THE UNIVERSITY OF OKLAHOMA

GRADUATE SCHOOL

ADMINISTRATION OF THE CENTRAL OKLAHOMA STATE HOSPITAL

A THESIS

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

MASTER OF ARTS

BY

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Norman, Oklahoma

1942

ADMINISTRATION OF THE CENTRAL OKLAHOMA STATE HOSPITAL

A THESIS

APPROVED FOR THE DEPARTMENT OF GOVERNMENT

BY

[redacted]

TO

MY FATHER AND MY MOTHER

ACKNOWLEDGMENT

My principal purpose in making this study has been to make available more information for the general public concerning the care and treatment of the mentally ill. If it will help to better their lot in the slightest its purpose will have been served.

I should like to state my appreciation of the constant flow of helpful suggestions and criticisms that Professor H. V. Thornton of the Government Department has always given. His high ideals have spurred me on to continued effort when my spirits have been at a low ebb. I also wish to thank Professor Joseph C. Pray for his help in editing the copy.

Mr. James L. Corbett and Mr. W. L. Gibbs, the chief clerk and steward of the Central Oklahoma State Hospital, have given freely of their time and have made all pertinent information available.

J. K. Knee

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PREFACE

PURPOSE

There are in the United States some 500,000 individuals who have been unable to orient themselves to our mode of living. Their inability to make the necessary day-to-day adjustments has resulted in a state of being commonly termed "insanity," or more appropriately "mentally ill."

Their condition has forced government to provide for their welfare. All of the states, the federal government, and a few of the counties and cities, together with various private agencies have set up hospitals for their care and treatment.

In 1933 there were 445,867 mental patients in 631 institutions that had been designed for a total capacity of 427,343. During 1933 they admitted 147,621 patients and dismissed 83,794; 34,089 died in these institutions during these years. These 631 institutions employed the full-time services of 2,337 physicians, 7,339 nurses, 38,790 attendants, plus

other employees in various capacities.[1]

Of these 631 institutions, 351 were run by the various governments and the remainder were owned by private agencies. The institutions operated by government were distributed as follows: 251 state institutions, 76 county and city institutions, and 24 federal institutions.[2] On breaking down the state institutions we find: 174 state hospitals, 65 institutions for the mentally deficient, 11 homes for epileptics, and one used for drug addicts.[3]

During 1933 the 251 institutions contained eighty-five per cent of all the mental patients in institutions, and received sixty-nine per cent of all patients admitted during the year.[4] Almost all of these institutions are small cities and have their own utilities.[5]

The distribution of state hospitals by states for 1933 shows:[6]

States	16	8	7	5	2	4	1	2	1	1	1
Number of Hospitals	1	2	3	4	5	6	7	8	10	13	21

The complete list of hospitals given in the Register of Hospitals for 1933 shows a total of 6,552 hospitals.

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[1] John Maurice Grimes, Institutional Care of Mental Patients in the United States. (Chicago: 1816 North Clark Street, 1934), p. 1.

[2] Ibid., p. 12. [3] Ibid., p. 15. [4] Ibid., p. 2.

[5] Ibid., p. 6. [6] Ibid., p. 10.

However, only 631 were mental institutions, or nine and six-tenths per cent of the whole. Population and capacity figures tell a different story. The total capacity of all the hospitals was 1,014,354; the capacity of the mental institutions was 427,343, or forty-two per cent of all the beds. In 1932 these 6,552 hospitals had 205,909 vacant beds, however the mental institutions had 18,524 more patients than their rated capacities.[7]

Until recent years it was the common belief that mental illness was incurable and for the safety of society mentally ill people were placed in institutions known as asylums. There, these unfortunates were allowed to live the remainder of their lives. But in the last few years medical science has been able to prove conclusively that many forms of mental illness are amenable to treatment, and that many persons thus afflicted may be returned to society as useful citizens. Nevertheless a large part of the general public and their elected officials assume that the function of these institutions is primarily custodial.

Oklahoma maintains and operates five hospitals for the care and treatment of persons afflicted with various degrees of mental illness. This thesis is mainly a study of the administration and operation of the Central Oklahoma State Hospital located at Norman. Choice of this particular institution for investigation rested upon convenience. Conclu-

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[7] Ibid., p. 6.

sions reached herein bear directly upon the Central Oklahoma State Hospital. However, superficial examination of other hospitals of this class in Oklahoma indicates that all encounter basically the same problems.

A more enlightened attitude toward the patient of the mental hospital is desperately needed, not entirely out of sympathy for the unfortunate individual but because of the growing financial burden which to a considerable degree is due to the belief of the people that the function of hospitals of this type is largely if not exclusively custodial. The mentally ill, in many instances, can be cured, partially or completely, and returned to active participation in our economic system. No space or attention has been given in this thesis to the problems of the mentally deficient. They present a special problem which must be solved in a different manner.

CHAPTER I

DEVELOPMENT OF MENTAL INSTITUTIONS

History of the Rise and Growth of Mental Institutions in the United States

On February 7, 1751, the provincial assembly of the Pennsylvania colony, with the approval of the proprietaries, Thos. and Richard Penn, passed an act to encourage the establishment of a hospital for the relief of the sick poor, and "for the reception and cure of lunatics." The act provided for an appropriation of two thousand pounds providing a like amount was raised by the people interested. Dr. Benjamin Rush, Dr. Thomas Bond, Benjamin Franklin and others raised the amount. A private dwelling was rented on February 11, 1752 and used as a hospital until December, 1756, when the first patients were admitted to the new building.

A charter for a hospital in New York was granted in 1771, but because of the war, it was not opened until 1797. The same year the Maryland hospital in Baltimore made provision for mentally sick patients.

The first state hospital, the entire appropriation

for building and maintaining coming from the state, was the Virginia hospital at Williamsburg which opening in 1773,[1] and for a period of fifty years, until the Eastern Lunatic Asylum at Lexington, Kentucky, was opened in 1824, it remained the only state hospital of its kind in the country.[2]

> During the first quarter of the nineteenth century, we find special institutions for the insane being established in eight different states for the first time. Of these, six were founded as semi-public institutions by incorporated groups, and two were completely under state auspices. A ninth state, Virginia, established its second state hospital during this period.[3]

While these institutions represented great strides forward, they could accommodate but a small fraction of the total number of persons suffering from mental diseases throughout the country. The dependent insane remained almost entirely neglected, although nominal provision for their reception at low rates was made in all existing public and semi-public asylums. In practice most poor law officials were loath to send their insane charges to these special institutions, being actuated by a sense of narrow-minded economy. In New York State, for example, while the weekly rates offered by the Bloomingdale Asylum for pauper lunatics were as low as two dollars, the dependent insane were being maintained in alms-

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[1] State Board of Control, A History of the State Board of Control of Wisconsin and the State Institutions, 1849-1939, Madison, Wisconsin, p. 158.

[2] Albert Deutsch, The Mentally Ill in America. (Garden City, New York: Doubleday, Doran & Co., Inc.), p. 71.

[3] Ibid., p. 112.

houses and jails throughout the state at costs ranging from fifty cents to a dollar a week per person. In some communities the cost per individual was as low as twenty-five cents weekly; in others they were disposed of by the barbaric custom of bidding them off on auction blocks to private individuals, sometimes bringing actual profit to towns and communities in exchange for their labor value. Hospital authorities were frequently reluctant to accept pauper patients at low rates while pay patients were applying for admission.[4]

The opening of the Worcester State Hospital in 1833 marked the beginning of an extensive asylum-building movement throughout the country. Hardly were hospitals opened than their capacities became overtaxed by the never ceasing flow of patients. The following table indicates the increase in insanity in relation to the increase in the general population of the United States during the latter half of the nineteenth century:[5]

Year	Total Population United States	Estimated Number of Insane	Insane in Hospitals and Asylums
1840	17,069,453	17,457*	2,561
1850	23,191,876	15,610	4,730
1860	31,443,322	24,042	8,500
1870	38,555,983	37,432	17,735
1880	50,155,783	91,959	38,047
1890	62,947,714	106,485	74,028

*This figure includes both the insane and the feeble-minded, since census takers at that time made no distinction between the two groups.

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[4] Ibid. [5] Ibid., p. 229.

However the policy pursued in most of the mental hospitals established during the 1830's and 1840's was for the maintenance of dependent patients to be charged to the localities in which these persons had settlement, the state paying only for non-residents and alien insane. This resulted in a great majority of the mentally ill being retained in county institutions because of lower costs of maintenance. The administration and supervision of these institutions was local.

> With the approach of the final decade of the nineteenth century, the reform movement in behalf of the mentally ill. . . was advancing in full swing along three parallel fronts. Its main objects were: (1) removal of all insane persons from almshouses; (2) discontinuance of the practice of maintaining separate institutions for the chronic and acute insane; (3) state control and supervision of all institutions for the mentally ill.[6]

In 1890 New York enacted a State Care Act which provided for the removal of all mentally ill from poorhouses, jails, etc. to state hospitals. Other provisions included: (1) support of all the indigent insane (except those in private institutions) in state hospitals at state expense; (2) by districting the state, and by obliging each state hospital to admit all the insane in its district, it abolished the legal distinction between chronic and acute cases; (3) by specifically ordering the substitution of the term "hospital" for asylum in all public institutions for the insane, it inaugurated a significant change in nomenclature, symbolizing the new ideal of having all such institutions curative in name and interest.[7]

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[6] Ibid., p. 257. [7] Ibid., p. 260.

> The great step taken by New York in 1890 was bound to have a deep influence on other states throughout the country. The principle of complete state care (as well as the creation of commissions in lunacy) was adopted in state after state following its momentous inauguration in New York.[8]

In 1937 some twenty-four states operate under well-defined systems of state care. A county care plan is in practice in a few states, notably Wisconsin, Iowa, Pennsylvania, and New Jersey. In still other states, no definite plan of public provision for the mentally ill has been formulated. Methods of care and treatment are of a patchwork character, representing merely the accretion of temporary expedients.[9]

History of the Rise and Growth of Mental Institutions in Oklahoma

From 1889 to 1895 Oklahoma Territory made annual contracts[10] with private institutions for the care of its mentally ill patients.[11] During this time contracts were made with the Oak Lawn Retreat for the insane at Jacksonville, Illinois. The terms called for payment of $25.00 a month for each patient, together with transportation costs. Early in 1895 similar contracts were made with the Oklahoma Sanitarium Company at Norman, Oklahoma, thus effecting substantial savings in transportation. Before statehood the mentally ill of Indian Terri-

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[8] Ibid., p. 262. [9] Ibid., p. 271.

[10] Statutes of Oklahoma, 1890, ch. 42.

[11] Annual Reports, Oklahoma Territorial Governors to to the Secretary of the Interior, 1894-1906.

tory were cared for at St. Vincent's Hospital,[12] St. Louis, Missouri.[13]

The Sanitarium at Norman was located in the buildings of the old High Gate College which had been remodeled to more nearly meet its needs. During August, 1895 a total of fifty-three patients were brought to the Sanitarium from Illinois, and in September of the same year there were 111 patients in the institution. In June, 1896 at the end of one year of work the Sanitarium had received 180 patients and discharged thirty-seven as cured or greatly improved.[14]

The Western Oklahoma State Hospital at Supply was originally established in 1868 by General Phil Sheridan as a United States depot for military supplies with the name of Camp Supply. It was abandoned as a military post in 1891.[15] In 1903 the Oklahoma Territorial Legislature provided for the establishment of the first mental hospital at Supply upon a site given by the national government[16] for this purpose; but

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[12] T. P. Tripp, "Oklahoma Hospital at Supply," Harlow's Weekly, Vol. 41, No. 5, July 29, 1933, p. 8.

[13] Oklahoma Planning and Resources Board, State Mental Hospitals in Oklahoma, 1937, Oklahoma City, Oklahoma, pp. 1-2.

[14] Norman Transcript, August 27, 1939, Vol. 51, No. 39, Sec. F.

[15] T. P. Tripp, op. cit., Vol. 44, No. 17, May 11, 1935, pp. 6-8.

[16] U. S. Statutes at Large, Vol. 35, pt. 1, ch. 220, sec. 4.

this institution was not ready to receive patients until 1908, one year after Oklahoma became a state.[17] In May, 1908 a total of 400 patients were transferred from the Oklahoma Sanitarium at Norman to the hospital at Supply; seventy-five patients also were brought to the institution from St. Vincent's Hospital, St. Louis, Missouri at this time.[18]

In 1908 the Legislature provided for the establishment of the Eastern Oklahoma State Hospital at Vinita to care for the mentally ill of Eastern Oklahoma.[19] This institution opened as a state hospital on January 28, 1913[20] when more than 300 patients were moved from the Norman Sanitarium.[21]

The Sanitarium at Norman was purchased by the state from the Oklahoma Sanitarium Company for $100,000 in March, 1915 and opened as a state institution on July 1, 1915, as the Central Oklahoma State Hospital.[22] Up to that time annual contracts were made with the company for the care of mental patients.[23]

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[17] Session Laws of Oklahoma, 1907-08, p. 627.

[18] T. P. Tripp, op. cit., Vol. 41, No. 5, July 29, 1933, p. 8.

[19] Session Laws of Oklahoma, 1907-08, p. 623.

[20] T. P. Tripp, op. cit., pp. 6-8.

[21] Norman Transcript, op. cit., Sec. G.

[22] Ibid., Sec. H.

[23] Oklahoma Planning and Resources Board., op. cit.

On April 14, 1917 a fire at the Central State Hospital destroyed two frame ward buildings and the dining room burning thirty-seven patients to death. Most of these were imbeciles who were unable to either comprehend the nature of the danger, or to care for their own safety. The origin of the fire was unknown. This was the second fire in an Oklahoma hospital for the insane, the first having occurred at the Western Oklahoma State Hospital at Supply in 1915.[24]

As a direct result of these fires the legislature made appropriations for the construction of fire proof buildings. For example, at the Central Oklahoma State Hospital four new buildings were constructed in April, 1918 and in February, 1919 the legislature appropriated $600,000 for four more new buildings.[25]

In April, 1923 the Legislature provided for the erection of a $100,000 Memorial Ward at the Central Oklahoma State Hospital for war veterans; this was opened in February, 1924.[26] Two additional wings for this section of the hospital were authorized by the Legislature in March, 1929.[27]

Formerly colored mental patients were sent to the Central Oklahoma State Hospital where they were kept in

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[24] Harlow's Weekly, Vol. 14, No. 16, April 17, 1918, p. 4.

[25] Norman Transcript, op. cit., Sec. H.

[26] Ibid. [27] Ibid., Sec. K.

separate wards.[28] The Legislature in 1931 authorized the establishment of a separate hospital for Negroes at Taft.[29] The State Hospital for Negro Insane was opened in June, 1934, at which time 308 patients were transferred to it from the Central Oklahoma State Hospital at Norman. This hospital helped to relieve crowded conditions at the Central Oklahoma State Hospital and provided a hospital equipped exclusively for treatment of mentally sick Negroes. All employees except the superintendent are Negroes. The superintendent is also in charge of the Deaf, Blind, and Orphans Institute and the State Training School for Negro Girls, all of which are located at Taft.[30]

The Central Oklahoma State Hospital Annex at McAlester was opened in July, 1939 and has a capacity of 250. It is used to house senile men. In July, 1939 a total of 225 patients were transferred to it from the Central Oklahoma State Hospital. All patients now received by the Annex are transferred to it from the Central Oklahoma State Hospital.[31]

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[28] Oklahoma Planning and Resources Board, op. cit.

[29] Session Laws of Oklahoma, 1931, p. 79.

[30] Harlow's Weekly, Vol. 42, No. 25, June 30, 1934, p. 5.

[31] Information received in an interview with hospital officials at the Central Oklahoma State Hospital during July, 1941.

CHAPTER II

POPULATION

The magnitude of the problem of mental disease in present day society is aptly stated by Albert Deutsch as follows:[1]

> There were about 480,000 patients on the books of mental hospitals in March, 1937. It has been estimated that if the same facilities for recognition and institutional treatment as exist in New York and Massachusetts were to be adopted in all other states, there would be nearly twice as many patients in mental hospitals as there are today. The population of mental hospitals is increasing at the rate of nearly 15,000 a year, and 100,000 new patients entering these hospitals annually. According to statistics compiled in New York State about one out of every twenty-two persons may be expected to spend some part of his life in a hospital for mental disease. . . . If the present rate of mental breakdown continues, approximately one million of the children now in public schools will be admitted to mental hospitals at some time in their lives. One out of every 331 persons in the United States is now a patient in a state hospital; in New York and Massachusetts, which afford greater facilities for care and treatment, the ratio is about one out of every 222 inhabitants. Horatio M. Pollock has estimated that the economic cost of mental disease to the nation, in terms of maintenance and loss of earnings, reaches the staggering total of nearly $750,000,000 annually. The cost of mental disease in terms of human misery--of broken homes, of the mental anguish of sufferers and their friends and relatives--is incalculable.

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[1] Albert Deutsch, "The Mentally Ill in America", op. cit., p. 486.

Scope of Population

Table Number 1[2] shows that the number of mental patients cared for by the state of Oklahoma has increased from 589 in 1907 to 7,477 in 1940. This trend is characteristic of the nation. As is shown in Table Number 2[3] the average daily resident patient population for all of the state hospitals in the United States increased from 248,852 in 1926 to 381,708 in 1938.[4] However in addition to state hospitals, there are veterans' administration, county and city, and private hospitals that care for mental patients. In 1938 there were in all 464 hospitals caring for the mentally ill. These reported an aggregate population of 499,919 on their books.[5] A figure commonly quoted, which seems to be supported by most recent estimates, is that for every patient in a mental hospital there is one other person afflicted with mental disease who has never been in such a hospital.[6]

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[2]See page 16. [3]See page 17.

[4]National figures for later years are not yet available.

[5]Bureau of the Census, "Patients in Mental Institutions, 1938," (Washington, D. C.: United States Government Printing Office, 1941), p. 4.

[6]This figure only takes into account the serious forms of mental illness, and does not include psychoneurotic and personality problem cases, any estimate of the total number of mentally disordered persons must be considerably in excess of the above figures. Indiana Department of Public Welfare, Public Welfare in Indiana, "Mental Hospital Statistics," Vol. XLIX, No. 9, Series 258, September, 1939, p. 6.

TABLE 1

POPULATION AND CAPACITY OF FOUR STATE HOSPITALS FOR MENTAL DISEASE IN OKLAHOMA 1895-1940*

Year	Population	Capacity	Year	Population	Capacity
1895	31	177	1918	2,282	2,365
1896	126	177	1919	--	2,755
1897	143	177	1920	2,608	2,975
1898	196	277	1921	2,725	2,975
1899	243	302	1922	--	3,035
1900	283	427	1923	2,988	3,145
1901	315	427	1924	3,200	3,175
1902	--	427	1925	--	3,095
1903	--	502	1926	3,476	3,340
1904	--	660	1927	3,713	3,570
1905	462	700	1928	4,222	3,808
1906	516	700	1929	4,499	4,068
1907	589	700	1930	4,562	4,068
1908	888	1,100	1931	4,886	4,514
1909	961	1,000	1932	5,327	4,820
1910	1,193	1,080	1933	5,735	4,840
1911	1,202	1,080	1934	6,104	5,640
1912	1,420	1,080	1935	6,572	5,660
1913	--	1,310	1936	6,864	5,660
1914	--	1,470	1937	7,244	5,690
1915	--	1,520	1938	7,211	
1916	2,190	1,990	1939	7,113	
1917	--	2,030	1940	7,477	

*State Mental Hospitals in Oklahoma, op. cit., Appendix A, Table I, p. 87.

Primary Sources: Reports of Oklahoma Territorial Governors, Commissioners of Charities and Corrections, and Superintendents of Hospitals.

TABLE 2

AVERAGE PATIENT POPULATION AND NORMAL CAPACITY OF STATE HOSPITALS FOR MENTAL DISEASES, 1926-1938

Year	Average Daily Resident Patient Pop.	Normal Capacity of Hospitals	Excess of Population over Capacity	
			Number	Percent
1938	381,708	348,809	32,899	9.4
1937	369,489	333,237	36,252	10.9
1936	358,429	321,708	36,721	11.4
1935	347,620	312,158	35,462	11.4
1934	336,637	302,759	33,878	11.2
1933	327,812	295,703	32,109	10.9
1932	307,939	279,807	28,132	10.1
1931	296,700	270,585	26,115	9.7
1930	278,829	247,407	31,422	12.7
1929	269,892	244,599	25,293	10.3
1928	264,072	239,471	24,601	10.3
1927	256,009	232,572	23,437	10.1
1926	248,852	232,321	16,531	7.1

*Table 44, p. 75, Patients in Mental Institutions: 1938, Bureau of the Census, U. S. Government Printing Office, Washington, D. C., 1941.

