist on the need for revision of the tests of criminal responsibility and elimination of the death penalty. The important problem of prevention of homicide tends to be overlooked in the midst of all this clamor. The sociopathic criminal, the prevention of serious crime, tests of criminal responsibility and the death penalty will be reviewed briefly from a psychiatric viewpoint.

THE SOCIOPATHIC OFFENDER

Sociopaths are social misfits who fail to conform to accepted social customs. The manifestations of their lawlessness are protean; alcholism, drug addiction, sexual perversions, theft, assault and even homicide may be seen. They seem unable to profit from experience or punishment and tend to continue their criminal behavior on release from prison. Under our "cash register" system of punishment, the convicted sociopath is sent to a penitentiary for a varying number of years depending on the number of citizens he has assaulted. Short sentences do not change his pattern of behavior. Harsh punitive sentences serve only to increase his resentment toward society. Rarely his incarceration may lead to his rehabilitation; more often, however, it serves only to complete any deficiencies in his knowledge of safecracking, assault or other forms of crime. He may acquire for the first time the habit of taking drugs, which, the writer understands from criminal acquaintances, are often available within prison walls.

Detention alone for a stated period of time means all too often that dangerous persons are released to continue their criminal behavior. From their ranks come a significant percentage of the murderer population.

A recent study of 588 cases of criminal homicide in Philadelphia showed that 64 per cent of the murderers had previous arrest records, that of these, 66 per cent had a record of offenses against the person, and that of these, 73 per cent had a record of aggravated assault. Many of the persons previously arrested were convicted but given relatively light sentences and probably little constructive atetntion. That two out

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of three of these murderers had previous arrest records shows the need to recognize early and treat more carefully the potential homicide offenders.[1] This study did not report on the incidence of sociopathy but local experience suggests a high incidence of this disorder among murderers with previous arrest records.

Unfortunately our society makes little provision for treatment of the aggressive sociopath. The inadequacy or deviation or failure to adjust to ordinary social life is not a mere wilfulness or badness which can be threatened or thrashed out of the individual but constitutes a true illness which should be treated.[2] The relatives of a sociopath may recognize the need for treatment and attempt to secure commitment to a mental hospital. Involuntary commitment is often essential as the sociopath seldom seeks help, unless he is facing a prison sentence. Under Colorado Civil Law, he is eligible for commitment "for his own welfare or for the welfare or safety of others." Medical commissions, however, rarely commit the sociopath as he is not psychotic. Yet the commitment laws make no reference to clinical diagnosis and there is no provision in the law restricting commitment to persons suffering from psychosis. The reluctance of medical commissions to commit the sociopath (unless he is also a chronic alcoholic) is perhaps understandable in view of the overcrowding and shortage of psychiatrists in our state mental hospital. This problem might be remedied by construction of another hospital in Denver and by increasing the salaries of physicians to levels offered by other states.

A partial solution to the problem of recidivism and the sociopathic offender would be the introduction of an "indeterminate sentence" law in Colorado. Many states have enacted indeterminate sentence laws under which the sentence imposed by the court is for an indeterminate period and the exact time of the defendant's release is decided upon later by an administrative board. The principal argument in favor of indeterminate sentence laws is that it is not desirable to decide at the outset how long a person should remain in confinement, but that it is advantageous to watch the development of his personality, his adaptability to training, and his desire and will to become rehabilitated, and to reach a decision as to when his release date should come on the basis of the progress of events.[3] An indeterminate sentence law to be effective

[1] Wolfgang, Patterns in Criminal Homicide, Philadelphia, University of Pennsylvania (1958).
[2] Henderson, Psychopathic States (1947).
[3] Holtzhoff, In Branham, V.C. and Kutash, S.B., Encyclopedia of Criminology, New York, Philosophical Library (1949).

must offer something more than punishment. The offender should be sent to prison as punishment and not for punishment. While he is in custody every effort should be made to modify his pattern of antisocial behavior.

Under the indeterminate sentence law in California, the Adult Authority, a seven member board appointed by the Governor, has the responsibility for setting sentence, fixing terms and paroling inmates of Department of Corrections institutions. The penal code requires that the Department of Corrections provide "a scientific study of each prisoner, his career and life history, the cause of his criminal acts and recommendations for his care, training and employment with a view to his reformation and the protection of society."

The average length of time required for a clinical case study ranges from six to ten weeks. During this time each inmate undergoes an extensive period of psychological testing in a reception-guidance center. Inmates with serious behavioral or emotional problems are examined by a psychiatrist. On completion of the study, each inmate is transferred to an appropriate institution in the department. The findings of the reception-guidance center are used by the institution to which the inmate is assigned in understanding the man and his problems and helping him to participate in a program that will help to correct his deficiencies.