TABLE 3

MOVEMENT OF PATIENT POPULATION IN ALL HOSPITALS FOR MENTAL DISEASE BY TYPE OF CONTROL OF HOSPITAL: 1938

Class of Patient	Total	Public Hospitals			Private Hospitals	Percent of Total			
		State	Veterans' Admin.	County and City		State	Veterans' Adm.	County and City	Private
Patients on Books at start of year	499,919	424,028	25,461	38,735	11,695	84.8	5.1	7.7	2.3
In Hospitals	444,989	374,169	24,353	35,421	11,046	84.1	5.5	8.0	2.5
In Family Care	1,366	1,366	---	---	---	100.0	---	---	---
On Parole	53,564	48,493	1,108	3,314	649	90.5	2.1	6.2	1.2
Admissions during year	153,390	106,220	11,651	10,317	25,202	69.2	7.6	6.7	16.4
1st Admissions	110,323	79,408	6,142	8,133	16,640	72.0	5.6	7.4	15.1
Readmissions	33,222	21,085	3,228	1,274	7,635	63.5	9.7	3.8	23.0
Transfers	9,845	5,727	2,281	910	927	58.2	23.2	9.2	9.4
Separations during year	139,415	95,156	9,176	9,791	25,292	68.3	6.6	7.0	18.1
Discharges	90,909	56,756	7,480	4,863	21,810	62.4	8.2	5.3	24.0
Direct	48,343	18,795	6,128	2,647	20,773	38.9	12.7	5.5	43.0
Parole	42,566	37,961	1,352	2,216	1,037	89.2	3.2	5.2	2.4
Transfers	11,368	6,682	606	1,995	2,085	58.8	5.3	17.5	18.3
Deaths in Hosp.	36,263	30,977	1,078	2,848	1,360	85.4	3.0	7.9	3.8
Deaths on Parole	875	741	12	85	37	84.7	1.4	9.7	4.2
Patients on Books at end of year	513,894	435,092	27,936	39,261	11,605	84.7	5.4	7.6	2.3
In Hospital	457,983	384,573	26,599	35,980	10,831	84.0	5.8	7.9	2.4
In Family Care	1,422	1,422	---	---	---	100.0	---	---	---
On Parole	54,489	49,097	1,337	3,281	774	90.1	2.5	6.0	1.4

The distribution of mental patients by types of hospitals is given in Table 3. Of these 499,919 patients, 444,989 were in institutions, 53,564 were on parole and 1,366 were in family care. During 1938, 84.8 per cent of the patients were in state hospitals, 5.1 per cent were in veterans' administration hospitals, 7.7 per cent were in county and city hospitals, and 2.3 per cent were in private hospitals.[7]

Table 4 lists the patients in state hospitals for mental disease at the beginning of the year 1938 by states. The total number of patients on the books of state hospitals varied from 355 in Nevada to 73,328 in New York. Oklahoma had 7,705 patients on the books of its state hospitals. The rate per 100,000 of estimated population of patients in mental hospitals was 289.3 for the United States, and the rate varied from a high of 516.5 in New York to a low of 70.1 in Wisconsin. The rate in Oklahoma was 270.7. At this time 11.8 per cent of the total number of patients on the books of state hospitals for the United States were absent;[8] for the states the high was 32.6 per cent for Virginia and the low was 0.4 per cent for South Dakota; Oklahoma had a 10.5 per cent of its hospital population absent at that time.[9]

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[7] See page 18.

[8] Absent--a Bureau of the Census term referring to patients who have been paroled by the hospitals but are still subject to readmission without being legally recommitted.

[9] See pages 20-21.

TABLE 4

PATIENTS IN STATE HOSPITALS FOR MENTAL DISEASE AT THE BEGINNING OF THE YEAR, BY STATUS ON BOOKS, BY DIVISIONS AND STATES: 1938

Division and State	Total on Books	Patients in Hospitals		Patients Absent[1]	
		Number	Rate per 100,000 Estimated Pop. 1938[2]	Number	Per Cent of Total on Books
U. S.	424,028	374,169	289.3	49,859	11.8
New England	40,751	36,989	430.3	3,762	9.2
Maine	2,768	2,602	304.0	166	6.0
N. Hamp.	2,244	2,043	400.6	201	9.0
Vermont	1,072	1,048	273.6	24	2.2
Mass.	24,477	21,882	294.4	2,595	10.6
R. I.	2,793	2,486	362.4	325	11.6
Conn.	7,397	6,946	399.0	451	6.1
Middle Atlantic	103,820	93,543	340.4	10,277	9.9
N. Y.	73,328	66,927	516.5	6,401	8.7
N. J.	11,186	10,154	233.8	1,032	9.2
Penn.	19,306	16,462	161.8	2,844	14.7
E. N. Central	78,736	70,848	247.2	7,888	10.0
Ohio	21,853	18,238	270.9	3,615	16.5
Ind.	8,594	7,971	229.4	623	7.2
Ill.	29,422	28,295	359.2	1,127	3.8
Mich.	16,346	14,294	295.9	2,052	12.6
Wisc.	2,521	2,050	70.1	471	18.7
W. N. Central	41,300	35,949	260.1	5,351	13.0
Minn.	11,200	9,573	361.0	1,627	14.5
Iowa	7,980	6,576	257.7	1,404	17.6
Mo.	8,777	7,787	195.2	990	11.3
N. Dak.	2,039	1,848	261.8	191	9.4
S. Dak.	1,617	1,610	232.7	7	0.4
Neb.	4,214	3,821	280.1	393	9.3
Kansas	5,473	4,734	254.0	739	13.5

TABLE 4 - Continued

Division and State	Total on Books	Patients in Hospitals		Patients Absent	
		Number	Rate per 100,000 Estimated Pop. 1938	Number	Per Cent of Total on Books
S. Atlantic	56,904	47,117	273.0	9,787	17.2
Del.	1,322	1,117	428.0	205	15.5
Md.	6,678	6,080	362.1	598	9.0
D. of C.	5,844	5,556	886.1	288	4.9
Va.	12,825	8,641	318.3	4,184	32.6
W. Va.	4,117	3,827	205.2	290	7.0
N. Car.	8,279	6,433	184.2	1,846	22.3
S. Car.	4,757	4,045	215.7	712	15.0
Geo.	8.239	7,204	233.5	1,035	12.6
Fla.	4,843	4,214	252.3	629	13.0
E. S. Central	23,839	20,661	192.5	3,178	13.3
Ky.	6,937	6,256	214.2	681	9.8
Tenn.	5,509	5,157	178.3	352	6.4
Ala.	6,094	5,379	185.8	715	11.7
Miss.	5,299	3,869	191.3	1,430	27.0
W. S. Central	32,593	28,333	219.6	4,260	13.1
Ark.	5,201	4,000	195.3	1,201	23.1
La.	6,487	5,604	262.9	883	13.6
Okla.	7,705	6,898	270.7	807	10.5
Texas	13,200	11,831	191.7	1,369	10.4
Mountain	11,082	9,833	259.3	1,249	11.3
Mont.	1,908	1,859	344.9	49	2.6
Idaho	1,053	903	183.2	150	14.2
Wyo.	608	545	231.9	63	10.4
Colo.	4,083	3,600	336.1	483	11.8
N. Mex.	866	756	179.1	110	12.7
Ariz.	1,069	843	204.6	226	21.1
Utah	1,140	1,008	194.2	132	11.6
Nevada	355	319	315.8	36	10.1
Pacific	35,003	30,896	346.8	4,107	11.7
Wash.	6,519	6,016	362.8	503	7.7
Oregon	4,880	4,143	379.7	737	15.1
Cal.	23,604	20,737	337.0	2,867	12.1

[1]Includes patients "in family care" and "patients on parole or otherwise absent."

[2]Estimated population as of July 1, 1937.

Admissions

As is shown in Table 3 during 1938 a total of 153,390 patients were admitted to mental institutions in the United States. Of these 69.2 per cent were admitted to state hospitals, 7.6 per cent to veterans' administration hospitals, 6.7 per cent to county and city hospitals, and 16.4 per cent to private institutions. There are three types of admission to a mental hospital. These types are first admission, readmission, and transfer.[10] In 1938, of patients entering mental institutions in the United States, 110,323 were first admissions, 33,222 were readmissions, and 9,845 were transfers.[11]

A breakdown of the total first admissions for 1938 shows 72.0 per cent entering state hospitals, 5.6 per cent entering veterans' administration hospitals, 7.4 per cent entering county and city hospitals, and 15.1 per cent entering private hospitals. Percentages for readmissions were 63.5 to state hospitals, 9.7 to veterans' administration hospitals, 3.8 per cent to city and county hospitals, and 23.0 to private hospitals. Transfer percentages were 58.2 per cent to state hospitals, 9.2 per cent to county and city hospitals, 23.2 per

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[10] First admission--designates all patients who have never been in a mental hospital before. Readmission--designates patients who have been released from a hospital and later suffer a relapse. Transfer--designates patients who became mentally ill while inmates of other state institutions; also patients moved from one hospital to another.

[11] See page 18.

cent to veterans' administration hospitals, and 9.4 per cent to private hospitals. These figures are shown in Table 3.[12]

First admissions and readmissions to all hospitals for mental disease and the rate per 100,000 of estimated population by states for 1938 are shown in Table 5. First admissions to all hospitals for mental disease by states shows New York having a high of 14,665 and Nevada a low of 81; Oklahoma had 1,476. The rate of first admissions per 100,000 of estimated population for 1938 was 85.4 for the United States; the high was 149.9 in Vermont and the low was 39.2 in Florida; Oklahoma's rate was 57.9. Readmissions by states for 1938 shows New York with a high of 4,419 and Nevada with a low of eleven. Oklahoma had 469. The rate of readmissions per 100,000 of estimated population for 1938 was 25.7 for the United States; Vermont had a high of 74.7 and Idaho a low of 5.3; Oklahoma's rate was 18.4.[13]

Separations

During 1938, as shown in Table 3, there were 139,415 separations from mental institutions in the United States. Of these, 68.3 per cent were from state hospitals, 6.6 per cent from veterans' administration hospitals, 7.0 per cent from city and county hospitals, and 18.1 per cent from private hospitals.[14] The three general types of separations are

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[12] See page 18. [13] See pages 24-25.

[14] See page 18.

TABLE 5

FIRST ADMISSIONS AND READMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE AND RATE PER 100,000 OF ESTIMATED POPULATION BY STATES: 1938*

Division and State	First Admissions		Readmissions	
	1938	Rate per 100,000 Estimated Population**	1938	Rate per 100,000 Estimated Population
U. S.	110,323	85.4	33,222	25.7
New England	8,735	101.6	3,666	42.6
Maine	518	60.5	124	14.5
N. Hamp.	448	87.8	153	30.0
Vermont	574	149.9	286	74.7
Mass.	4,277	96.6	1,848	41.8
R. I.	641	94.1	108	15.9
Conn.	2,277	130.8	1,147	65.9
Middle Atlantic	24,885	90.6	6,856	25.0
N. Y.	14,665	113.2	4,419	34.1
N. J.	5,031	115.8	1,064	24.5
Penn.	5,189	51.0	1,373	13.5
E. N. Central	22,834	88.4	7,149	27.7
Ohio	5,178	76.9	891	13.2
Ind.	1,997	57.5	480	13.8
Ill.	8,662	110.0	3,112	39.5
Mich.	4,281	88.6	1,243	25.7
Wisc.	2,716	92.8	1,423	48.6
W. N. Central	9,699	70.2	2,388	17.3
Minn.	1,999	75.4	324	12.2
Iowa	1,929	75.6	656	25.7
Mo.	3,278	82.2	809	20.3
N. Dak.	415	58.8	85	12.0
S. Dak.	287	41.5	96	13.9
Neb.	742	54.4	155	11.4
Kansas	1,049	56.3	263	14.1
S. Atlantic	13,844	80.2	4,337	25.1
Del.	246	94.3	41	15.7
Md.	2,399	142.9	909	54.1
D. of C.	789	125.8	170	27.1
Va.	3,159	116.7	808	30.0

TABLE 5 - Continued

Division and State	First Admissions 1938	First Admissions Rate per 100,000 Estimated Population**	Readmissions 1938	Readmissions Rate per 100,000 Estimated Population
S. Atlantic, cont.				
W. Va.	1,083	58.1	238	12.8
N. Car.	2,404	68.8	771	22.1
S. Car.	1,372	73.2	504	26.9
Geo.	1,737	56.3	750	24.3
Fla.	655	39.2	146	8.7
E. S. Central	9,212	85.8	3,561	33.2
Ky.	2,289	78.4	661	22.6
Tenn.	1,961	67.8	854	29.5
Ala.	2,916	100.7	1,466	50.6
Miss.	2,046	100.1	580	28.7
W. S. Central	8,723	67.6	2,366	18.3
Ark.	1,913	93.4	560	27.3
La.	2,012	94.4	318	14.9
Okla.	1,476	57.9	469	18.4
Texas	3,322	53.8	1,019	16.5
Mountain	2,078	54.8	644	17.0
Mont.	365	67.7	166	30.8
Idaho	244	49.5	26	5.3
Wyo.	111	47.2	48	20.4
Colo.	592	55.3	272	25.4
N. Mex.	188	44.5	27	6.4
Ariz.	253	61.4	37	9.0
Utah	244	47.0	57	11.0
Nevada	81	80.2	11	10.9
Pacific	10,313	116.7	2,255	25.5
Wash.	1,503	90.7	324	19.5
Oregon	1,081	105.3	201	19.6
Cal.	7,729	125.6	1,730	28.1

*Table 7, p. 15, Patients in Mental Institutions, 1938, Bureau of the Census, U. S. Department of Commerce, U. S. Government Printing Office, Washington, D. C., 1941.
**Estimated population as of July 1, 1937.

discharge, transfer, and death.

Discharges are either parole or direct. In 1938 there were 48,343 direct discharges from United States mental hospitals. The percentages by type of hospital shows 38.9 per cent from state hospitals, 12.7 per cent from veterans' administration hospitals, 5.5 per cent from city and county hospitals, and 43.0 per cent from private hospitals. During the same year 42,566 patients were paroled. Their distribution shows 89.2 per cent paroled from state hospitals, 3.2 per cent from veterans' administration hospitals, 5.2 per cent from city and county hospitals, and 2.4 per cent from private hospitals.[15]

During 1938 there were 11,368 transfers from mental institutions to other institutions in the United States. Percentages for the types of hospital: 58.8 per cent from state hospitals, 5.3 per cent from veterans' administration hospitals, 17.5 per cent from city and county hospitals, and 18.3 per cent from private hospitals. These figures are shown in Table 3.[16] The large percentage of transfers from city and county hospitals indicate that these institutions strive to keep a population that can be cured in a relatively short length of time. Patients whose prognosis is negative or nearly so are transferred to state or veterans' administration hospitals. The relatively large percentage of transfers

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[15]See page 18.

[16]See page 18.

from private hospitals mainly represents those patients whose mental illness has outlasted their financial resources, forcing them to enter a public institution.

The deaths in all of the mental hospitals in the United States during 1938 aggregated 36,263; an additional 875 died while on parole. These figures are shown in Table 3. Of these 85.4 per cent died in state hospitals, 3.0 per cent in veterans' administration hospitals, 7.9 per cent in city and county hospitals, and 3.8 per cent in private hospitals.[17] Among reasons for the large number of deaths in state hospitals is their inability to refuse admittance to any patient and a lack of funds to use the best medical care in an adequate fashion.

Contrasting the United States averages for separation with those of Oklahoma for 1938 shows that while 34.67 per cent of the separations for the United States were direct discharges only 12.81 per cent of Oklahoma's were direct discharges. However, while 30.53 per cent of the United States separations were paroled, 54.98 per cent of Oklahoma separations were by this method. Only 0.49 per cent of separations in Oklahoma were transferred but 8.15 per cent of the total United States separations were. These figures are graphically presented in Chart Number 1 and Table 6.[18]

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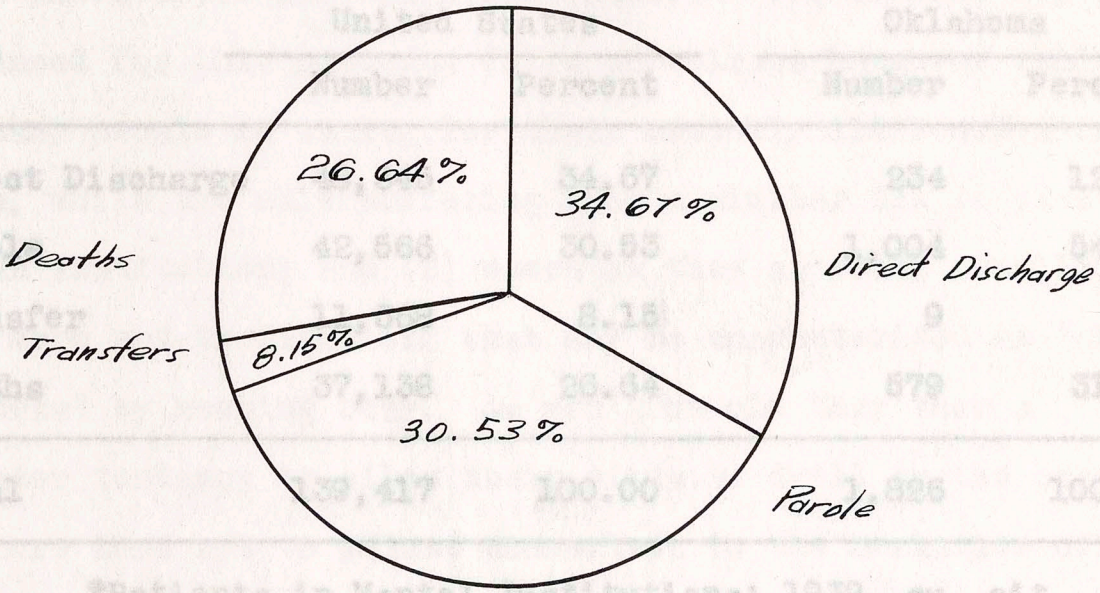
[17] See page 18. [18] See pages 28-29.

Chart 1. SEPARATIONS FROM STATE HOSPITALS

UNITED STATES



OKLAHOMA

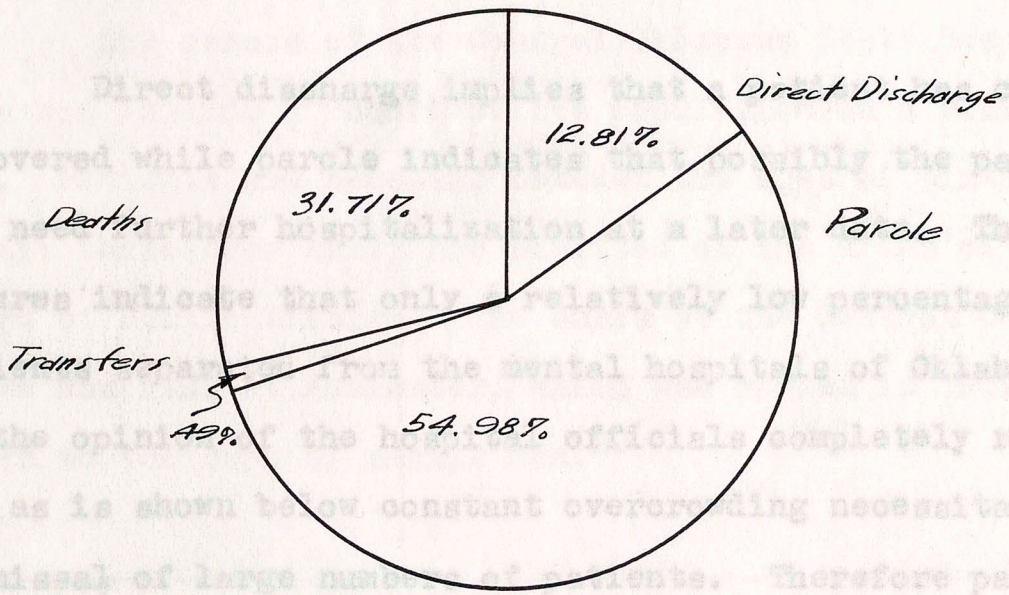


TABLE 6

SEPARATIONS DURING YEAR: 1938*

Type	United States		Oklahoma	
	Number	Percent	Number	Percent
Direct Discharge	48,345	34.67	234	12.81
Parole	42,566	30.53	1,004	54.98
Transfer	11,368	8.15	9	.49
Deaths	37,138	26.64	579	31.71
Total	139,417	100.00	1,826	100.00

*Patients in Mental Institutions: 1938, op. cit., Table 3, pp. 8-9.

Direct discharge implies that a patient has completely recovered while parole indicates that possibly the patient may need further hospitalization at a later date. The above figures indicate that only a relatively low percentage of patients separated from the mental hospitals of Oklahoma are in the opinion of the hospital officials completely recovered. Yet as is shown below constant overcrowding necessitates the dismissal of large numbers of patients. Therefore parole is used as a last resort. This results in a high rate of re-admissions because many patients who had been paroled were not sufficiently recovered and later had relapses.

Sex

The census of the Central Oklahoma State Hospital for 1940 shows 1,406 men and 1,160 women.[19] Two reasons may be advanced for this pattern: (1) a chivalrous hangover exhibited by many people in caring for their mentally ill females in the home, while the male suffering from a similar ill is placed in an institution; and (2) women as they approach senility are more apt to fight off what may be characterized as "childishness" by keeping busy. As men grow old they show a greater tendency to allow their minds to dwell on the past and are less apt to adjust themselves to the realities of the present world.

Age

The census of the Central Oklahoma State Hospital does not include a record of its population on a basis of age. Patients are accepted between the ages of sixteen and sixty; those over sixty are admitted on the order of the State Board of Public Affairs. The Annex of the Central Oklahoma State Hospital at McAlester, which was opened in 1939, is devoted to the care of senile men.[20]

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[19] Information received in an interview with hospital officials at the Central Oklahoma State Hospital during August, 1941.

[20] Ibid.

Residence

Some passing consideration should be given to the distribution by residence of these mental patients. The greatest number of patients are received from the eastern, southeastern, and central counties while fewer patients come from the western half of the state. This may be confirmed by comparing the 1940 population census of the white hospitals with the total population of the district[21] served by each hospital:

*Name of Hospital	Number of Counties in District	Population of District Served by Hospital	Population of Hospital	Ratio/
COSH	21	863,637	2,532	341.1
WOSH	29	550,909	1,486	374.8
EOSH	27	921.798	2,566	359.2

* Abbreviation of names of hospitals.
/ Ratio is obtained by dividing population of district by population of hospital.

However as may be seen from column five of the above table the hospitals serve approximately the same ratio of patients to total population.