The Department of Corrections includes among its institutions the "California Medical Facility" which has as its primary purpose the confinement, treatment and care of inmates who are mentally abnormal including sociopathic offenders. The Medical Facility differs from the usual prison in that the superintendent is a physician and that special emphasis is given to psychological treatment by psychiatrists and psychologists. The mainstay of the program is group psychotherapy.

The Patuxent Institution in Maryland has as its aim the treatment and rehabilitation of convicted offenders. Offenders who have shown persistent antisocial or criminal behavior and who, on examination after conviction of a crime, are found to be sociopaths are committed to this institution. The prisoner is confined and treated under an indeterminate sentence and the length of time he stays is determined not so much by what crime was committed but by his readiness to rejoin society. Inmates who do not respond to treatment may be transferred to a penitentiary. The director is a psychiatrist and the professional staff includes psychiatrists, psychologists and social workers.

The first combined penal and psychiatric facility of this type was established near Copenhagen in 1935. The medical superintendent claims that 50 per cent of the detainees return to normal life in the community.

It is hoped that Colorado will follow the lead set by California and Maryland. An experimental center could be set up within the Colorado State Penitentiary to provide for psychiatric treatment of a small number of sociopathic offenders. A major advantage of such a treatment center would be the valuable experience gained by prison guards assigned to the center. In time, the lessons learned within the center would have a beneficial influence on the prison as a whole. This has been the experience in California.

The Childrens' Diagnostic Center established at the University of Colorado Medical Center by an act of the legislature in 1955, provides for psychiatric examination of juvenile delinquents and emotionally

disturbed children upon the order of the county judge. Specialized psychiatric treatment may be indicated but is not always available within the state due to a lack of trained staff and suitable facilities. The center does, however, perform a valuable service by providing expert guidance for the courts and by contributing to the early treatment of potential sociopathic offenders.

TESTS OF CRIMINAL RESPONSIBILITY

In almost all of the states the tests of criminal responsibility are based on the *M'Naghten* rules formulated in England in 1843. These rules state in essence, that in order to establish a defense of insanity, it must be shown that the accused "was laboring 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." In Colorado and some other states, the "right-wrong test" has been supplemented by the "irresistible impulse" test and the "ability to adhere to the right and refrain from doing the wrong" test.

The Colorado rules may be criticized on four grounds. Firstly, many psychiatrists object because they are required to make a moral decision in applying the tests. That the determination of criminal responsibility is a moral decision is freely acknowledged by the courts. The psychiatrist would prefer to give a medical opinion and leave the moral decision entirely to the jury. The medical opinion would involve a review of the findings of a thorough psychiatric examination in terms which would be within the understanding of a jury of lay persons.

A second objection to Colorado procedure is that the psychiatrist in forming his opinion is not permitted to consider hearsay material. This means that he is not permitted to consider information obtained from relatives or from previous medical records of the accused. Guttmacher comments that the courts of Colorado are notorious for their extreme position in this matter. There are many jurisdictions that have far more liberal and enlightened procedural rules. The Colorado procedure inflicts a particular burden on psychiatrists who appear as witnesses for the State as they are required to testify according to the strict letter of the law. The courts, however, sometimes relax the rule when psychiatrists testify upon behalf of the defendant.

The third major defect of the Colorado rules is that a person who is found not guilty by reason of insanity may be released from the hospital

within a short period even though there may have been no significant change in his mental condition. Thus a person who pleads insanity may be found sane by the psychiatrists at the Pueblo State Hospital. If the jury rejects their finding, the accused is committed to the Pueblo State Hospital. When his lawyer requests his release the Pueblo psychiatrists must certify that he is sane. Yet the person though legally sane by medical standards may be a menace to society by reason of mental disease which does not amount to legal insanity. Thus after less than a year in custody following a serious crime he may be set free to continue his criminal activities.

The fourth defect arises from the fact that a person may be found not guilty by reason of insanity and committed to the State Hospital in the absence of his conviction of the crime charged. The possibility exists that an innocent person may be held responsible for a crime and that the guilty person may escape detection because further police action is prevented.

An escapee from a mental hospital in another state was arrested on a charge of murder and over his strenuous objections his attorney entered a plea of not guilty by reason of insanity. During his hospital stay he was steadfast in maintaining his innocence. In this case, the murder charge was later withdrawn and the possibility of wrongful commitment on the basis of an insanity plea was avoided.

In contrast to the Colorado rules stands the *Durham* decision of the United States Court of Appeals for the District of Columbia. Under this decision an accused is not held criminally responsible if his unlawful act was the product of mental disease or mental defect. "Disease" is defined as a condition which is capable of either improving or deteriorating, and "defect" as a condition which is not considered capable of either improving or deteriorating and which may be either congenital, or the result of injury, or the residual effect of a physical or mental disease.