Overcrowding

According to Table 2 the average daily resident patient population of mental hospitals in the United States was in excess of their normal capacity from 1926 to 1938; while figures for the last three years are unavailable, an overcrowded condition probably still exists.

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[21] See Chart Number 4, page 58.

As seen in Table 2 the excess of population over capacity increased from 7.1 per cent in 1926 to 12.7 per cent in 1930 and then dropped to 9.4 per cent in 1938. Increases in housing facilities are totally dependent on legislative caprice. Legislatures are inclined to appropriate funds only when an overcrowded condition has become acute.[22]

Only twelve states and the District of Columbia reported an excess of capacity over population in 1938. These varied from 11 in Nebraska to 476 in Rhode Island. Overcrowding for the United States was 32,899. Overcrowding in the remaining thirty-six states varied from a low of eight in Louisiana to a high of 6,434 in New York; Oklahoma had an excess of 1,241 patients. These figures are shown in Table 7.

The per cent of overcrowding, as may be seen in Table 7, for the United States was 9.4 per cent. Louisiana with 0.1 per cent had the least amount of overcrowding while Kentucky with 43.5 per cent had the greatest amount of overcrowding. The percentage of overcrowding in Oklahoma was 20.8--a figure which only eleven states exceeded.[23]

A glance back at Table 1 shows that in Oklahoma population has constantly exceeded capacity since 1924.[24] In that year the excess numbered twenty-five but by 1935 the gulf had widened to 1,554. Only one of Oklahoma's five state

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[22]See page 17. [23]See pages 33-34.

[24]See page 16.

TABLE 7

AVERAGE RESIDENT PATIENT POPULATION AND NORMAL CAPACITY OF STATE HOSPITALS FOR MENTAL DISEASE, BY DIVISIONS AND STATES: 1938*

Division and State	Av. Daily Resident Patient Population	Normal Capacity of Hospitals	Excess of Population over Capacity	
			Number**	Percent**
U. S.	381,708	348,809	32,899	9.4
New England	37,529	32,866	4,663	14.2
Maine	2,685	2,376	309	13.0
N. Hamp.	2,091	1,650	441	26.7
Vermont	1,054	833	221	26.5
Mass.	22,124	19,408	2,716	14.0
R. I.	2,524	3,000	-476	-15.9
Conn.	7,051	5,599	1,452	25.9
Middle Atlantic	95,291	86,350	8,941	10.4
N. Y.	68,487	62,053	6,434	10.4
N. J.	10,365	9,500	865	9.1
Penn.	16,439	14,797	1,642	11.1
E. N. Central	72,767	68,070	4,679	6.9
Ohio	18,991	15,210	3,781	24.9
Ind.	8,040	7,759	281	3.6
Ill.	28,802	29,139	-337	-1.2
Mich.	14,865	14,048	817	5.8
Wis.	2,069	1,914	155	8.1
W. N. Central	36,356	33,924	2,432	7.2
Minn.	9,594	9,266	328	3.5
Iowa	6,637	5,034	1,603	31.8
Mo.	8,058	8,046	12	0.1
N. Dak.	1,854	2,000	-146	-7.3
S. Dak.	1,624	1,285	339	26.4
Neb.	3,855	3,866	-11	-0.3
Kansas	4,734	4,427	307	6.9
S. Atlantic	47,829	45,131	2,698	6.0
Del.	1,115	850	265	31.2
Md.	6,224	6,402	-178	-2.8
D. of C.	5,723	6,100	-337	-6.2
Va.	8,799	8,604	195	2.3

TABLE 7 - Continued

Division and State	Av. Daily Resident Patient Population	Normal Capacity of Hospitals	Excess of Population over Capacity	
			Number	Percent
S. Atlantic, cont.				
W. Va.	3,836	3,293	543	16.5
N. Car.	6,500	6,835	-335	-4.9
S. Car.	4,171	3,752	419	11.2
Georgia	7,187	5,000	2,187	43.7
Florida	4,274	4,295	-21	-0.5
E. S. Central	21,061	18,395	2,666	14.5
Ky.	6,315	4,400	1,915	43.5
Tenn.	5,316	5,045	271	5.4
Alabama	5,408	4,800	608	12.7
Miss.	4,022	4,150	-128	-3.1
W. S. Central	29,192	28,213	979	3.5
Ark.	4,173	4,200	-27	-0.6
La.	5,708	5,700	8	0.1
Okla.	7,211	5,970	1,241	20.8
Texas	12,100	12,343	-243	-2.0
Mountain	10,093	8,790	1,303	14.8
Montana	1,897	1,715	182	10.6
Idaho	925	850	75	8.8
Wyoming	553	604	-51	-8.4
Colo.	3,687	2,760	927	33.6
N. Mex.	786	720	66	9.2
Ariz.	863	735	128	17.4
Utah	1,016	1,066	-50	-4.7
Nevada	366	340	26	7.6
Pacific	31,590	27,070	4,520	16.7
Wash.	6,089	5,776	313	5.4
Oregon	4,220	4,065	155	3.8
Cal.	21,281	17,229	4,052	23.5

* Patients in Mental Institutions: 1938, op. cit., Table 45, p. 76.

** A minus sign (-) denotes excess of capacity over population.

hospitals, the State Hospital for Negro Insane at Taft, has had a smaller population than its capacity. This institution, opened in 1934, has started to fill and 88.38 per cent of its capacity was occupied in 1940.[25] The tendency to overcrowd is not particularly confined to custodial wards but is general throughout this institution. A poll taken on August 28, 1941 of the wards of the Central Oklahoma State Hospital at Norman showed only seven out of forty wards having less population than capacity. Of these six are reserved for receiving and infirmary purposes, while the other ward has only been in use for two months.

In the decade of 1931-41 only three buildings having a combined capacity of 416 patients were constructed at the Central Oklahoma State Hospital. In addition the Central Oklahoma State Hospital Annex at McAlester with a capacity of 200 was opened in 1939. However as shown in Table 10 the percentage of overcrowding for the hospital increased from 120.3 per cent in 1931 to 142.3 per cent in 1941.

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[25]The population and capacity figures for this hospital are listed in Table 8, page 36.

[26]See page 38.

TABLE 8

POPULATION AND CAPACITY OF THE STATE HOSPITAL FOR THE NEGRO INSANE AT TAFT, OKLAHOMA 1934-1940*

Fiscal Year Ending	Population	Capacity	Per Cent
1934	308	800	38.5
1935	589	800	73.6
1936	632	800	79.0
1937	658	800	82.25
1938	678	800	84.75
1939	679	800	84.88
1940	707	800	88.38

* The information used in this table was obtained from: State Mental Hospitals in Oklahoma, op. cit., p. 54 for the years of 1934 through 1936; the remaining figures were obtained from the State Board of Affairs during July, 1941.

TABLE 9

POPULATION AND CAPACITY BY WARDS OF THE CENTRAL OKLAHOMA STATE HOSPITAL AT NORMAN ON AUGUST 28, 1941

Name of Building	Population	Capacity	Percent of Overcrowding	Year of Construction
Hope Hall	109	150	72.67	1928
Annex 1	110	108	101.85	1931
Annex 2	111	108	102.78	1932
Rest Hall	27	24	112.50	1924
O, P & Q	324	200	162.00	1926
Vet. Bldgs.	230	221	104.07	1929-32
Women's Bldg. #1	281	175	160.57	1918
" " #2	207	150	138.00	1922
" " #3	269	180	149.44	1923
Hospital A	105	60	175.00	1916
Hospital B	116	60	193.33	1916
Hospital C	106	80	132.50	1914
Hospital D	98	80	122.50	1914
Hospital E*	vacant	(80)		1920
Hospital F	113	80	141.25	1920
Hospital G	108	80	135.00	1920
Hospital H	108	80	135.00	1920
Ward M. G.	190	200	95.00	1941
Ward Y*	vacant	(120)		1924
Total	2,612	2,036		

* These two buildings are being remodeled.

The above data were obtained from the records of the Central Oklahoma State Hospital at Norman, Oklahoma.

TABLE 10

POPULATION AND CAPACITY OF CENTRAL OKLAHOMA STATE HOSPITAL AT NORMAN 1931-1940*

Fiscal Year Ending	Population	Capacity	Per Cent
1931	2,135	1,774	120.3
1932	2,376	1,880	126.4
1933	2,539	1,880	135.1
1934	2,619	1,880	139.3
1935	2,332	1,880	124.0
1936	2,442	1,880	129.9
1937	2,492	1,880	132.5
1938	2,555	1,880	135.9
1939	2,563	1,880	136.3
1940	2,532	1,880	134.1

* The above information through 1936 was obtained from the report, State Mental Hospitals in Oklahoma, op. cit., p. 21; the remainder was obtained from the records at the Central Oklahoma State Hospital, Norman, Oklahoma, during July, 1941.

Future Trend

Is mental disease increasing and if so, at what rate? This aspect of the problem of mental disease has occasioned much gloom and alarm in certain quarters. United States census figures for the past fifty years or more would seem to afford considerable cause for concern, since they indicate that the rate of mental disease has been rising by leaps and bounds. In 1880 the total number of patients in public mental hospitals was less than 41,000 (there were, in addition, about 50,000 insane persons in poorhouses, prisons, under home care, etc.); in 1910 it was about 188,000; in 1935 it was 403,519. While the population of the United States is now slightly more than twice that of 1880, the number of patients in state hospitals has increased eightfold in the same period. To put it another way, in 1880, the number of patients in state hospitals was 63.7 per 100,000 of the general population; in 1935 the comparative figures were 317.5, or more than four times as high. Does this mean that the rate of increase in the incidence of mental disease is five times that of fifty years ago? On the surface this would appear to be true.

Yet there are a number of important reasons for doubting that the real rate of incidence in mental disease has been increasing to any great extent. The major explanations for the apparent increase in the rate of mental disease would include the following points:

(1) The concept of "insanity" has widened considerably in scope during the past half-century; mental disease is more rapidly recognized. Mental hospitals have increased rapidly in number, have expanded in size, and have become more accessible to the community. Experience has shown that the rate of increase in the number of patients tends to follow the increase in hospital accommodation and the proximity of the hospital to the community served. Federal statistics show that the incidence of mental disease in Massachusetts and New York is about 450 per 100,000 of the general population, while in Alabama, Tennessee, and Mississippi it is under 175 per 100,000. Does this indicate that the former states have more than twice as many mentally ill persons than the latter? Not at all. The explanation is to be found partly, if not entirely, in the wide difference in hospital facilities for the mentally ill.

(2) As mental hospitals have improved, and education has gradually diminished vague fears, superstitions and suspicions on the part of the public toward "crazy houses", the mentally ill are more readily committed to hospitals

by their friends and relatives. In other words, increased public confidence in state hospitals has been a factor in the increase of patients.

(3) A steady improvement in standards of hospital accommodation and treatment has prolonged the average length of hospital life of patients resulting in a progressive accumulation of the latter.

(4) A most important factor has been the prolongation of the average span of life in the general population. Larger numbers of people are growing into old age. As a consequence, a larger proportion of the population is becoming susceptible to those mental diseases that are associated with maturity and senility. About twenty per cent of patients admitted to mental hospitals suffer from the two major psychoses of advanced age, senile psychosis and psychosis with cerebral arteriosclerosis."[27]

Authorities seem to agree that the number of mentally ill in institutions will continue to increase. The State Planning and Resources Board in 1937 predicted that by 1960 our mental hospitals will have a population of 12,200 as contrasted with a population of 7,244 at that time.[28]

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[27] Albert Deutsch, op. cit., pp. 486-488.

[28] State Mental Hospitals in Oklahoma, op. cit., p. 10. Predictions are based on an average taken of the number of patients admitted annually over a period of years. From this same source it is possible to determine the trend of percentage change. On these figures forecasts of institution population are made.

CHAPTER III

GOVERNING CONTROL OF OKLAHOMA MENTAL HOSPITALS

History of Governing Bodies

The first legislative provision for the care of the mentally ill was made by the Oklahoma Territorial Legislature in 1890. The Territorial Governor was authorized to provide hospitalization for mental patients upon the request of the county commissioners.[1] As previously stated, the territories contracted with private institutions for the care of their mentally ill.

In 1908 the state opened two mental hospitals. The Western Oklahoma Hospital, which is located at Supply, was originally governed by a Board of Trustees composed of the Governor as ex officio chairman and two other members from different political parties appointed by him with the approval of the council. The Eastern Oklahoma Hospital, located at Vinita, was originally managed by a Board of Trustees composed of three members appointed by the governor with senatorial approval for three year terms.[2] In 1915 these Boards

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[1] Statutes of Oklahoma, 1890, ch. 42, art. 303.

[2] Oklahoma Statutes, 1931, vol. 1, ch. 26.

were abolished and their functions entrusted to the State Board of Public Affairs.[3] The Central Oklahoma State Hospital, located at Norman, was purchased in 1915 and also placed under the control of the State Board of Public Affairs. The State Hospital for Negro Insane has been under the control of this board since its creation in 1931.[4] All of these institutions are subject to the regulations of the State Lunacy Law.[5]

Present Governing Bodies of the Mental Hospitals

While mental hospitals of Oklahoma are under the direct managerial control of the State Board of Public Affairs, four other state agencies in addition to the Governor are charged with certain duties relating to their operation. These are: the Commissioner of Charities and Corrections; the State Health Commissioner; the Soldiers' Relief Commission; and the State Lunacy Commission. In order to present as clearly as possible the powers and functions of these governing bodies each is discussed separately.

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[3] Ibid., Sec. 5071.

[4] Oklahoma Session Laws, 1931, ch. 26, art. 2, sec. 3.

[5] The white hospitals have always been subject to the Lunacy Law. The State Hospital for Negro Insane was made subject to it in 1937, Session Laws of Oklahoma, 1937, ch. 26, art. 6, sec. 1. See Oklahoma Planning and Resources Board, State Mental Hospitals in Oklahoma, 1937, Oklahoma City, Oklahoma, p. 4.

The Governor

The governor, through his powers of appointment and removal, exercises an indirect control over the mental hospitals. He appoints with senate confirmation, the members of the State Board of Public Affairs. He appoints, without senatorial confirmation, the State Health Commissioner, and the members of the Soldiers' Relief Commission. The appointees to these offices hold their positions at the pleasure of the appointing power.

In the past individuals appointed to these posts have been selected primarily on a basis of their loyalty to the chief executive. After being appointed they are inclined to shape the policies of their office to conform with the policies of the governor.

Commissioner of Charities and Corrections

This elected official may be of either sex. Candidates[6] must be at least twenty-five years of age and have been residents of this state for three years.[7] The governor fills the office by appointment[8] in case of death, illness,

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[6] Oklahoma is the only state in the union having a constitutional Department of Charities and Corrections providing for a commissioner to be elected in the same manner, at the same time, and for the same term as the governor. M. C . Maxted, "Oklahoma Laws Relating to Social Work," 1939, Norman, Oklahoma, p. 15.

[7] Oklahoma Constitution, Art. VI, Sections 3, 27.

[8] Oklahoma Statutes, 1931, Sec. 3426.

or impeachment of the incumbent.[9]

The State Constitution gives the Commissioner the power and makes it his duty to examine into the condition and management of all prisons, reformatories, reform and industrial schools, hospitals, and orphanages, which derive their support wholly or in part from the state.[10]

The statutes require the Commissioner to visit, inspect, and inquire into the condition and management of all state, county and city, penal, reform and correctional institutions, and all eleemosynary institutions, including city and county hospitals, dispensaries, and pest houses, at least once each year.[11]

The Commissioner, upon the sworn complaint of any citizen against any institution of the above named types,[12] or at the request of the governor,[13] can make an investigation of the institution under criticism and order the wrongful condition abated.

The Commissioner has the power to summon any person to appear and produce all books and papers designated in the

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[9]The Commissioner can be impeached by the Supreme Court or the Legislature for neglect of duty, corruption, drunkenness, moral offense, or incompetency. Ibid.

[10]Oklahoma Constitution, Art. VI, Sec. 28.

[11]Oklahoma Statutes, 1931, Sections 3601, 3602, 3603.

[12]Ibid., Sections 3607, 3609.

[13]Ibid., Sec. 3604.

summons; to take testimony under oath concerning the matter and institution under investigation. Evidence may be taken out of the hearing of persons in authority and used to correct any wrong that is disclosed.[14]

An annual report is made to the Commissioner on or before the first of November by all charitable and penal institutions in the state.[15]

The Commissioner makes an annual report to the governor on the thirty-first of December, and a duplicate report to the legislature on the day of its assembling.[16]

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[14] Ibid., Sections 3604, 3610, 13545.

[15] Ibid., Section 3611.

[16] Oklahoma Statutes, 1931, Sec. 3611. The supervisory powers of the commissioner extend to 655 institutions. The last annual report printed for general distribution by this department covered the year 1929. The present commissioner states that since then appropriations have been too small to allow the printing of reports. The incumbent also states that it is no longer possible to employ an adequate staff for the same reason. At the present time (July 21, 1941) the staff of this department is limited to six members. Annual appropriations made by the Legislature to the Commissioner of Charities and Corrections from 1929 to 1939 are:

$19,401.75 per annum, Oklahoma Session Laws, 1929, p. 277;
13,950.00 per annum, Ibid., 1931, p. 290;
8,470.00 per annum, Ibid., 1933, p. 7;
7,800.00 per annum, Ibid., 1935, p. 362;
19,100.00 per annum, Ibid., 1937, pp. 501-08;
7,870.00 per annum, Ibid., 1939, p. 590.

State Board of Public Affairs[17]

The State Board of Public Affairs has three members. They are appointed by the governor, with senatorial approval, and serve at the pleasure of the appointing power. The only qualifications required by the statutes are that the members must be experienced in public affairs, qualified electors, and not more than two may be of the same political party.[18]

The chairman receives an annual salary of $5,400, while the other two members each receive $4,800. In addition, all are allowed necessary expenses, approved by the board.[19] Sixteen other positions and their accompanying salaries under the board are fixed by the legislature.[20]

Board members are prohibited from engaging in any other business for compensation for their personal services during their term of office. No contract may be made by them with any firm in which any member has an interest, or with any

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[17]The State Board of Public Affairs is a statutory board created in 1909. As originally set up this board acted as purchasing agent for the various state agencies. It was also given authority to contract for the construction and repair of all state owned properties. Oklahoma Session Laws, 1909, ch. 37, art. 1. Since then the legislature has given it managerial control over eighteen penal and eleemosynary institutions. The board also acts in a quasi-judicial capacity in sterilization cases where inmates of state institutions are involved.

[18]Oklahoma Statutes, 1931, Sec. 3569.

[19]Oklahoma Statutes, 1931, Sec. 3488.

[20]Oklahoma Session Laws, 1937, ch. 20, art. 3.

relative of any member either by blood or marriage within the third degree.[21]

Managerial powers and duties. The State Board of Public Affairs manages and controls the five mental hospitals:

Central Oklahoma State Hospital, Norman;
Central Oklahoma State Hospital Annex, McAlester;
Western Oklahoma State Hospital, Supply;
Eastern Oklahoma State Hospital, Vinita;
State Hospital for Negro Insane, Taft;

in addition to:

Northern Oklahoma Hospital, Enid;
Western Oklahoma Charity Hospital, Clinton;
Eastern Oklahoma Tuberculosis Sanitarium, Talihina;
Western Oklahoma Tuberculosis Sanitarium, Clinton;
Oklahoma State Penitentiary, McAlester;
Oklahoma State Reformatory, Granite.

All of these institutions are presented graphically in Charts 2 and 3.[22]

In practice the State Board of Public Affairs also manages and controls the four correctional institutions and the three children's homes, even though this power is delegated by law to the Board of Managers for children's institutions.[23] This is due to the fact that the legislature has made no appropriation for the latter board since 1919. It has been the policy of governors to appoint the three members of the State Board of Public Affairs on the Board of Managers,

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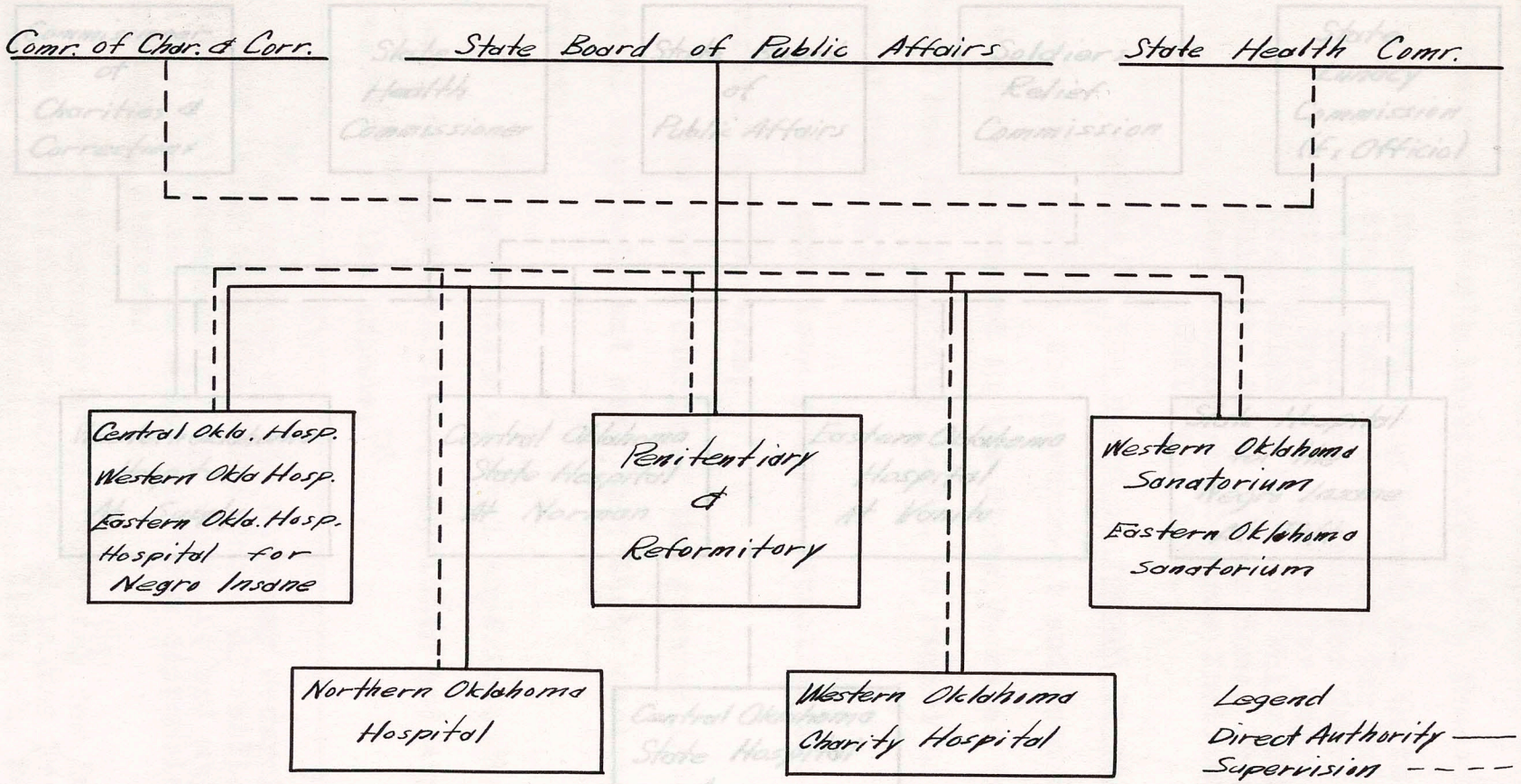
[21] Oklahoma Statutes, 1931, Sec. 3574.

[22] See pages 48 and 49.

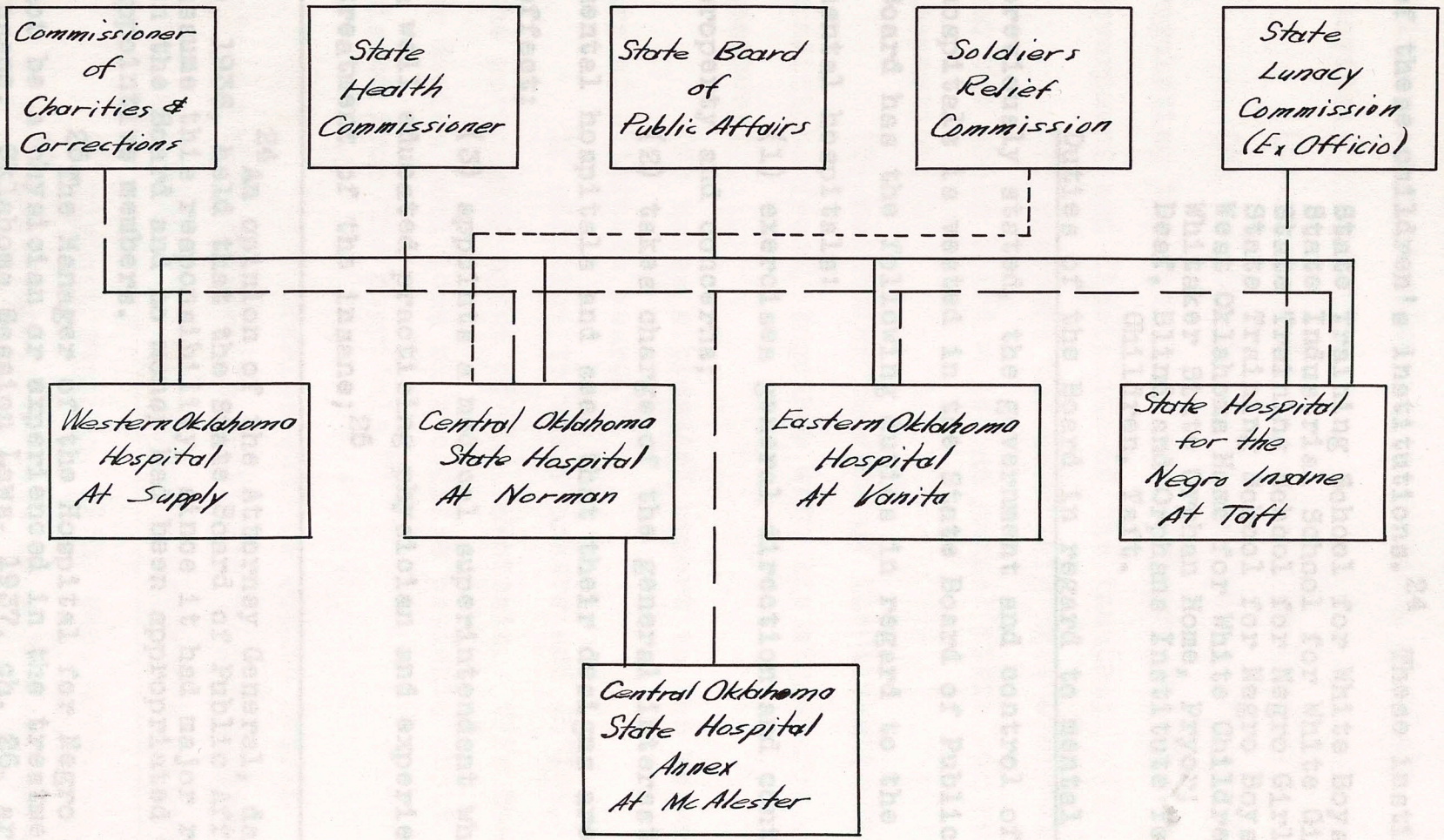
[23] The Board of Managers for children's institutions, a five member board, was created in 1919. Oklahoma Statutes, 1931, Sections 5147, 5151.

Chart 2. INSTITUTIONS GOVERNED BY STATE BOARD OF AFFAIRS



Wardens of the Reformitory & the Penitentiary are appointed by the Governor.

Chart 3. GOVERNING BODIES OF OKLAHOMA STATE (MENTAL) HOSPITALS



and they have assumed all responsibility of the management of these children's institutions.[24] These institutions are:

State Training School for White Boys, Pauls Valley;
State Industrial School for White Girls, Tecumseh;
State Training School for Negro Girls, Taft;
State Training School for Negro Boys, Boley;
West Oklahoma Home for White Children, Helena;
Whitaker State Orphan Home, Pryor;
Deaf, Blind and Orphans Institute for Negro Children, Taft.

Duties of the Board in regard to mental hospitals. As previously stated, the government and control of the mental hospitals is vested in the State Board of Public Affairs. This Board has the following duties in regard to the management of mental hospitals:

(1) exercises general direction and control of all property and concerns;

(2) takes charge of the general interests of the mental hospitals and sees that their designs are carried into effect;

(3) appoints a medical superintendent who has to be a well educated practicing physician and experienced in the treatment of the insane;[25]

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[24]An opinion of the Attorney General, dated February 5, 1936, held that the State Board of Public Affairs could assume this responsibility, since it had major representation on the Board and no money had been appropriated for the other appointive members.

[25]The Manager of the Hospital for Negro Insane need not be a physician or experienced in the treatment of the insane. Oklahoma Session Laws, 1937, ch. 26, art. 6, sec. 1.

(4) appoints upon motion of the medical superintendent, all necessary physicians, a steward, chaplain, and other employees;

(5) fixes salaries of all employees;

(6) establishes by-laws, rules and regulations for regulating the duties of the officers and for the internal government and discipline of the inmates;

(7) inspects the hospitals once every three months, and the whole board makes an annual visit for purposes of inspection;

(8) maintains records of these visits showing the conditions found, together with the signatures of the inspectors;

(9) makes a biennial report to the governor in January of alternate years.[26]

In addition to these powers and duties, the Board is the purchasing agent of the hospitals. This Board also grants or denies petitions to sterilize patients about to be dismissed from the hospitals.[27]

Commissioner of Public Health

This officer is appointed by the governor to serve a four year term.[28] The statutes prescribe no qualifications

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[26] Oklahoma Statues, 1931, Sec. 4996.

[27] These functions will be discussed in later sections of this thesis.

[28] Oklahoma Statutes, 1931, Sec. 4443.

for this office, nor do they state any method for removal. Since 1907 there have been ten state health commissioners, including the present one. The first appointee served two terms, since that time each administration has seen one or more new commissioners. Personnel turnover in the health department has been fifty per cent or more every four years.[29]

One of the statutory duties of the commissioner is the inspection of sanitary conditions of persons and public institutions, and to recommend, prescribe and enforce any sanitary regulations deemed advisable. The commissioner makes a report in writing to the governor twenty days preceding each session of the legislature upon the sanitary conditions, prospects, and needs of the state.[30]

The State Planning Board report on mental hospitals states:[31]

> Along with other duties, the State Commissioner of Public health makes annual inspections of the health, medical, and sanitary facilities at each state institution.

The report of the commissioner for the fiscal year ending June 30, 1938 makes only one observation in this respect, namely: "state institutions were inspected and sanitary

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[29] Organization and Administration of Oklahoma, The Brookings Institution, (Oklahoma City, Oklahoma: Harlow Publishing Corp., 1935), p. 108.

[30] Oklahoma Statues, 1931, Sec. 4446.

[31] State Mental Hospitals in Oklahoma, op. cit., p. 6.

conditions improved."[32] The department's report for the fiscal year 1939-40 makes no comment in regard to conditions of state institutions.[33]

The Assistant Commissioner in a letter states that these laws were passed in 1908 at the time when these institutions were first being established and their superintendents had little experience in operating such places. At the present the commissioner is wholly taken up in directing the functions of his department, however he does make occasional visits to these institutions. No formal reports have ever been written concerning any findings of these visits.[34]

Soldiers' Relief Commission

This commission consists of three members appointed by the governor from a list of ten, five from each of the major political parties, furnished by the American Legion. Members serve two year terms. Not more than two of the members may belong to the same political party.[35] Members of the commission retain their office at the pleasure of the appointing power.[36]

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[32] Annual Report of the State Department of Public Health of Oklahoma, 1938, Oklahoma City, p. 20.

[33] Ibid., 1940.

[34] Letter from the Assistant Commissioner of Health, written on August 2, 1941.

[35] Oklahoma Statutes, 1931, Sec. 12,091.

[36] Opinion Attorney General, January 20, 1923.

The commission was authorized by the legislature to provide buildings for mentally diseased ex-service men at the Central Oklahoma State Hospital at Norman. The commission was given no real authority by the legislature save in regard to supervision of construction.[37]

State Lunacy Commission

This is an ex officio commission consisting of the State Commissioner of Public Health, Chairman of the State Board of Public Affairs, and the superintendents of the three state hospitals for white mental patients.[38]

The commission has general supervision of the policies pursued by each of the state hospitals for the insane, and is authorized to formulate and adopt a permanent plan and system for the proper care and treatment of the insane.[39]

This commission does not hold meetings at stated intervals, nor does it keep minutes. However the various above named officials meeting one another or by means of correspondence often propose suggestions and criticisms. If these gain a favorable response they are frequently put into operation. While meetings of this type may not be as effective or efficient, it is presumably safe to say that these officials believe that functioning the way they do is satisfactory.

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[37] Oklahoma Statutes, 1931, Sections 12,100, 12,102. However many ex-service patients do write letters of complaint to the commission, resulting in occasional investigation by the commission.

[38] Ibid., Sec. 5072. [39] Ibid.

CHAPTER IV

MENTAL ILLNESS: TREATMENTS

The purpose of this chapter is to outline briefly the functions of the Central Oklahoma State Hospital in the performance of its principal job--namely the care and treatment of its patients.

Commitment

Patients granted admission to any one of the state hospitals for the mentally ill may be classified in one of three groups. They are:[1]

(1) Public patients, who are insane persons and are kept and maintained at the expense of the state;

(2) Private patients, who are insane and are kept and maintained at no expense to the state;

(3) Voluntary patients, who are not insane and are kept and maintained without expense to the state.

With very few exceptions all of the patients in these hospitals

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[1] Oklahoma Statutes, 1931, Sec. 5002.

are in the first class.[2]

All patients who are held, either as a public or private patient, must be admitted upon a certificate of insanity and an order for admission.[3]

Any inmate of any other state institution[4] who may be deemed insane by its administrative head may be examined and sent to a mental hospital, when cured he is returned to the institution from which he came.[5]

Non-residents may be admitted for temporary care but must be removed as soon as possible to the state to which they belong. The hospital pays the cost of removal.[6]

County Insanity Proceedings

The great majority of the patients are admitted as a result of court commitment by the county judge of the county where the patient resides.

Any blood relative, husband, wife, the county sheriff, the superintendent of the poor or the supervisor of any township or any peace officer within the patient's county may petition the county court for an order directing admission

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[2]It should not be assumed that the poor have a corner on mental disease. The possession of wealth allows an individual to seek the aid of a psychiatrist at the first signs of mental illness, also the wealthy are more apt to enter a private institution when hospitalization is necessary.

[3]Oklahoma Statutes, 1931, Sec. 5003.

[4]This refers to any and all penal and eleemosynary state institutions other than the mental hospitals.

[5]Oklahoma Statutes, 1931, Sec. 5014. [6]Ibid., Sec. 5019.

of the patient to an institution for the care of the insane. The court fixes the day of the hearing and appoints two reputable, state-registered physicians to make the required examination and file the certificate on or before the hearing. The two physicians must not be related by blood or marriage to the patient or anyone applying for the certificate. At least twenty-four hours must elapse between the serving of the notice on the patient and his relatives, and the hearing. The judge may or may not require a jury, at his discretion. A jury consists of six freeholders having the qualifications required of jurors in courts of record.[7]

In practice there are no voluntary admissions in the state. The voluntary patient is required to go through the usual court commitment, or to have the approval of the county court in writing. Such a patient can be retained only three days after giving written notice of desire or intention to leave.[8]

In 1917 the legislature[9] authorized the State Board of Public Affairs, the State Health Commissioner, and the superintendents of the three white hospitals to divide the state into three districts, each to be served by one of the hospitals. These geographical districts are presented in

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[7] House Bill Number 321, 18th Legislature, Approved June 6, 1941.

[8] Oklahoma Statutes, 1931. Sec. 5018.

[9] See page 58.

The information used in this map was taken from Plate VII, State Mental Hospitals in Oklahoma, op. cit.

Chart 4. Geographical Districts served by the white mental hospitals

Chart Number 4.[10] Admission applications are sent direct to the hospital of the district by the county judge. If that hospital has no vacancy the application is sent to the State Board of Public Affairs who send it to the nearest hospital having vacancies.

Typical Passage of a Patient through the Central Oklahoma State Hospital

A person after having been found insane by the proper county authorities is taken by the sheriff of that county to one of the state hospitals. Upon being received at the hospital the patient is taken to a receiving ward and there closely observed for a week or more. During this time he is given a complete physical examination and interviewed by the various staff doctors. All of this material plus any given in the committing order is compiled into a case history. Then some three weeks after admission the patient is brought before a clinic, composed of the staff doctors, at which time a tentative diagnosis is made. After the diagnosis the patient is given treatment best suited to his type of ailment. Later if the patient reacts in a positive manner his daignosis is confirmed. If the patient shows improvement the specific treatment is continued, but if no improvement is shown the patient remains in the institution as a custodial case. Those patients who improve sufficiently are paroled back to their

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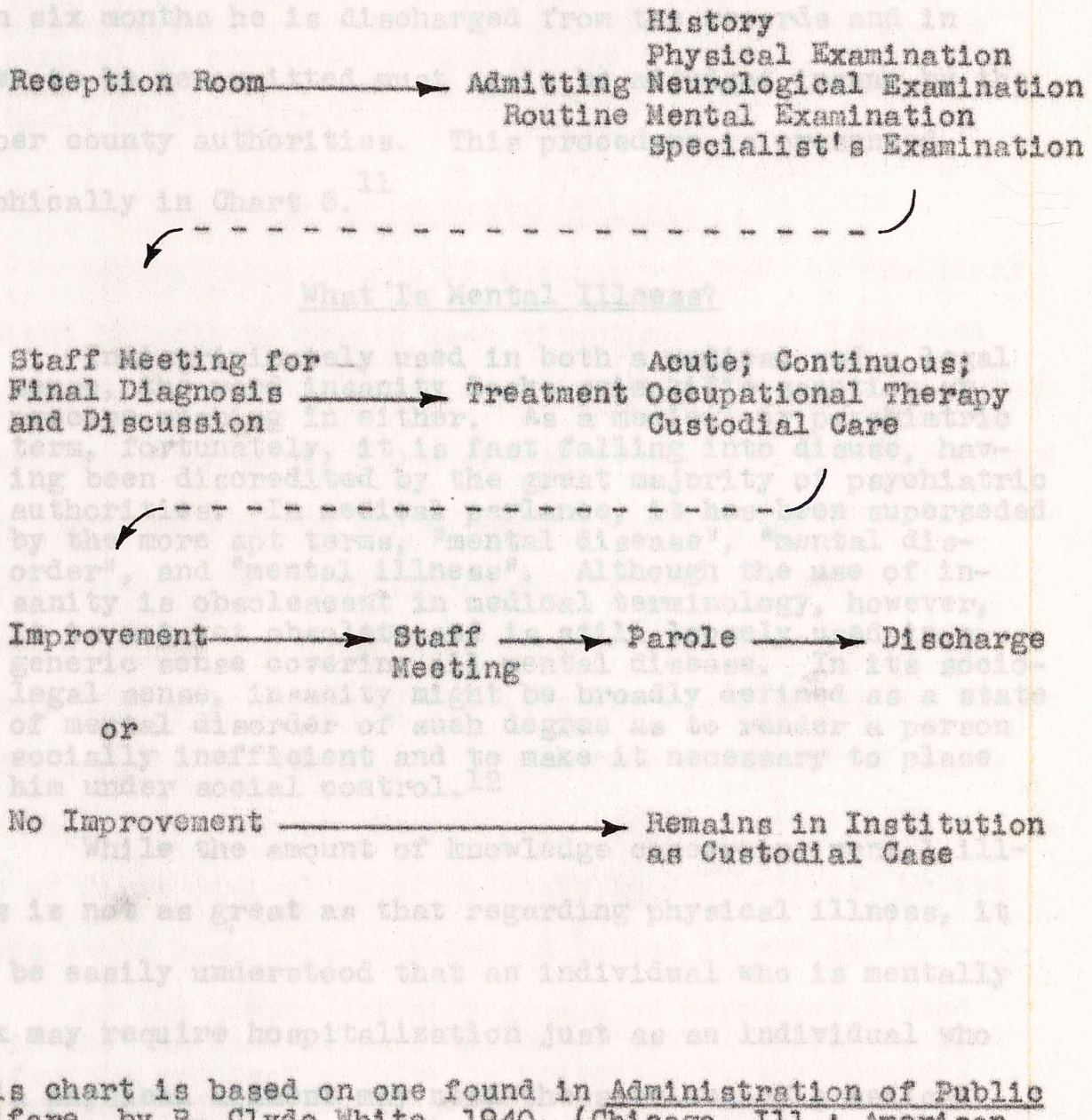
[10] Session Laws of Oklahoma, 1917, ch. 174, Sec. 6.

Chart 5. FLOW CHART REPRESENTING PASSAGE OF PATIENT THROUGH THE CENTRAL OKLAHOMA STATE HOSPITAL*



*This chart is based on one found in Administration of Public Welfare, by R. Clyde White, 1940, (Chicago, Ill.: American Book Co.), p. 226.

guardians for a six month probationary period. During this period of the patient has a relapse he may be returned to the hospital without going through another formal committing process. However, if he remains out of the hospital longer than six months he is discharged from the records and in order to be recommitted must again be adjudged insane by the proper county authorities. This procedure is presented graphically in Chart 5.[11]

What Is Mental Illness?

> Indiscriminately used in both a medical and a legal sense, the word insanity lacks scientific sanction or precise meaning in either. As a medical or psychiatric term, fortunately, it is fast falling into disuse, having been discredited by the great majority of psychiatric authorities. In medical parlance, it has been superseded by the more apt terms, "mental disease", "mental disorder", and "mental illness". Although the use of insanity is obsolescent in medical terminology, however, it is not yet obsolete and is still loosely used in a generic sense covering all mental disease. In its socio-legal sense, insanity might be broadly defined as a state of mental disorder of such degree as to render a person socially inefficient and to make it necessary to place him under social control.[12]

While the amount of knowledge concerning mental illness is not as great as that regarding physical illness, it can be easily understood that an individual who is mentally sick may require hospitalization just as an individual who has a physical ailment may need the services of a medical

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[11] See page 60.

[12] Albert Deutsch, The Mentally Ill in America, op. cit., p. 386.

hospital. Persons who are mentally ill may require treatment in a hospital where orderly routine, trained personnel, and vigilance are provided.

> Mental illness may be defined as an abnormal condition of the brain or the nervous system, or of both, characterized by deficiency of rational control and in general by perverted action of one or more of the mental facilities. These may or may not be developed on a basis of heredity.[13]

Types of Mental Illness

Before going into a discussion of types of treatment it might be well to devote some attention to the types and incidence of mental diseases. A census of the populations of mental hospitals as to types of mental diseases has never been made. However figures are available showing the types of mental illness for first admissions to mental hospitals. Mental diseases may be roughly divided into functional and organic diseases; that is, diseases whose origin may be traced to the body or to behavior. A breakdown of the chief types of maladies in each of these types, together with the per cent of first admissions of patients to Oklahoma and United States state hospitals is shown in Tables 11 and 12.[14]

> Of the twenty definite groups of psychoses listed in the standard classification of mental diseases, by far the greatest problem is presented by the dementia praecox (schizophrenia group), which occupies more than half the beds in the United States. As its name implies,

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[13] State Mental Hospitals in Oklahoma, op. cit., p. 2.