Roche believes that the product question can only be answered affirmatively or not at all. "The psychiatrist can do no more than say that a causal connection invariably exists, for no other reason than that in his experience and within his psychological model he has never encountered a case where outward behavior was unrelated to inward mental life—at best the product question can only remain within the realm of moral definitions." He submits that if the product question is withheld from the expert and confined to the jury, psychiatry can function properly.[4]

Some psychiatrists mistakenly believe that the *Durham* rule frees the psychiatrist from having to answer questions based on the "right-wrong," "irresistible impulse" and "the ability to adhere to the right and refrain from doing the wrong" tests. This is not correct as expert witnesses are liable under the *Durham* rule to examination and cross examination on these points. However, the physician in giving his opinion, and the jury in reaching their verdict are not restricted within the confines of these criteria.

Premature release from hospital is prevented by a law requiring that anyone acquitted by reason of insanity be committed to a mental hospital

[4] Roche, The Criminal Mind (1958).

until the superintendent certifies that the person has recovered his sanity and that he is no longer a danger to the community. Release is subject to approval by the court.

The *Durham* rule has been criticized because it does not provide a precise definition of insanity, but as Sobeloff emphasizes, what we ought to fear is not the absence of a definition but a false definition. The medical profession would be baffled if asked to write into the legal code universally valid criteria for the diagnosis of the many types of psychotic illness which may seriously disturb a person's responsibility and even if this were attempted, the diagnostic criteria would have to be rewritten from time to time with the progress of psychiatric knowledge.[5]

The fear has been expressed that juries will abuse the discretion granted to them and acquit persons who should probably be punished. Statistics from the District of Columbia show that from 1952 to 1955, the three-year period before the *Durham* rule became effective, 0.8 per cent of felony trials resulted in verdicts of not guilty by reason of insanity. In a similar period since the rule has become effective, the percentage has increased to 1.6 per cent. Such an increase, as Guttmacher points out, is not sufficiently momentous to lead to the conclusion that the *Durham* rule threatens to undermine the criminal law, or that it inspires the susceptible to become felons.[6]

The advantages of the *Durham* rule have been stated by Mr. Justice Douglas. "The *Durham* rule aids the jury in a solution of the problem by letting the psychiatrist talk, unfettered by arbitrary legal formulae. The psychiatrist will be free to present his testimony about the mental condition of the accused in concepts that are familiar to him and medically realistic. The psychiatrist merely expounds on the theoretical and clinical aspects of the problem. The jury evaluates his testimony, as it does the evidence on every other factual issue. That is the correct disposition, for the question whether society should assess punishment for criminal conduct is, in the last analysis, a moral judgment. The jury, being of the community, reflects its attitudes and speaks for it."[7]

THE DEATH PENALTY

Advocates of the death penalty draw attention to the Old Testament teaching of a life for a life, argue that death is more humane than long imprisonment and claim that if the deterrent effect of the death penalty were removed more murders would be committed.

Opponents of the death penalty refer to a later text in the Old Testament (Ezekiel 33:11. "As I live, saith the Lord God, I have no pleasure in the death of the wicked, but that the wicked turn from his way and live.") and also emphasize the New Testament teaching which forbids the taking of life by way of retribution. Capital punishment, according to Gardiner, surrounds trials for murder with an atmosphere of morbid press sensationalism which panders to the sadistic impulses of mankind, and itself lessens public respect for the sanctity of human life. A deep reverence for human life is worth more than a thousand executions in the prevention of murder; it is, in fact, the great security of

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[5] Whitehorn, Report to the Governor's Commission on Legal Psychiatry, Maryland.
[6] Guttmacher, Guilty or Insane? A New Test. Nation, 186:229 (1958).
[7] Douglas, Law and Psychiatry (1956).

human life. The law of capital punishment, whilst pretending to support this reverence does in fact tend to destroy it.[8]

The Royal Commission on Capital Punishment after studying statistics from many countries including the United States concluded that there is no clear evidence that the abolition of capital punishment has led to an increase in the homicide rate or that its re-introduction has led to a fall. That the public is not generally in favor of the death penalty is shown by the infrequency with which juries impose the death penalty. Curiously enough more murderers commit suicide than are put to death by legal execution.[9]

Gowers is doubtless correct in his assumption that emotion rather than reason will decide the issue of the death penalty.*

[8] Bright, J., cited by Gardiner, Capital Punishment as a Deterrent (London 1956).
[9] See note 1, *supra*.

*Additional Bibliography

[1] Durham v. United States, 214 F.2d 862 (1954).
[2] Gowers, A Life for a Life (1956).
[3] Guttmacher, Book review, J. Nerv. Ment. Dis., 126:492 (1958).
[4] Macdonald, Psychiatry and the Criminal (1958).
[5] Royal Commission on Capital Punishment Report, London (1953).
[6] Sobeloff, Insanity and the Criminal Law, 41 A.B.A.J. 793 (1955).