[14] See pages 64-65.

dementia praecox is mainly a disease of early life; about one-half of such cases occur between the ages of 15 and 30. Each year about 20,000 individuals, many of them in the first flush of youth, enter our mental hospitals as dementia praecox victims, constituting about twenty per cent of all first admissions. According to the federal census, 19,149 new cases of dementia praecox entered our mental hospitals in 1935 out of a total of 101,462 first admissions. About twenty-eight per cent of readmissions to mental hospitals are dementia praecox cases. They are the youngest to be admitted, and they stay the longest. Of the patients who died in New York state hospitals in 1933, the dementia praecox group showed an average length of hospital life of over sixteen years, as compared with 5.6 years of hospital life for manic-depressives and less than two years for general paretics. Despite the encouraging prospects held out by experiments with prolonged sleep, insulin shock, oxygen inhalation and other forms of therapy, cold statistics show that, in terms of recovery, dementia praecox is one of the least hopeful of all mental diseases. The recovery rate for this disease in 1934 was only six per cent. The nature and cause of this type of psychosis still remains a mystery.

Although the nature of that other great functional disease, manic-depressive psychosis, is also unknown, it presents a brighter statistical picture. The recovery rate for this disease in our state hospitals in 1934 was 41.5 per cent, while 27.2 per cent more were discharged as improved. More than twelve per cent of all new admissions are in this category.

The so called organic psychoses, which are known to have physical causes, constitute about forty-five per cent of the total admissions to mental hospitals. Included among the principal organic mental diseases are the senile psychoses (8.4 per cent of new admissions in 1934) psychosis with cerebral arteriosclerosis (9.4 per cent), general paralysis (7.5 per cent), psychosis with cerebral syphilis (1.6 per cent), and alcoholic psychoses (4.9 per cent).[15]

It may well be emphasized that 11.972 per cent of first admissions to Oklahoma state hospitals, and 9.059 per cent of total first admissions to United States state hospitals,

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[15] Albert Deutsch, op. cit., pp. 484-5.

TABLE 11

FIRST ADMISSIONS TO ALL UNITED STATES STATE HOSPITALS FOR MENTAL DISEASES, BY MENTAL DISORDERS: 1938*

Mental Disorder	Per Cent	Per Cent
Total		99.979
I. Organic Diseases		
1. Those due to the germs of syphilis	9.059	
2. Those arising from accidents in which the brain was injured	.593	
3. Those caused by hardening of the arteries of the brain	13.795	
4. Those resulting from excessive use of alcohol or drugs	10.578	
5. Those due to tissue changes associated with old age	8.241	
6. Those due to convulsive disorders	2.451	
7. Those due to epidemic encephalitis	.447	
8. Those due to other physical disorders	6.077	
II. Functional Diseases		35.819
1. Dementia Praecox	20.646	
2. Manic Depressive Psychoses	10.841	
3. Paranoia and paranoid conditions	1.519	
4. Psychoneuroses	2.813	
III. Other		12.919
1. Other psychogenic disorders	2.270	
2. Undiagnosed	5.712	
3. Without psychoses	4.937	

*The above table form was taken from an article entitled "Mental Hospital Statistics", page 6 of the magazine, Public Welfare in Indiana, which is the official publication of the Indiana Department of Public Welfare, Vol. XLIX, No. 9, Series 258 (Sept., 1939), Indianapolis, Ind.

The data on which the above figures are based was taken from Patients in Mental Institutions, 1938, Bureau of the Census, 1941, U.S. Government Printing Office, Table 15, p. 26.

TABLE 12

FIRST ADMISSIONS TO OKLAHOMA STATE HOSPITALS FOR MENTAL DISEASES, BY MENTAL DISORDER: 1938*

Mental Disorder	Per Cent	Per Cent
Total		99.988
I. Organic Diseases		48.839
1. Those due to the germs of syphilis	11.972	
2. Those arising from accidents in which the brain was injured	.612	
3. Those caused by hardening of the arteries of the brain	4.489	
4. Those resulting from excessive use of alcohol or drugs	.408	
5. Those due to tissue changes associated with old age	11.360	
6. Those due to convulsive disorders	3.401	
7. Those due to epidemic encephalitis	6.802	
8. Those due to other physical disorders	9.795	
II. Functional Diseases		36.116
1. Dementia Praecox	19.387	
2. Manic Depressive Psychoses	12.653	
3. Paranoia and paranoid conditions	2.240	
4. Psychoneuroses	1.836	
III. Other		15.033
1. Other psychogenic disorders	2.517	
2. Undiagnosed	5.850	
3. Without psychoses	6.666	

*The above table form was taken from an article entitled "Mental Hospital Statistics", page 6 of the magazine, Public Welfare in Indiana, which is the official publication of the Indiana Department of Public Welfare, Vol. XLIX, No. 9, Series 258, (Sept. 1939), Indianapolis, Ind.

The data on which the above figures are based was taken from Patients in Mental Institutions, 1938, op. cit.

in 1938 were due to syphilis.[16] This is an intolerable situation because the cause and the cure for syphilis are known and readily available.

The rate of first admissions of senile patients is large. Senile psychoses are due to those organic diseases caused by hardening of the arteries of the brain and to those resulting from tissue changes associated with old age. During 1938 these accounted for a total of 15.849 per cent in Oklahoma and 22.036 per cent in the United States of all first admissions.[17] There is little that a mental hospital can offer these people other than comfortable surroundings and upkeep. It has been truly said that there is no cure for old age. Human machines have a way of wearing out, in some it is the mental mechanisms that show signs of impairment; these are the senile patients.

Alcoholic and drug addicts as a general rule are not admitted to the state hospitals of Oklahoma. There is considerable difference of opinion among medical authorities as to whether this type of patient is a mental patient. The prevailing opinion in Oklahoma is that they have no business in its state hospitals.

Oklahoma has a much larger percentage of first admissions due to epidemic encephalitis than the nation.[18] While

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[16] Note Tables 11 and 12, pages 64-65.

[17] Ibid. [18] Ibid.

the cause of encephalitis is unknown and its method of treatment is vague it is known as a spot disease, that is, being more prevalent in certain areas than in others.

Dementia praecox patients occupy sixty per cent of the beds in mental hospitals. Its cause is unknown. Its victims belong to no particular class. There are a number of methods of treatment but their effectiveness is never certain. Around twenty per cent of all first admissions to mental hospitals are due to this disease.

The tendency toward manic depressive psychoses may be found in people outside of hospitals. They may be characterized as people who are very happy one day and very gloomy the next. Often in those who reach extremes it is necessary to hospitalize. These extreme cases stay in institutions for relatively short periods but are often readmitted when another bad attack occurs.

Facilities

Hospital facilities consist of those used for purposes of treatment and maintenance. In actual operation these tend to dovetail together. However for purposes of description they are best described separately. Facilities of the Central Oklahoma State Hospital, while being far from adequate, are sufficient to give reasonable care to patients.

Treatment Facilities

The American Association of Psychiatry[19] recognizes twenty-one different types of insanity.[20] Individuals who are hospitalized may be afflicted with one of these, or a combination of them and may or may not have a form of physical illness in addition thereto. It is therefore necessary in a mental hospital to provide treatment facilities other than those used for strictly psychiatric purposes. Treatment may be subdivided into medical, dental, psychiatric, and therapeutic.

Medical Treatment. This type of treatment requires the use of general medical facilities. These are similar to those found in any general hospital and includes laboratories, x-ray, examination and surgical rooms. While facilities are not elaborate and most of the equipment is old it is adequate for normal needs. The most pronounced need is

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[19] In Philadelphia on October 16, 1844, thirteen medical superintendents founded what is not the American Psychiatric Association. Its objects: "the medical gentlement connected with lunatic asylums should be better known to each other, should communicate more freely the results of their individual experience; should cooperate in collecting statistical information relating to insanity, and above all, should assist each other in improving the treatment of the insane." Albert Deutsch, op. cit., p. 191.

[20] H. S. Bossard, Social Change and Social Problems, (New York: Harper and Bros., 1934), pp. 490-497.

found in the number of trained technicians and the care that must be used in the use of supplies. The Central Oklahoma State Hospital has only six medical doctors and three technicians to care for over 2,500 patients.[21] The Mental Hospital Survey Committee recommends one medical doctor for every 150 patients.[22]

Limited budgets are labeled as the cause of this unsatisfactory situation. Only a cursory physical examination can be given newly admitted patients and treatments given to those cases where medical attention is clearly indicated as being needed. Because of this fault many patients who are badly in need of medical attention are allowed to suffer. The same logic applies for the great mass of patients in the hospital.

In 1933 the legislature passed a law permitting inmates of any penal or eleemosynary institution supported in whole or in part by public funds to be sterilized when they are about to be discharged, if they are apt to become a partial or complete public charge.[23] While patients in mental hospitals could be sterilized, they are not. This is due to

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[21]Information received in an interview with hospital officials at the Central Oklahoma State Hospital during July, 1941.

[22]Mental Hospital Survey Committee, A Survey of the Oklahoma State Hospitals, 1937 (New York: 50 West 50th Street, Room 822), p. 48.

[23]Oklahoma Statutes, 1936, Sec. 5039.

two reasons, first, there is no clear proof that mental disease is due to heredity; and second, those types of mental deficiency that would best be sterilized are in almost all cases never released from institutions.

Psychiatric Treatment. This term includes methods of treatment whose uses are restricted to those afflicted with mental disease. They may be subdivided on a basis of:

(1) Treatment for immediate results. In order to prevent a badly disturbed patient from inflicting injury on himself or on others and to prevent his becoming destructive some form of mechanical restraint or a sedative is used. Frequently hydrotherapy is used, that is, the patient is placed in a constant flow bath for a period of four or five hours.

(2) Treatment to cure. This treatment includes chemo-therapy, insulin and metrazol, special diets, rest and others. For the purposes of this paper it is not considered wise to dwell in any detail on these forms of treatment.

Therapeutic Treatment. Therapy may be defined as the activities of the patient while in the hospital. In so far as possible patients should be encouraged to use their minds and bodies. There are two general types of therapy, occupational and recreational. To achieve the best results therapists, that is, individuals trained in various aspects of these fields, should be employed to plan activities and supervise patients in their performance.

The Central Oklahoma State Hospital has not employed any trained therapists, however, many of the employees function as therapists.

Examples of the two types are as follows:

(1) Occupational--this includes employment in the various handicrafts, and on the farm, dairy, landscaping, kitchens and dining rooms, wards and laundry.

(2) Recreational--this includes plays, calisthenics, shows, picnics, outdoor walks, visits and letter writing, dances, library, radio, and the playing of various outdoor and indoor games.

Occupational therapy at the Central Oklahoma State Hospital is largely restricted to the performance of necessary chores around the institution by patients. However during the fiscal year of 1939-40, a number of patients were enrolled in various therapy classes. During this year there was an average daily enrollment of seventy in the art classes, seven-hundred and eighty-one in classes of occupation, and ninety-six in the shops. The women's art room had an average enrollment of thirty-five; they do fine needle work, operate looms for weaving, hooked rugs, knitting, crocheting, and embroidery work. The industrial building for men had an average enrollment of forty; here various handicrafts such as shoe repairing, broom and brush making, wood carving, rug weaving, towel weaving, basketry, wicker funiture making, painting, and

other types of repair are taught.[24]

Methods of Employment for Patients:[25]

Farm	32	Blacksmith	2
Garden	46	Bakery	18
Dairy	28	Plumbing	3
Poultry	6	Porters	4
Power House	5	On Lawn	24
Laundry	55	Industrial Building	40
Wards	200	Commissary	7
Horse & Mule Barn	3	Greenhouse	3
Machine Shop	2	Yards and Cleaning	10
Trucks	6	Canteen	3
Chapel	2	Marking Room	3
Garbage Truck	5	Veterans' Dept.	35
Ice Plant	2	Carpenter Shop	18
Butcher Shop	3	Mattress Factory	7
Kitchens	35	Laundry Collecting	15
Dining Rooms	85	Painters	3
Canning	40	Lake Grounds	2
Art Rooms	35	Miscellaneous	50
Sewing Room	20		
Hope Hall	20	Total	877

During the fiscal year ending June 30, 1940, 149 different events that may be classified as recreation were given at the Cental Oklahoma State Hospital. These included religious services, picture shows, dances, parties, and other events. The average attendance was 1,100.

Various types of programs were given by outside organizations, such as the YM and YWCA, the WPA, and groups of entertainers from the penitentiary at McAlester and the training school at Pauls Valley. Equipment for softball, croquet, horse shoes, and other games has been furnished by the institution to encourage patients to engage in outdoor exercise.

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[24]Information taken from the Steward's Report, The Central Oklahoma State Hospital, July, 1941.

[25]Ibid.

An annual nativity scene, depicting the birth of Christ is erected by the patients for the Christmas holidays.

A canteen, which is housed in its own building, and owned and operated by patients under institutional supervision gives both patients and employees an opportunity to enjoy the pleasures of a confectionery. Profits are used to provide articles for the recreation of the patients. During the fiscal year of 1939-40 the following articles were purchased out of the canteen's profits:[26]

24	New Radio and radio repairs	$326.13
265	Books for library were purchased	254.90
50	Magazines, newspapers and journals	140.87
52	Picture shows, film and operating expense	310.84
97	Vaudeville and musical entertainments	312.37
1	Christmas Scene	71.86
	Softball and recreational equipment	252.90
40	Prizes to patients	10.00
2	Pianos	100.00
150	Song books	38.64
1000	Christmas cards	84.85
	(And many other small items too numerous to mention)	

Mental Hospital Standards. In 1925 the American Psychiatric Association set forth a schedule of the minimum requirements for a modern mental hospital. These have been reaffirmed several times since then. While Oklahoma hospitals do not come up to these standards it is considered worth while to include them in full:[27]

> (1) The chief executive officer must be a well-qualified physician and experienced psychiatrist whose appointment and removal shall not be controlled by partisan politics.

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[26] Ibid. [27] Albert Deutsch, op. cit., pp. 445-446.

(2) All other persons employed at the institution ought to be subordinate to him and subject to removal by him if they fail to discharge their duties properly.

(3) The positions and administrations of the institution must be free from control for the purposes of partisan politics.

(4) There must be an adequate medical staff of well-qualified physicians, the proportion to total patients to be not less than 1 to 150 in addition to the superintendent, and to the number of patients admitted annually not less than 1 to 40. There must be one or more full time dentists.

(5) There must be a staff of consulting specialists at least in internal medicine, general medicine, general surgery, organic neurology, diseases of the eye, ear and throat, and radiology, employed under such terms as will ensure adequate services.

(6) The medical staff must be organized, the services well defined and the clinical work under the direction of a staff leader or clinical director.

(7) Each medical service must be provided with an office and an examining room, containing suitable conveniences and equipment for the work to be performed, and with such clerical help specially assigned to the services as may be required for the keeping of the medical and administrative records.

(8) There must be carefully kept clinical histories of all the patients in proper files for ready reference on each service.

(9) Statistical data relating to each patient must be recorded in accordance with the standard system adopted by the association.

(10) The patients must be classified in accordance with their mental and physical condition, with adequate provision for the special requirements for the study and treatment of the cases in each class, and the hospital must not be so crowded as to prevent adequate classification and treatment.

(11) The classification must include a separate reception and intensive study and treatment department or building, a special unit for acute physical illnesses and surgical conditions, and separate units for the tuberculosis, and the inform and bedfast.

(12) The hospital must be provided with a clinical and pathological laboratory, equipped and manned in accordance with the minimum standards recommended by the Committee on Pathological Investigation.

(13) The hospital must be provided with adequate X-ray equipment and employ a well qualified radiologist.

(14) There must be a working medical library and journal file.

(15) The treatment facilities and equipment must include: a) A fully equipped surgical operating room; b) A dental office supplied with modern dental equipment; c) Tubs and other essential equipment for hydrotherapy operated by one or more specially trained physiotherapists; d) Adequately equipped examination rooms for the specialties in medicine and surgery required by the schedule; e) Provision for occupational therapy and the employment of specially trained instructors; f) Provision for treatment by physical exercises and games and the employment of specially trained instructors; g) Adequate provision for recreation and social entertainment.

(16) Regular staff conferences must be held at least twice a week where the work of the physicians and the examination and treatment of the patients will be carefully reviewed. Minutes of the conference must be kept.

(17) There must be one or more out-patient clinics conducted by the hospital in addition to any on the hospital premises. An adequate force of trained social workers must be employed.

(18) There must be an adequate nursing force, in the proportion to total patients of not less than 1 to 4. Provision must be made for adequate systematic instruction and training of the members of the nursing force.

(19) Mechanical restraints and seclusion, if used at all, must be under strict regulations and a system of control and record by the physicians, and must be limited to the most urgent conditions.

Maintenance Facilities

This includes housing, the preparation and serving of food, the furnishing of clothing, laundry, and various types of utility service such as water, heat, and sewage.

Housing. The white mental hospitals of Oklahoma are overcrowded and have been since 1923. During the ten year period from 1931 to 1940 the Central Oklahoma State Hospital was always overcrowded.[28]

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[28]Figures for this hospital are unavailable for previous years; note Table 10, page 38.

The ward buildings of the Hospital at Norman were designed and constructed with the primary thought of custody in mind. That is, these structures, composed of huge piles of masonry reinforced with steel, are in reality prisons. Patients are crowded together under the watchful eyes of attendants throughout their stay in the hospital. There can be no individual privacy.

With the exception of wards used for purposes of receiving and as infirmaries,[29] all wards are overcrowded.[30] This condition is characteristic of most state hospitals in the United States. A number of evils can be traced to overcrowding. Among these are delayed recovery from mental illness, increased friction between irritable patients, and the spread of physical disease and infection.

Ward buildings of this hospital may be roughly divided on a basis of those constructed before and after 1924.[31] There are eleven buildings in use that were constructed before 1924. These are now used primarily to house chronic cases. In design they consist of one large room with the majority of floor space being used for beds. A narrow aisle is kept open through the center of the ward, along the sides of which benches and chairs are lined. Bath facilities are found in

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[29]For therapeutic reasons efforts are made to keep the number of patients on these wards at a minimum.

[30]Overcrowding may be defined as a larger number of patients than the capacity of the buildings were constructed for.

[31]Note Table 9, page 37.

the back of the building behind partitions. These are generally inadequate. Buildings constructed since 1924 have day rooms and dormitories and, as a rule, more adequate bath facilities. Most of the buildings are heated by floor radiators, although of late the tendency has been to install ceiling radiators thus eliminating the possibility of a patient getting burned. Only three of the wards are equipped with air conditioning equipment. On these wards the air is changed every few minutes thus producing more healthy living conditions.

All buildings are fireproof and the materials used were picked to foil the onslaughts of destructive patients. All windows are barred, walls are reinforced with concrete, steel and brick, and floors are made of either cement or hardwood. The Veterans' Buildings are the most pleasing in design giving an outward appearance of an oversized rambling cottage that sharply contrasts from the rest of the buildings which have an appearance of huge ungainly jails. The art of landscaping has been used wherever possible in efforts to soften and enhance the harsh appearance of the buildings. All buildings are in a good state of repair and during the past few years a policy of systematically remodeling the older buildings has been followed.[32]

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[32]Information received in an interview with hospital authorities during June, 1941, at the Central Oklahoma State Hospital.

Food. The Central Oklahoma State Hospital operates six patient dining rooms and five kitchens, also an additional kitchen and three dining rooms for the employees. The physically sick and the badly disturbed patients are fed in the wards. Four kitchens and five dining rooms are located in ward buildings and their use is restricted to those buildings. However, approximately 2,000 of the chronic patients are fed in two central dining rooms, one for each sex. Each has its own kitchen. The combined seating capacity of these two dining rooms is 1,200, thus making it necessary to have two seatings.

The food served is a balanced ration. Due to limited appropriations nutritive foods having the lowest costs must be purchased. This results in a constant sameness of diet. It is often possible to tell the day of the week by the food served, for instance link sausages are served for breakfast only on Sunday. Foods that are fed the most frequently and in the larger quantities include longhorn cheese, flour, oatmeal, dried fruits, greens, cabbages, potatoes, turnips, peas, green beans, dry beans, rice, syrup, low grade coffee and tea, canned tomatoes, and peanut butter. The cheaper grades of meat are served one or two times a day. Milk, eggs, butter, and other fruits and vegetables are fed to patients who require special diets. While these foods supply a balanced diet they cannot be said to be pleasing to the palate when served continuously.

TABLE 13

PATIENTS' MENU FOR THE WEEK OF AUGUST 17, 1941 AT THE CENTRAL OKLAHOMA STATE HOSPITAL*

Sunday, 17th	Monday, 18th	Tuesday, 19th	Wednesday, 20th
Breakfast:			
Peaches	Peaches	Peaches	Peaches
Oatmeal	Oatmeal	Oatmeal	Oatmeal
Sausage	Toast	Toast	Toast
Gravy	Biscuit	Biscuit	Biscuit
Biscuit	Butter	Butter	Butter
Milk	Milk	Milk	Milk
Sugar	Sugar	Sugar	Sugar
Coffee	Coffee	Coffee	Coffee
Dinner:			
Beef Stew	Bread	Bread	Bread
Gravy	Milk	Milk	Milk
Lima Beans	Fresh Tom.	Peaches	Peaches
Tomatoes	Pumpkin	Bologna	Tomatoes
Bread	Pinto Beans	Beet Pickles	Pinto Beans
Peach Cobbler	Peanut Butter		Chili
Milk	Peaches		Cobbler
Supper:			
B. Rice	Stew-Gravy	Bread	Carrots, Glazed
B. Peas	Macaroni	Peaches	Bread
Chow-Chow	Carrots	Milk	Peaches
Bread	Bread	Cheese	Milk
Peaches	Peaches	Creamed Spuds.	Boiled Weiners
Milk	Milk	Peas	Corn

TABLE 13 - Continued

Thursday, 21st	Friday, 22nd	Saturday, 23rd
Breakfast:		
Oatmeal	Oatmeal	Oatmeal
Toast	Toast	Toast
Biscuit	Biscuit	Biscuit
Butter	Butter	Butter
Milk	Milk	Milk
Sugar	Sugar	Sugar
Coffee	Coffee	Coffee
Syrup	Syrup	Syrup
Dinner:		
Bread	Bread	Bread
Peaches	Milk	Milk
Milk	Peaches	Tomatoes
Tomatoes	Pinto Beans with	Navy Beans
Navy Beans	Chili Powder	Apple Sauce
Fried Liver	Beet Pickles	
Gravy	Cheese	
Supper:		
Bread	Stew-Gravy	Bread
Peaches	Carrots	Peaches
Milk	Bread	Milk
Stew with Mac.	Peaches	Stew with Mac.
Green Beans	Milk	Green Beans
	Potatoes	

* These menus were taken from records kept by the Steward of the Central Oklahoma State Hospital at Norman, Oklahoma on the 28th of August, 1941.

The kitchens are inadequate. None of them have sufficient quantities of equipment to allow food to be prepared in a wide number of ways. Almost every meal requires the use of a pressure cooker. This tends to destroy food flavor. Stove space is insufficient to allow large amounts of food to be fried at one time.

The hospital employs no trained chefs. Cooks and dining room attendants are recruited from the ranks of the regular employees. Cooking for large groups of people is an art that cannot be learned overnight and cannot be mastered solely by practice. Learning requires a certain amount of instruction; however, no instructions in cooking are given at this hospital.[33]

A number of possible improvements, many of which would cost little, can be suggested. For instance:

1. Good food preparation is of special importance in institutions caring for the mentally ill. It costs no more to have food properly cooked and served than to have it improperly cooked and served. This simply means more satisfying meals and less refuse.

2. Menus should be so arranged that it will be impossible for a patient to know what foods will be served prior to mealtime. Cafeteria style serving should be insti-

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[33]Information obtained in an interview with hospital officials at the Central Oklahoma State Hospital in August, 1941.

tuted wherever possible.[34] This has a therapuetic effect on the patient in that it forces him to use his own initiative in selecting the foods he desires from those that are available. It also keeps the food in a better condition and prevents any left over food being exposed on the tables.

3. Every kitchen should have a file of tested, standardized recipes which the cook should follow accurately. Recipes not properly followed may result in a poor product which finds its way into a garbage can.

4. Each kitchen should be under the direction of a trained chef. His worth would soon be seen in smaller amounts of refuse, more satisfying meals, and an attitude of looking forward to meals with enjoyment on the part of the patients.

5. A careful daily analysis of waste would be of value. At least six reasons can be advanced for doing this. They are:

a. Stimulating waste consciousness;

b. Proper regulation of amount of food served;

c. Standardizing recipes;

d. Educating wards to return to main kitchens leftover foods which are clean;

e. Educating wards to report an excessive or inadequate supply of food;

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[34]At the present time this hospital operates only one cafeteria. It is located in the Veterans' Buildings and its use restricted to veterans.

f. Inspection of garbage cans to learn which foods are most unpopular.

Activities of the various farm departments and certain utilities help to reduce the costs of maintenance.[35] These include:

1. The bakery, which produces an average of 2,800 sixteen ounce loaves of bread daily. Corn bread, pies, cakes, cookies, rolls, and other items are baked whenever menus call for them.

2. At the poultry farm during the fiscal year 1939-40 the flock which consisted of 800 laying hens produced 104,544 eggs. During the year 6,000 chickens, turkeys, and guineas were hatched and raised for institutional consumption.

3. The hog department raises around 150 head of hogs annually. These are fed on garbage from the kitchens and pastured in the fields after the crops are gathered. During the last fiscal year 34,736 pounds were slaughtered for institutional use.

4. The dairy herd which consisted of 130 registered and high grade Holstein cows, fifty-seven heifers, thirty-nine calves, and five bulls produced 128,420 gallons of milk during the fiscal year 1939-40. All milk is pasteurized.

5. The refrigerating plant consists of four small storage rooms which are insufficient and an ice plant with a

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[35] Information taken from the Steward's Report, op. cit.

capacity of ten tons which is adequate.

6. Water is obtained from three deep wells operated by electric rotary pumps with an average of 432,000 gallons pumped daily, one underground reservoir, and one tower with a storage capacity of 150,000 gallons.

Clothing. The Central Oklahoma State Hospital furnishes all bedding and clothing used by the patients, however patients may, if they have them, wear their own clothing.

All laundering is done in a central plant. During the last fiscal year 1,208,000 pounds, or an average of 23,230 pounds per week was handled by this plant.[36]

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[36] Ibid.

CHAPTER V

ADMINISTRATION

The purpose of this chapter is to show the internal administrative set-up of the Central Oklahoma State Hospital. Other state hospitals in Oklahoma are similar in operation.

The primary function of a mental hospital is to care for its patients and all of its activities are coordinated toward achieving that objective. The affairs of the Central Oklahoma State Hospital are carried on by a number of departments,[1] chief of which is the medical department.[2] Before discussing these departments a description of the Oklahoma statutory provisions governing the internal management of its state hospitals must be set forth.

Statutory Provisions

Medical Superintendent

The medical superintendent of each mental hospital is

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[1]These departments are presented graphically in Chart 6, page 86.

[2]The subdivisions of the medical department are depicted in Chart 7, page 87.

Chart 6.

ORGANIZATION OF THE STATE HOSPITAL, NORMAN, OKLAHOMA, JULY, 1941

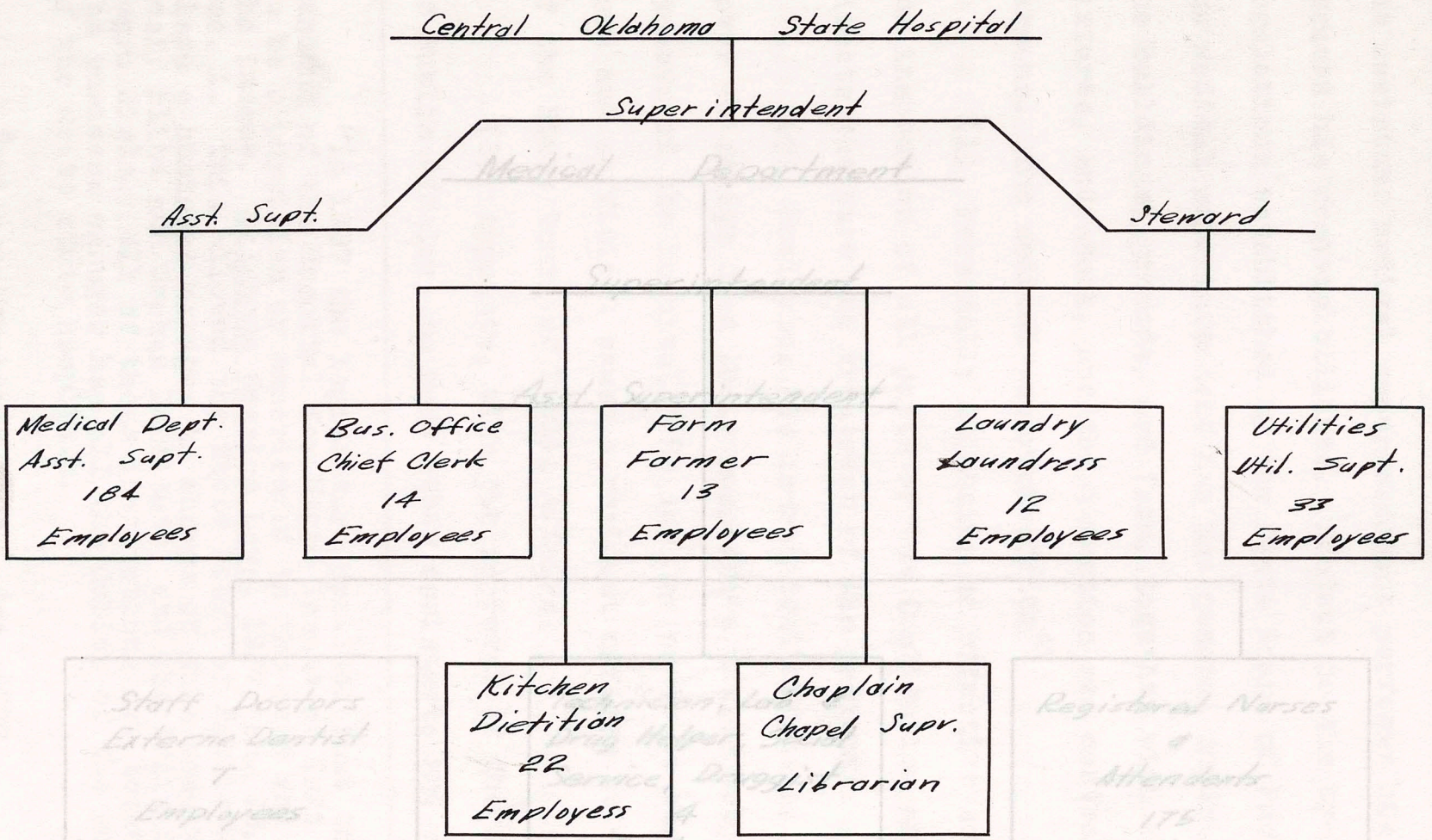
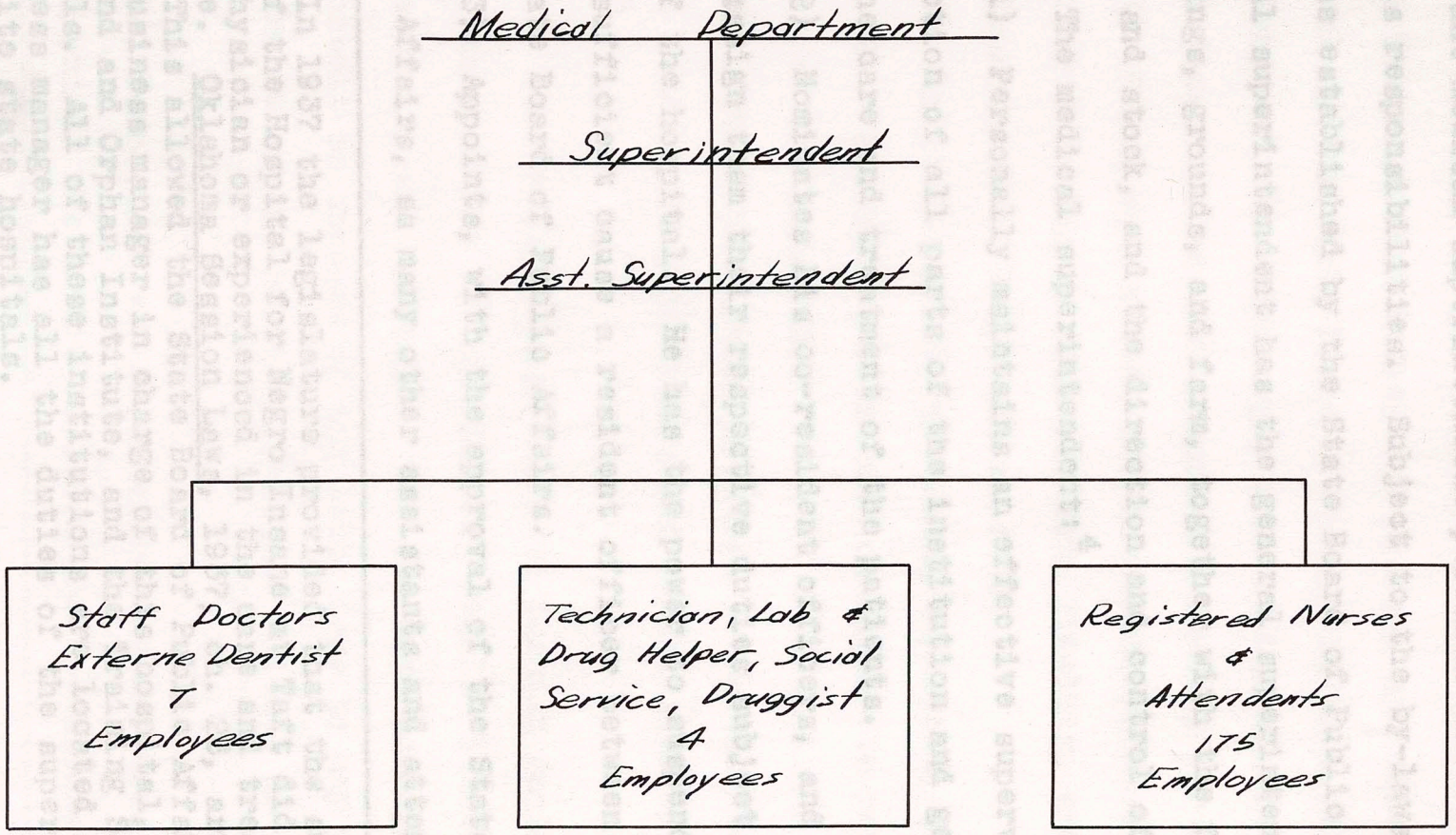


Chart 7.

ORGANIZATION OF THE MEDICAL DEPARTMENT OF THE CENTRAL OKLAHOMA STATE HOSPITAL



its chief executive officers,[3] and in his absence or illness, the assistant medical superintendent performs his duties and assumes his responsibilities. Subject to the by-laws and the regulations established by the State Board of Public Affairs, the medical superintendent has the general superintendence of the buildings, grounds, and farm, together with the furniture, fixtures, and stock, and the direction and control of all persons. The medical superintendent:[4]

(1) Personally maintains an effective supervision and inspection of all parts of the institution and generally directs the care and treatment of the patients.

(2) Nominates his co-resident officers, and has the power to assign them their respective duties subject to the by-laws of the hospital. He has the power to suspend for good and sufficient cause a resident officer between meetings of the State Board of Public Affairs.

(3) Appoints, with the approval of the State Board of Public Affairs, as many other assistants and attendants

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[3]In 1937 the legislature provided that the superintendent of the Hospital for Negro Insane at Taft did not have to be a physician or experienced in the care and treatment of the insane. Oklahoma Session Laws, 1937, ch. 26, art. 6, sec. 1. This allowed the State Board of Public Affairs to place a business manager in charge of this hospital, also the Deaf, Blind and Orphan Institute, and the Training School for Negro Girls. All of these institutions are located at Taft. The business manager has all the duties of the superintendents of the white state hospitals.

[4]Oklahoma Statutes, 1931, Sec. 5000.

as he believes necessary and proper for the economical and efficient performance of the business of the hospital, and prescribes their several duties and places, and fixes, with the approval of the State Board of Public Affairs, their compensation, and also discharges them at his discretion; but in case of discharge he must record his reasons for doing so.

(4) Gives such orders and instructions as he deems best calculated to insure good conduct, fidelity, and economy in every department of labor and expense.

(5) Maintains discipline among employees, enforces compliance with his instructions and obedience to rules and regulations of the hospital.

(6) Establishes and supervises a training school for nurses and attendants under rules and regulations of the hospital.[5]

(7) Uses every proper means to furnish employment to such persons as may be benefited by regular labor suited to their capacity and strength. (He can make no payment or give any credit on account of any labor done by any patient while an inmate of the hospital, whether private or otherwise).[6]

(8) Keeps full and fair accounts and records of all his doings and of the entire business and operations of the

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[5]No mental hospital now operates a training school.

[6]Refers to type of patient. See page 55.

institution from day to day, in books provided for that purpose, in the manner and to the extent prescribed in the by-laws.

(9) Admits any member of the State Board of Public Affairs to any part of the hospital and shows any records asked for.

(10) Presents a report to the State Board of Public Affairs on the last day of June showing all records and accounts made up to date.

(11) Keeps a book of receipts of patients and all pertinent information. This is sufficient to keep the superintendent immune from suit for error in the handling of patients' funds.

Business Management: Steward

The steward under the direction of the medical superintendent is accountable for the careful keeping and economical use of all furniture, stores and other articles provided for the hospital and under the direction of the superintendent.[7]

(1) Makes all requisitions except those made by the medical superintendent himself, and preserves the original bills and receipts and keeps full and correct accounts of the same, and copies of all orders drawn by himself on the State Board of Public Affairs.

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[7] Oklahoma Statutes, 1931, Sec. 5001.

(2) Has general oversight and charge of all the industrial departments and farming operations, and such other business as may be prescribed by the by-laws or directed by the State Board of Public Affairs.

These constitute the statutes that govern the internal management of the state hospitals of Oklahoma.

Duties of Departments

Medical Department

The medical department is managed by the assistant superintendent. Its personnel consists of the staff, technicians, various types of therapists, social workers, registered nurses, attendants, and the chaplain.[8]

The functions of this department are twofold: (1) care and maintenance; and (2) treatment. The borderline between these two functions cannot be clearly drawn. In general, care and maintenance refer to the personal comfort and well being of the patients, while treatment refers to special forms of attention that are given to patients.

In June, 1941 this department had 188 employees, Of this number 173 were attendants, two were registered nurses, four were technicians, one was a social worker, a dentist, and six including the assistant superintendent were doctors.[9]

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[8]The subdivisions of the medical department are depicted in Chart 7, page 87.

[9]Information received in a visit to the office of the State Auditor during July, 1941.

Business Office

This office, with fourteen employees,[10] is under the direct supervision of the chief clerk. Its office has five principal duties:[11]

(1) The purchasing of all supplies needed by the institution through the State Board of Public Affairs;[12]

(2) Furnishing file clerks, stenographers, and other types of clerical helpers to the various other departments;

(3) Keeping all financial and other records on and of the patients;

(4) Paying all legitimate claims against the hospital;

(5) Keeping all valuables and cash of the patients.

This office and all other departments of the hospital are under the general supervision of the steward.

Farm

This department is supervised by an experienced farmer. The farm is operated with a dual purpose--reducing food and maintenance costs, and providing occupation for the patients whenever possible.[13]

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[10] Ibid.

[11] Information obtained from an official of the Central Oklahoma State Hospital in July, 1941.

[12] The hospital may purchase directly incidental supplies that are needed immediately.

[13] Much of the following is based on information obtained in visits to the Central Oklahoma State Hospital, also the Steward's Report, op. cit.

Farm and Garden. During the past fiscal year 590 acres were in cultivation. All land is terraced, crops are rotated and the land is fertilized whenever necessary. Plans for varieties of vegetables, amount of acreage, planting at intervals, are worked out far in advance to eliminate the possibility of flooding the hospital market.

Thirty-two head of horses and mules and two tractors are used in the farming, several colts being raised each year to replace losses and old stock.

During the past fiscal year an average number of seventy-eight patients were employed on the farm. In June, 1941 the hospital employed five farmers and one gardener[14] to supervise and assist the patients in the above operations.

Vegetables grown included Irish and sweet potatoes, roasting ear corn, black-eyed peas, and other miscellaneous vegetables. Crops included ensilage, alfalfa hay, corn, oats, sweet clover seed, straw, sudan hay, and cotton. The following table lists the crops and produce grown at the hospital from July 1, 1939 to June 30, 1940 and their value:[15]

Eggs	8,714 doz.	$ 1,742.80
Misc. Garden Vegetables		2,187.40
Irish Potatoes	447 bu.	233.90
Sweet Potatoes	94 bu.	47.00
Other Sales		190.20

[14]Information received in a visit to the office of the State Auditor during July, 1941.

[15]The above table was taken from the Steward's Report to the Superintendent, op. cit.

Roasting Ear Corn	2,550	doz.	$ 102.00
Ensilage	624	1/2 tons	2,498.00
Alfalfa Hay	87	1/2 tons	1,050.00
Corn	450	bu.	225.00
Oats	1,090	bu.	272.50
Sweet Clover Seed	1,000	bu.	40.00
Straw	400	bales	60.00
Sudan Hay	40	tons	540.00
Cotton	1,903	lbs.	190.30
Black-Eyed Peas	2,500	lbs.	125.00
Feed Inventory Adj.			59.31
Raised and Apprec. Livestock			4,271.09
Hogs Butchered	34,736	lbs.	2,778.88
Poultry "	1,834		704.00
Sheep "	724	lbs.	28.96
Cattle "	7,701	lbs.	616.08
Total Earnings			$17,346.41

Poultry Farm. During the past fiscal year the flock consisted of 800 laying hens producing 104,544 eggs. Egg production is improved by breeding and culling. Around 6,000 chickens, guineas, and turkeys were hatched and raised during the year. All products were consumed by the hospital. This division employed six patients under the supervision of a poultryman during June, 1941.[16]

Swineherd. This division is supervised by an experienced farmer[17] and uses some of the patients employed in the farm and garden division. Around 150 head of hogs are maintained. They are fed garbage from the kitchens and pastured in the fields after the crops have been gathered. During the

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[16]Information received in a visit to the office of the State Auditor during July, 1941.

[17]Ibid.

last fiscal year hogs weighing 34,736 pounds were butchered for institutional consumption.

Dairy. In June, 1941 the dairy herd consisted of 150 registered and high grade holstein cows, 57 heifers, 39 calves, and 5 bulls. It is recognized as one of the best herds in the state. Regular tests for T.B. and Bangs disease are made by state and federal authorities. Regular tests on milk production are made by an official tester from the A. and M. College at Stillwater. This enables all non-profitable producers to be culled out. No female calves are ever sold, but are kept to replenish the herd.

During the past fiscal year 128,420 gallons of milk was produced and 7,701 pounds of culled cows were butchered for institutional consumption. All milk is pasteurized and precautions are taken to insure sanitary handling.

This division provided employment for twenty-eight patients under the supervision of four dairymen and one milk tester during June, 1941.[18]

Kitchen

Staple foodstuffs are kept in the storeroom and perishable foods in four small cold storage lockers. The dietitian, after ascertaining the types of food on hand, makes up the menus and amounts of food for the various kitchens. Copies

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[18] Ibid.

of the menu are delivered to the various cooks, the storeroom, the butcher, and the baker when some type of pastry is called for. The storeroom and the butcher set out the types and amounts of foods prescribed by the menus, which are collected by patients and delivered to the various kitchens. The farm and dairy have regular quotas which they deliver from day to day. Food is prepared by the cooks according to the directions of the menus and served by the dining room attendants. The dining room attendants, in addition to serving food, keep the rooms and its equipment in the proper order.

During the past fiscal year an average daily number of 166 patients were employed in phases of the above operations. In June, 1941 they were supervised and assisted by twenty-two employees.[19]

Patients perform most of the drudge work, such as dish-washing, scrubbing, and the moving of groceries and other articles. One criticism that must be levied at the cooks is their lack of knowledge of cookery. This could be remedied by employing competent chefs. At the present time most of the cooks are women whose previous experience was limited to cooking for a family. They do not know how to cook for large groups.

Laundry

The laundry is supervised by a laundress. Soiled

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[19] Ibid.

linens are picked up at the various wards by patients having "outside privileges" and delivered to the laundry.

All new linens belonging to the hospital and those belonging to patients are marked when first brought into the institution. The actual work of washing and ironing is done by patients and machines under the supervision of laundry employees. All torn linens, after being laundered, are taken to the sewing room for mending.

The sewing room has twenty tailoring machines and numerous other types of equipment which are in constant operation. During the fiscal year of 1939-40 this room made 44,774 garments and mended 10,781 old ones. During this year an average of ninety-three patients were employed at this type of work. The work of this department was supervised by twelve employees during June, 1941.[20]

Utility

The utility department, under the direct supervision of a utility superintendent, is charged with the maintenance and reapir of the buildings and grounds, and the furnishing of utility services.

During the fiscal year ending in 1940 an average daily number of 100 patients assisted in carrying out its functions. During June, 1941, this department maintained a personnel of thirty-three employees.[21]

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[20] Ibid. [21] Ibid.

A mattress factory is operated by the hospital. Mattresses and pillows are made out of cotton or straw. Untidy and unruly patients sleep on straw mattresses; these must be replaced at frequent intervals. The factory has production facilities sufficient to care for the needs of the hospital. Its production during the 1939-40 fiscal year was:

New mattresses, cotton, single, made	150
Old mattresses, cotton, single, renovated	599
New mattresses, cotton, double, made	12
New mattresses, straw, single	3,600
New pillows, cotton, made	200
Old pillows, kapok and straw, renovated	3,000

Types of Employees and Description of Their Duties

The Staff Doctor

Staff doctors must have the qualifications of a medical doctor. Supervisory control of the wards is divided among them and one of their chief duties is to see that patients on their wards receive reasonable care. Each doctor has a hand in the giving of some special type of treatment, for instance, while all of the doctors could give insulin shock treatment, only one or two do so. All doctors actively participate in bi-weekly clinics and staff meetings. The staff doctors take turns being officer of the day, that is, one doctor must always be available to care for unforseen incidents. In addition all doctors help to maintain adequate discipline. Staff doctors generally spend their mornings making daily calls on their patients and their afternoons writing up case

histories and other correspondence. They must also devote considerable time to discussing the condition of patients with their relatives.[22]

The American Psychiatric Association in 1926 accepted a standard of 150 patients per physician exclusive of the superintendent as the minimal standard of adequate care. The Central Oklahoma State Hospital falls below this standard with an overloading on their medical staff of 435.22 or 190.15 per cent.[23]

For comparative purposes states whose rate of hospitalization per 100,000 of general population in 1938 are used. Only ten states and the United States average are used, all of whom fall between the limits of a class interval of 250 to 300.[24] Comparison of this sort is not an infallible indicator of quality of service. Nevertheless, the problem of adequate personnel and satisfactory service cannot be divorced.

Table 15[25] shows the number of patients per assistant physician in state hospitals of Oklahoma and the patient load in other states. The total patient load in Oklahoma hospitals

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[22]Information obtained in interviews with hospital officials at the Central Oklahoma State Hospital during July, 1941.

[23]Average patient population of above hospital for August, 1941 divided by number of staff doctors at that time.

[24]These facts are presented in Table 14, page 100.

[25]See page 101.

TABLE 14

PATIENTS IN STATE HOSPITALS, RATE PER 100,00 OF ESTIMATED POPULATION FOR 1938 IN CLASS INTERVAL RANGE OF 250 TO 300

State	Patients in Hospitals rate per 100,000 Population	Average Daily Resident Patient Population	Per Capita Expenditures for Maintenance
Oklahoma	270.7	7,211	$224.18
U. S.	289.3	379,678	297.13
Vermont	273.6	1,054	284.66
Ohio	270.9	18,991	193.61
Michigan	295.9	14,865	491.28
N. Dakota	261.8	1,854	321.79
Nebraska	280.1	3,855	225.14
Kansas	254.0	4,656	207.54
Florida	252.3	4,274	264.57
Louisiana	262.9	5,708	202.15
Iowa	257.7	6,637	194.09

TABLE 15

PATIENT LOAD PER ASSISTANT PHYSICIAN IN OKLAHOMA STATE HOSPITALS AS COMPARED WITH STATE HOSPITALS IN OTHER STATES, 1938

State	Patients	Super-intendent	Assistant Physicians	Patient Load per Assistant Physician	Excess		Required Number of Assistant Physicians
					Number	Per Cent	
Oklahoma	7,211	4	18	400.61	251	167.07	48
U. S.	380,595	177	1,443	263.75	114	75.83	2,537
Vermont	1,054	1	4	263.50	114	75.67	7
Ohio	18,991	9	47	404.00	254	162.67	127
Michigan	14,865	7	64	232.30	82	54.87	99
N. Dak.	1,854	1	7	264.90	115	76.60	12
Neb.	3,855	3	17	226.80	77	54.53	26
Kansas	4,656	3	19	245.10	95	63.40	31
Florida	4,274	1	15	284.90	135	89.93	29
La.	5,708	2	15	380.50	231	153.67	38
Iowa	6,637	5	18	368.72	219	145.81	44

is 400.61 or 167.07 per cent in excess of the standard of the American Psychiatric Association. In the other states the patient load per physician ranges from 232.3 to 404.0; all being in excess of the above mentioned standard. In the United States as a whole there are 263.75 per assistant physicians, an excess of 75.83 per cent over the minimal standards.

The patient load per assistant physician in the five Oklahoma hospitals for mental disease is lowest in the Central Oklahoma State Hospital Annex with one physician caring for 249 patients. Figures for the other hospitals are:[26]

Name of Hospital	Number of Patients per Physician
Western Oklahoma State Hospital	371.5
Central Oklahoma State Hospital	422.0
Eastern Oklahoma State Hospital	427.67
State Hospital for Negro Insane	707.0

All hospitals in Oklahoma are guilty of exceeding the standard of one physician per 150 patients set by the American Psychiatric Association.

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[26]Populations of these institutions were obtained from the State Board of Public Affairs in July, 1941 and are for the year 1940. The number of doctors at the various hospitals were obtained from the State Auditor's office in July, 1941 and are for June, 1941. Figures at that time showing the populations of these hospitals for 1941 were unavailable at that time. Figures showing the staffs of these hospitals for 1940 were unavailable.

Attendants and Graduate Nurses

Attendants and graduate nurses are in continuous personal contact with the patients acting in the varied capacities of friend, nurse, guard, and companion. They guide the patients through the course of their daily activities, reporting any change from the ordinary behavior of a patient. Whenever and wherever possible they assist and supplement the medical staff in the treatment of the patients. A big part of their job is to keep wards and patients clean and in order.

There were 175 nurses and attendants in the Central Oklahoma State Hospital caring for the mental patients, of these, three were graduate nurses.[27] All of the latter are employed on Hope Hall, which houses the infirmary, receiving, and convalescent wards. One graduate nurse is in general charge of all activities. Another is in charge of the receiving wards and sees that all newly admitted patients are made as comfortable as possible. The third graduate nurse is in charge of the surgery and also assists and supplements the medical staff in the giving of various treatments.[28]

The patient load per nuse and attendant in the five Oklahoma hospitals for mental disease is lowest in the Eastern

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[27]Information received from the State Auditor's office in July, 1941.

[28]Information obtained in an interview with hospital officials at the Central Oklahoma State Hospital during July, 1941.

Oklahoma State Hospital with one nurse or attendant for each 8.64 patients. Figures for the other hospitals are:[29]

Name of Hospital	Number of Patients
State Hospital for Negro Insane	11.05
Western Oklahoma State Hospital	13.63
Central Oklahoma State Hospital Annex	13.83
Central Oklahoma State Hospital	14.47

These figures are not accurate because part of these attendants are employed during the day and the others at night.[30] The American Psychiatric Association in 1926 set up a minimal standard of one nurse or attendant to each eight patients.

The patient load per nurse and attendant in Oklahoma state hospitals for 1938 was 11.9. The load in Oklahoma state hospitals is midway among states compared in Table 16.[31] The range in these states varied from a low of 7.0 in Michigan to 16.8 in Iowa.

The per cent of graduate nurses on the staffs, 11, in Oklahoma state hospitals was lower than all other states compared. These varied from 0.21 per cent in Louisiana to 1.9 per cent in Ohio. The per cent of graduate nurses for the entire United States was 1.01. These figures are given in Table 16.

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[29] Information obtained from the same source as that listed in Footnote Number 26.

[30] Figures showing the breakdowns are unavailable.

[31] See page 104.

TABLE 16

PATIENT LOAD PER NURSE AND ATTENDANT IN STATE HOSPITALS OF OKLAHOMA AS COMPARED WITH STATE HOSPITALS IN OTHER STATES, 1938

State	Patients	Nurses and Attendants	Patient Load per Nurse and Attendant	Excess		Graduate Nurses	
				Number	Per Cent	Number	Per Cent
Oklahoma	7,211	606	11.9	3.9	45.8	8	.11
U. S.	380,595	41,101	9.3	1.3	16.3	3,828	1.01
Vermont	1,054	118	8.9	0.9	11.3	20	1.90
Ohio	18,991	1,267	15.0	7.0	87.5	210	1.11
Michigan	14,865	2,128	7.0	-1.0	12.5	133	.89
N. Dak.	1,854	199	9.3	1.3	16.3	12	.65
Neb.	3,855	375	12.8	4.8	60.0	20	.52
Kansas	4,656	312	14.9	6.9	86.2	47	1.01
Florida	4,274	415	10.3	2.3	28.8	19	.44
Louisiana	5,708	429	13.3	5.3	66.3	12	.21
Iowa	6,637	396	16.8	8.8	11.0	48	.72

Dentist

The Central Oklahoma State Hospital is the only state hospital in Oklahoma that retains the full time services of a dentist. All other institutions are visited one day each week by a dentist from a nearby town. None of the hospitals employ the services of a dental nurse.[32]

The function of the dentist is to care for the dental needs of the patients. Teeth are a focal point of infection and to insure a mental patient the best possible chance for recovery teeth must be put into good order. In 1926 the American Psychiatric Association adopted a minimal standard of one full time dentist to each 1,500 patients. This implies the assistance of at least one dental nurse to each dentist.

The dentist at the Central Oklahoma State Hospital can only work on selected cases that offer the best prospects of recovery. In addition he and the part time dentists at the other state hospitals care for all emergency cases requiring dental work.

The Central Oklahoma State Hospital falls below this standard with an overloading on their dentist of 1,112 patients or 74.13 per cent.[33] It is impossible to determine the relative amounts of overloading for the other state

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[32]Information obtained from the State Auditor's office in July, 1941.

[33]Information obtained from officials of the above named hospital during August, 1941.

TABLE 17

PATIENT LOAD PER DENTIST IN OKLAHOMA STATE HOSPITALS AS COMPARED WITH STATE HOSPITALS IN OTHER STATES, 1938

State	Patients	Dentists	Patient Load per Dentist	Excess		Required Number of Dentists	Deficit of Dentists
				Number	Per Cent		
Oklahoma	7,211	1	7,211	5,700	380.0	5	4
U. S.	380,595	164	2,357	857	57.2	254	90
Vermont	1,054	0	1,054	---		1	1
Ohio	18,991	4	4,748	3,248	216.5	13	9
Michigan	14,865	7	2,124	624	41.6	10	3
N. Dak.	1,854	1	1,854	354	23.6	1	0
Nebraska	3,855	2	1,928	428	28.5	2	0
Kansas	4,656	2	2,328	828	55.2	3	1
Florida	4,274	4	1,069	-433	-28.8	3	0
Louisiana	5,708	2	2,854	1,354	92.7	3	1
Iowa	6,637	5	1,327	-173	-11.6	4	0

hospitals because the services of their dentists are only part time.

Table 17 shows the patient load per dentist in Oklahoma state hospitals as compared with other states and the United States average. In this table Oklahoma is credited with having only one dentist because the time spent by dentists at other state hospitals in this state aggregates only eight days a month which would seem to be an insufficient length of time to do only urgent emergency work. In total number of patients per dentist Oklahoma had a higher rate than any other state compared. The United States average was only 2,357 patients. Vermont had no dentist. Only Florida and Iowa had more dental care available than the minimal standard of the American Psychiatric Association.[34]

The wide spread prevalence of this condition is highly regretable. Continuance of such practices cannot be conducive to the best treatment for our mental patients. That Oklahoma is not the only state in such a predicament is no excuse.

Occupational Therapist

The function of the occupational thereapist is to around and keep up the interest of the patient in various forms of constructive enterprises, such as the handicrafts.

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[34] See page 107.

Another type of therapist is one who interests patients in recreation of various types. All state hospitals use their personnel to direct both types of activity to the greatest possible extent. However as yet there are few trained therapists employed by the state hospitals. Most of these are concentrated in the more wealthy states.

In 1941 there were eight occupational therapists employed in three of the mental hospitals of Oklahoma.[35] The patient load per therapist at these institutions varied from 871 at the Central Oklahoma State Hospital to 708 at the State Hospital for Negro Insane to 646 at the Eastern Oklahoma State Hospital.[36]

The patient load per occupational therapist in Oklahoma state hospitals as compared with state hospitals in certain other states in 1938 is presented in Table 18. In 1938 there were 821 occupational therapists employed in the state hospitals of the United States making a patient load of 463.57 each. However patient loads varied widely for the states compared. Oklahoma had a patient load per occupational therapist of 801.22. The extremes were 232.27 per occupational therapist in Michigan to 1,902.67 in Louisiana.[37]

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[35]Information obtained from the State Auditor's office in July, 1941.

[36]See page 110

[37]Information obtained from the State Board of Public Affairs in July, 1941.

TABLE 18

PATIENT LOAD PER OCCUPATIONAL THERAPIST IN OKLAHOMA STATE HOSPITALS AS COMPARED WITH STATE HOSPITALS IN OTHER STATES, 1938

State	Patients	Occupational Therapist	Patient Load per Occupational Therapist
Oklahoma	7,211	9	801.2
U. S.	380,595	821	463.6
Vermont	1,054	3	351.3
Ohio	18,991	23	825.7
Michigan	14,865	64	232.3
N. Dakota	1,854	4	463.6
Nebraska	3,855	6	642.5
Kansas	4,656	1	4,656.0
Florida	4,274	1	4,274.0
Louisiana	5,708	3	1,902.7
Iowa	6,637	7	948.1

Social Worker

The social worker collects all available data on newly admitted patients. This data, which is included in case histories, has considerable value in assisting the hospital authorities to determine the cause of the patient's illness and suggests possible methods of successfully treating the patient. In addition the social worker assists in recreationaly activity.

In June, 1941 the Central Oklahoma State Hospital was the only mental hospital in Oklahoma to employ a social worker.[38] At that time this hospital had 2,160 patients.[39] The minimal criterion is one social worker to each 150 patients.[40] The remainder of the patients in other Oklahoma state hospitals are completely without the services of a social worker.

In 1938 there were only 275 social workers employed in all the state hospitals of the United States. Each had a case load of 1,384, as is shown in Table 19.[41] Of the ten states compared five employed no social workers. Michigan

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[38] Information obtained from the State Auditor's office in July, 1941.

[39] Information obtained from the Central Oklahoma State Hospital in July, 1941.

[40] Estimate made by Dr. A. J. Rigier, Assistant Physician, Central Oklahoma State Hospital.

[41] See page 112.

TABLE 19

PATIENT LOAD PER SOCIAL WORKER IN OKLAHOMA STATE HOSPITALS AS COMPARED WITH STATE HOSPITALS IN OTHER STATES, 1938

State	Patients	Social Workers	Patient Load per Social Worker
Oklahoma	7,211	2	3605.5
U. S.	380,595	275	1383.9
Vermont	1,054	0	----
Ohio	18,991	5	3798.2
Michigan	14,865	30	495.5
N. Dakota	1,854	0	----
Nebraska	3,855	1	3855.0
Kansas	4,656	1	4656.0
Florida	4,274	0	----
Louisiana	5,708	0	----
Iowa	6,637	0	----

employed a social worker to every 496 patients, however Kansas employed only one social worker for 4,656 patients. At that time the state hospitals of Oklahoma employed two social workers. Each had a case load of 3,606.

Personnel

Unfortunately a great part of the personnel of the Central Oklahoma State Hospital, like most other state institutions in Oklahoma, owe their jobs to one or two reasons: (1) they know or knew the right politician; or (2) they asked for a job when the institution was short-handed. Many of the attendants have been employed by the state hospitals for a number of years. They owe their job security to a combination of two factors: (1) their low pay and long hours are not appealing to patronage hunters; and (2) the superintendents of these institutions have held their posts through many administrations. The superintendents of the Eastern Oklahoma Hospital and the Central Oklahoma Hospital have served for twenty-three and twenty-six years.

Employees are retained so long as they do good jobs, unless outside pressure is brought to bear on the superintendent to make room for the favored follower of a politician. It then becomes a case of who has the most backing. Those having the least are naturally let out. If an employee does not do his work he is fired, unless his political backing is strong. In such a case it is better to retain a worthless

employee than to incur the wrath of a prominent state politician. Harmony must be kept at all costs.

Salary Schedule

Some attention should be drawn to the fact that attendants at the various state hospitals are paid a very low wage. The highest paid attendants are those at the Central Oklahoma State Hospital Annex in McAlester. All of the other hospitals pay attendants between thirty to forty dollars on the average per month.[42] The majority of the attendants receive room and board in addition to their wage.[43]

However, take the case of an attendant who receives $40.00 a month, which is more than the average attendant receives. He works twenty-six days out of a thirty day month. This amounts to $1.33 per day or 13 cents an hour.

Attendants at these hospitals work twelve hours a day, six days a week. This is a direct violation of the Oklahoma Constitution, which states: "Eight hours shall constitute a day's work in all cases of employment by and on behalf of the state or any county or municipality."[44] No test case of the application of this section to state employees has ever been made. The reason given by various officials for this

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[42]Information received from the State Auditor's office in July, 1941.

[43]Information received from the State Board of Public Affairs in July, 1941.

[44]Constitution of Oklahoma, Art. 23, Sec. 1.

state of affairs is a lack of funds with which to hire enough employees to enable them to work eight hour shifts.

Staff doctors, whose pay varies from $185 to $275 per month plus a residence with utilities furnished, may be classified roughly in two types. The former class consists of those individuals who have specialized in the field of psychiatry. Most of these could earn more money in private practice, and the only reason that can be suggested for their remaining is the love of their work. The latter class is made up of those who have used their political influence to gain an appointment.

Promotions

Very few advancements or demotions in rank are made. Attendants are employed, at say $30.00 a month. If their work is good the supervisors and staff doctors may recommend that their pay be increased a few dollars. Taking the Central Oklahoma State Hospital as an example, the average attendant does not have more than an eighth grade education. He cannot hope to be promoted to any higher position than that of supervisor, which in this case pays $90.00 a month. The present male supervisor has held that job for sixteen years. Many of the attendants at this institution have served in their original capacity at practically the same salary for ten or more years. These are dead-end jobs; no ups and no downs.

In Service Training

The Statutes prescribe that the superintendent of each hospital shall establish and supervise a training school for nurses and attendants.[45] No hospital operates such a school. No lectures or any other kind of formal training of any kind is given to any of the attendants or nurses. When an individual is employed he is placed on a ward under the guidance of other attendants. All that he learns is through doing and observation. Very few of the attendants are sufficiently interested to take the initiative and attempt to learn any more than is required for the performance of their job.

Vacations

All employees are given an annual ten day vacation with pay. However no employee can plan with any great certainty as to just when his vacation will be given. He is given leave when the officials feel that they will need him least.

Retirement

No provision is made for retirement. In some cases the employee is given a relatively simple job that has no real importance at a reduced scale of pay. In the majority of cases the employee is let out and a new younger person employed. Officials, again, place the blame on lack of funds.

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[45] Oklahoma Statutes, 1931, Sec. 5000.

CHAPTER VI

COSTS

Source of Funds

The mental hospitals are supported by appropriations from the general revenue fund,[1] the public building fund, the governor's contingent fund, and the various hospital funds of the institutions. The hospital funds[2] are maintained by fees[3] imposed for the care of private and ex-service patients. During 1925 and 1926 fees imposed on the counties[4] for the care of public patients were placed in this fund when collected but the act providing for their levy was held unconstitutional[5] in 1927 on the grounds that the Oklahoma Constitution specifically provides[6] that the state shall support these

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[1]Note Table 20, page 118.

[2]Hospital funds are set up for Central, Eastern, and Western State Hospitals. Oklahoma Statutes, 1931, Sec. 5449. Fees collected at the Negro Hospital are credited to its revolving fund.

[3]Ibid., Sec. 5026.

[4]Session Laws of Oklahoma, 1925, p. 117.

[5]Board of Commissioners of Logan County v. State of Oklahoma, 122 Okla. 268.

[6]Oklahoma Constitution, Art. XXI, Sec. 1.

TABLE 20

LEGISLATIVE APPROPRIATIONS FOR STATE MENTAL HOSPITALS IN OKLAHOMA 1931-1940*

Fiscal Year Ending	Central	Western	Eastern	Negro
1931	$696,200	$236,000	$562,500	$
1932	732,440	457,400	594,328	
1933	577,449	259,454	454,528	416,650
1934	420,070	195,000	354,710	64,000
1935	415,070	210,000	354,710	97,250
1936	546,500	250,000	399,500	126,250
1937	476,815	255,558	456,240	187,212
1938	678,805	316,920	709,170	148,010
1939	556,905	306,000	629,000	138,510
1940	556,100	350,225	467,035	147,877
1940	Central Annex	$95,270.		

*These figures through 1939 were obtained from the report: State Mental Hospitals in Oklahoma, op. cit., Appendix A, Table V, p. 92.

The figures for 1940 were taken from Budget Estimates for each fiscal year, of the biennium, Beginning July 1, 1942 and Ending June 30, 1943, pp. 47-49.

institutions. Each institution also maintains a revolving fund[7] which is a depository for all profits from industries and provides working capital for these activities. Expenditures[8] from this fund may be authorized by the State Board of Public Affairs for meeting the expenses of the various industrial activities and for regular maintenance under certain emergency conditions.[9]

Appropriations

> Appropriations represent official estimates of needs and vary from year to year according to fluctuation in institution population, price levels, past deficiencies, and authorized capital outlay.[10]

These constitute the chief sources of support for the state hospitals of Oklahoma. Other sources offer revenue but their amount and reliability is never large or steady. Table 20 shows the legislative appropriations for the Oklahoma state hospitals from 1931 to 1940.[11] It can be clearly seen from a

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[7] Oklahoma Statutes, 1931, Sec. 5441; Session Laws of Oklahoma 1935, p. 99.

[8] Oklahoma Statutes, 1931, Sec. 5442; Session Laws of Oklahoma, 1937, ch. 27, art. 2, sec. 1; see also Senate Bill Number 243, and House Bill Number 448, Eighteenth Legislature in regular session, 1941.

[9] Oklahoma Planning and Resources Board, State Mental Hospitals in Oklahoma, 1937, Oklahoma City, Oklahoma, p. 13.

[10] State Mental Hospitals in Oklahoma, op. cit., p. 13.

[11] See page 118.

glance at this table that size of appropriations for the various years have not been consistent. The amount of building done has been insufficient to account for these fluctuations.

The steps followed by officials of the Central Oklahoma State Hospital in making their requests for appropriations are as follows:

(1) The steward, at the request of the superintendent, prepares estimates of the needs of the various departments of the hospital for the coming biennium; these estimates are based on past expenditures, together with urgent needs and needs that are not so pressing.

(2) These estimates are carefully studied singly and by groups of the hospital authorities. This results in a statement of what the hospital actually needs plus items that they hope to get.

(3) This estimate or proposed budget is submitted to the State Board of Public Affairs whose members may or may not make changes.

(4) The Board in turn submits the budget to the State Budget Officer for any recommendations he may care to make.

(5) The budget is then submitted to the legislature, where it may or may not be changed. An appropriation bill, after passage by the legislature.

(6) The budget is submitted to the governor who has the power to veto part or all if he sees fit to do so.

Earnings

Earnings of the Central Oklahoma State Hospital come from three chief sources:[12]

(1) Revolving Fund sales. This includes all incidental sales made by various departments of the hospital.

(2) Sale of food raised on the hospital farm. All of this is sold by the farm to the hospital for internal consumption. Sales of this type are recorded by the hospital authorities in order to help determine the efficiency of the farm.

(3) Fees collected from patients. Payments of this type are not compulsory. Patients whose guardians are financially able may if they wish pay $25.00 a month toward the patient's maintenance in the hospital. Pay patients are divided into two classes, private and ex-service.

During the fiscal year ending June 30, 1940 the earnings of the Central Oklahoma State Hospital amounted to $34,804.02.

A breakdown of this figure shows:[13]

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[12]Information received in an interview with hospital authorities of the Central Oklahoma State Hospital in August, 1941.

[13]Information taken from the Steward's Report, op. cit.

Revolving Fund Sales		
Sundry	$ 445.16	
Occupational Therapy	1,325.22	
Livestock	2,035.29	
Sheep Pelts	4.45	
Hides	85.40	
Total (sub)	3,895.52	$ 3,895.52
Sale of Foods		
Farm and Dairy	5,820.72	
Poultry butchered	704.00	
Hogs butchered	2,778.88	
Cattle butchered	616.08	
Sheep butchered	28.96	
Total (sub)	9,948.64	9,948.64
Pay Patients		
Ex-Service	11,437.12	
Private	9,522.74	
Total (sub)	20,959.86	20,959.86
TOTAL		$34,804.02

How Funds Are Spent

Monies expended by the Central Oklahoma State Hospital may be divided into three general classes. These are: (1) salaries and wages, (2) maintenance, and (3) capital outlay. Of these only the latter is not constant, the former two being costs that must be met from day to day.

The total costs, including salaries, maintenance, and capital outlay, amounting to $5,052,271.25 from 1931 through 1940. Salaries accounted for $1,870,486.32 or 36.91 per cent of the total costs, $2,444,849.14 or 48.39 per cent was spent for maintenance, and $736,935.79 or 14.58 per cent was spent for capital outlays. These figures are itemized by years in Table 22.[14]

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[14] See page 124.

TABLE 21

GENERAL COST OF MAINTENANCE FROM JULY 1, 1939, TO JUNE 30, 1940*

		Avg. Mo. Per Capita Cost
Average number Patients	2509	
Administration Cost:		
Salary - Superintendent	6,000.00	.20
Asst. "	1,650.00	.05
Office Employees	13,568.56	.45
Physicians	18,429.98	.61
Nurses, Attds.	81,773.84	2.71
Steward	2,700.00	.09
Laundry Employees	5,065.00	.17
Engineer & Firemen	4,896.00	.16
Other Employees	46,744.39	1.57
	180,826.77	6.01
Maintenance Cost:		
Food	154,217.86	5.12
Clothing	25,693.60	.85
Hospital Supplies	5,292.07	.18
Laundry "	1,263.99	.04
Household "	26,958.90	.90
Sundry "	64.65	--
Traveling Expense - General	611.40	.02
" " Escaped patients	19.33	--
Transferred	4.88	--
Tel., Tel., & Postage	2,257.24	.08
Printing & Office Supplies	733.75	.02
Heat, Light, Water & Power	28,573.95	.96
Repair to Equipment - H-1	13,281.22	.44
" " " H-2	7,074.22	.23
" " Vehicles	972.82	.03
" " Buildings	17,040.18	.57
" " Other Improvements	5,585.76	.19
Freight & Express	106.82	--
Oil and Gasoline	2,510.22	.08
Entertainment	699.45	.02
Time Service - Clock Rent	48.00	--
Administration Feed Consumed	549.57	.02

*This information obtained from the Biennial Reports of the State Auditor.

TABLE 21 - Continued

		Avg.Mo. Per Capita Cost
Bonds	87.50	--
Burial Expense	350.00	.01
Inventory Adj. - General Store	11.81	--
Rent	240.00	.01
Deprec. - Admr. Livestock	5.00	--
	294,254.19	9.77
	$ 475,080.96	15.78

*Steward's Report to the Superintendent, op. cit.

TABLE 22

COSTS OF CENTRAL OKLAHOMA HOSPITAL *

Fiscal Year Ending	Salaries	Maintenance	Capital	Total
1931	$165,615.32	$229,486.75	$169,273.38	$564,375.45
1932	175,320.75	222,780.42	159,633.79	557,734.96
1933	179,258.23	262,852.34	26,206.43	468,317.00
1934	172,533.29	247,979.37	10,707.67	431,220.33
1935	189,314.62	191,195.99	7,774.56	388,285.17
1936	184,802.63	263,583.89	32,302.56	480,689.08
1937	183,788.82	258,464.14	13,225.59	455,478.55
1938	209,115.89	158,496.95	225,462.54	593,075.38
1939	220,753.11	341,090.33	73,138.49	634,981.93
1940	189,983.66	268,918.96	19,210.78	478,113.40
All Years	1,870,486.32	2,444,849.14	736,935.79	5,052,271.25

*This information obtained from the Biennial Reports of the State Auditor.

Salaries and Wages

This includes all monies paid to the various types of individuals needed to run a state hospital. During June, 1941 the Central Oklahoma State Hospital used 294 employees in carying for a population of 2,566 patients or a ratio of one employee to each 8.7 patients.[15] Table 21 shows the administrative costs at this hospital for the fiscal year ending in June, 1940.[16] During that year the average monthly cost per patient was $6.01. The annual costs of this hospital for the years from 1931 through 1940 are given in Table 22.[17] The trend was steadily upward until 1940 when expenditures declined. This can be satisfactorily accounted for as being part of the present governor's economy program. Table 23 presents the monthly per capita expenditures by months.[18] The latter table shows a decline of $6.45 to $6.25. During this ten year period salaries amounted to $6.38 when computed on a monthly per patient basis.

Table 14 gives a comparison of the per capita expenditures for 1938 of Oklahoma, the United States, and certain other selected states.[19] Of these only two states, Iowa and Florida, pay a lower wage per capita than Oklahoma. The United States average is slightly less than double the

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[15]Information received from the above named hospital during July, 1941.

[16]See page 123. [17]See page 124.

[18]See page 126. [19]See page 100.

TABLE 23

AVERAGE MONTHLY PER PATIENT OPERATING COSTS OF THE CENTRAL OKLAHOMA HOSPITAL*

Fiscal Year Ending	Salaries	Maintenance	Capital	Total
1931	$6.46	$8.96	$6.61	$22.03
1932	6.14	7.81	5.60	19.56
1933	5.88	8.63	.86	15.37
1934	5.49	7.89	.34	13.72
1935	6.76	6.83	.28	13.92
1936	6.31	8.59	1.10	16.40
1937	6.15	8.64	.44	15.23
1938	6.82	5.17	7.35	19.34
1939	7.51	11.09	2.34	20.65
1940	6.25	8.85	.63	15.74

*This information obtained by dividing the figures in the previous table by the population of the institution.

Oklahoma figure. Three states paid even more than the United States average figure, Michigan paying more than twice as much. However in total amounts paid there were thirty-one states that spent less for wages than Oklahoma. Expenditures of state hospitals for mental disease, with per capita expenditures for maintenance, by states for 1938 are presented in Table 26.[20]

Purchasing by the State Board of Public Affairs[21]

One of the chief functions of the State Board of Public Affairs is that of state purchasing agent. The board acts in this capacity for thirty-seven state institutions and sixty-one departments.[22]

The great bulk of the goods needed for maintenance in the various penal and eleemosynary institutions are purchased on a quarterly basis by the board. These are bought under eight headings:

(1) Groceries, which include groceries proper, and maintenance items used in the preparation and care of foods;

(2) Meats;

(3) Sea food products;

(4) Dry goods;

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[20] See page 136.

[21] The information given in this section was obtained in a series of interviews with the Chief Clerk of the State Board of Public Affairs during June, July, August, and September, 1941.

[22] Oklahoma Statutes, 1931, Sec. 4996.

(5) Hospital equipment and medical supplies;

(6) Produce items;

(7) Paper service, this refers to sanitary drinking cups, paper towels, and similar items but not to stationery and office supplies;

(8) Flour and seed.

Each institution submits a list of its needs for the next quarter. These various lists are combined and the board notifies all business organizations that might be interested in bidding on part of the needs. Bidding is always competitive, the board reserving the right to accept the lowest and best bid submitted.

Due to the fact that the board has no central warehouse for storage delivery is always made to the institutions. Because the state does not have a central warehouse it is impossible to check quality of goods purchased. Up until recently the board had no standard specifications; hence specifications were set up for each order. About a year ago the board started using the specifications recommended by the United States Bureau of Standards. These are being put into operation on a piecemeal basis.

At the present time only those items included under the headings of meats, produce items, and hospital equipment and medical supplies are being bought under Bureau of Standard specifications. The board plans to set up a catalog of items

for use by institutions in making up their requisitions which will be coordinated with their purchasing specifications.

In addition to goods bought on a quarterly basis it is often necessary for institutions to buy goods the need for which cannot be forseen. Because of this institutions are allowed to make individual purchases on the open market. These are termed "emergency supplies."

Office supplies and the printing of reports are contracted for by the board whenever any institution submits a requisition. The board does not have facilities in which to store large quantities of these supplies and therefore can only buy them when the various institutions need them.

The Chief Clerk of the State Board of Public Affairs is in actual charge of all purchasing done by the board, although the board itself formulates policy and must okay his purchases. The chief clerk, as a rule, is a close friend of the governor and although technically appointed by the board, he generally owes his job and allegiance to the governor.

Maintenance

Maintenance costs at the Central Oklahoma State Hospital varied from $229,486.75 in 1931 to $268,918.96 in 1940, while monthly per patient rates varied from $8.96 to $8.85, the average for the latter being $8.05. These figures are itemized on a yearly basis in Tables 22 and 23.[23] This

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[23] See pages 124, 126.

heading includes all expenditures except those for salaries of the employees and capital outlays for improvements and additions to the hospital. Table 21 shows these expenditures at the Central Oklahoma State Hospital on an average monthly per capita basis for the fiscal year ending in June, 1940.[24] The biggest expense of the hospital was for food, $5.12; other large items included: clothing, 85¢; household supplies, 90¢; heat, light, water and power, 96¢.

In the past two years the trend in consumers' goods prices has been upward. During the summer of 1941 the Central Oklahoma State Hospital purchased around $450.00 worth of food daily. Tables 24 and 25 show the quantity and price of foods purchased by the hospital for two days during this period.[25] As may be seen in these tables food tends to be sufficiently nutritious however it tends to have a constant sameness in types. The reason for this is that the hospital operates on limited funds, and unless economy is practiced it would be necessary for the hospital to request additional funds from the governor's "cushion" fund.

The cost of maintenance was $9.14 per patient per month. This amount fed, clothed, treated, furnished laundry, heat, water, light, and power, and operated all industries

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[24] See page 123.

[25] See pages 131 and 132. Sample menus for this hospital are given in Table 13, pages 79-80.

TABLE 24

FOOD ISSUED AND CONSUMED AT THE CENTRAL OKLAHOMA STATE HOSPITAL ON AUGUST 27, 1941*

Amount	Item	Price Per Item	Total Price
4 sacks	Navy Beans	$ 3.27	$ 13.08
185 lbs.	Oats	.19	5.31
110 lbs.	Apple Butter	5.04	5.04
90 lbs.	Coffee, Bulk	.0833	7.50
24 lbs.	Coffee, 3#	.14	3.36
360 gals.	Milk, sweet	.20	72.00
40 gals.	Milk, butter	.10	4.00
17 cans	Milk, evap. No. 10	.48	8.16
12 cans	Peaches	.30	3.60
12 cans	Pears	.48	5.79
12 cans	Pineapple	.53	6.40
162 cans	Pumpkin	.27	44.27
3 sacks	Sugar	5.00	15.00
153 cans	Tomatoes	.29	43.98
100 lbs.	Bacon	10.40	10.40
501 lbs.	Weiners	.15	72.65
110 lbs.	Compound	.12	12.73
250 lbs.	Cheese	.22	53.73
85 lbs.	Butter	.37	31.42
20 sacks	Flour	2.07	41.40
29 lbs.	Yeast	.12	3.48
20 doz.	Eggs	.20	4.00
75 lbs.	Lamb	.04	3.00
575 lbs.	Raisins	.05	30.65
Total			$ 500.95

*This information was obtained from the office of the store-room at the Central State Hospital at Norman, Oklahoma.

TABLE 25

FOOD ISSUED AND CONSUMED AT THE CENTRAL OKLAHOMA STATE HOSPITAL ON JUNE 9, 1941 *

Amount	Item	Price Per Item	Total Price
4 sacks	Navy Beans	$ 3.40	$ 13.60
2 sacks	Beans, Pink	.38	7.67
185 lbs.	Oats	.27	4.90
18 lbs.	Coffee, 1#	.13	2.25
24 lbs.	Coffee, 3#	.13	3.00
27 bottles	Grapejuice	.16	4.19
152 cans	Kraut #10	.24	36.60
400 gallons	Milk, sweet	.20	80.00
40 gallons	Milk, butter	.10	4.00
12 cans	Pineapple, #10	.53	6.40
3 sacks	Salt	.86	2.58
3 sacks	Sugar	5.00	15.00
156 cans	Tomatoes	.24	37.64
100 lbs.	Bacon	.10	10.00
50 lbs.	Ham	.21	10.25
500 lbs.	Weiners	.11	53.65
110 lbs.	Compound	.11	11.99
81 lbs.	Butter	.33	26.69
20 sacks	Flour	.18	34.90
3 sacks	Meal	.15	4.31
28 sacks	Yeast	.12	3.36
27 dozen	Eggs	.20	5.40
15 bu.	Potatoes	1.00	15.00
2,000 lbs.	Cabbage	.00 1/2	10.00
1,400 lbs.	Onions	.01	14.00
Total			$ 417.38

*This information was obtained from the office of the store-room at the Central Oklahoma State Hospital at Norman, Oklhoma.

and utilities. Food cost was sixteen cents per capita per day. An average of $470.00 per day was paid for food needed to feed the entire institution.

During the fiscal year ending in June, 1940, 157,680,000 gallons of water were pumped at a cost of five cents per 1,000 gallons, 1,642,500 kilowatts of electricity were generated at a cost of one-fourth of a cent per kilowatt, 5,475 tons of ice were made at a cost of fifty cents per ton. These costs do not include labor.

The laundry washed 1,208,000 pounds during the fiscal year ending in June, 1940, or an average of 23,230 pounds per week, at a total cost, including all labor, utilities, and materials of one and a half cents per pound.

A total of 3,003,345 meals were served during the year at an average cost of .051¢ per meal. The bakery produced an average of 2,800 sixteen ounce loaves of bread per day at one and half cents each. The dairy produced 128,420 gallons of milk at a cost of twenty cents per gallon.[26]

On pages 93 and 94 a table shows a breakdown of the earnings of the farm during the fiscal year ending in June, 1940. These earnings represent savings to the hospital.[27] Operating costs were thereby lowered because produce raised on the farm can be used to supplement that which is bought on the open market.

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[26]This information was taken from the Steward's Report, op. cit.

[27]See pages 93 and 94.

Comparative maintenance costs of Oklahoma, certain other states, and the United States average for 1938 are presented in Table 14.[28] The United States average monthly per capita cost was $140.54, that of Oklahoma $147.86. Costs ranged from a low of $101.01 for Louisiana to a high of $205.59 for Michigan.

Only twelve states in the union spent more money on maintenance than Oklahoma and only thirteen had a higher average daily resident patient population. However when these expenditures are placed on a per capita basis thirty-one states spent more than Oklahoma. Expenditures of state hospitals for mental disease, with per capita expenditures for maintenance, by states for 1938 are given in table 26.[29]

Capital Outlay

This includes all additions and improvements. The amount expended by the institution vary with urgency of need and the willingness of the legislature to appropriate funds. Often while hospital authorities feel that they need a new building or new equipment the legislature may be inclined to believe that repairs can be made to the present plant or that the institution does not need any funds. While it is true that the hospital authorities would like to have a great deal more in the way of capital outlays than they have had in the past it is probably true that they do not need absolutely

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[28] See page 100. [29] See pages 136-138.

all that they request. Possibly the chief reason that the mental hospitals do not have larger appropriations for capital outlays is due to the fact that their inmates have no voting power. Their relatives are not aware of the need of buildings and therefore very little pressure can be brought to bear on members of the legislature. Legislatures, as a rule, tend to act in those directions that the strongest pressure groups request.

Annual costs of new buildings and equipment at the Central Oklahoma State Hospital were subject to wide fluctuations, similar to other mental hospitals. These ranged from as high as $225,462.54 in 1938 to as low as $7,774.56 in 1935 or $7.35 to 44¢ when placed on a monthly per patient cost. Annual amounts spent for capital outlays at the Central Oklahome State Hospital from 1931 to 1940 are shown in Tables 22 and 23.[30]

A comparison of capital outlay expenditures for Oklahoma, the United States average and certain other states for 1938 is given in Table 14.[31] The United States average for this period was $38.67, that of Oklahoma $34.43, while the high was $97.68 for Nebraska and the low $3.76 in Louisiana. Only thirteen states spent more on total expenditures for capital outlay than Oklahoma.[32] However figures on the amount spent for capital outlay by states are of little value, being subject in all states to needs and abilities to get funds.

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[30] See pages 124 and 126. [31] See page 100.

[32] See pages 136-138.

TABLE 26

EXPENDITURES OF STATE HOSPITALS FOR MENTAL DISEASE, WITH PER CAPITA EXPENDITURES FOR MAINTENANCE BY DIVISIONS AND STATES: 1938*

Division and State	Total	Wages	Supplies	Additions	Av. Daily Resident Patient Population	Per Capita Expenditures for Maintenance
U. S.	$112,812,589	$59,449,107	$53,363,482	$14,658,227	379,678	$297.13
New England	13,937,657	7,579,458	6,358,199	1,520,644	36,157	385.48
Maine	756,767	375,605	381,162	116,975	2,685	281.85
New Hamp.	804,314	394,105	410,209	95,450	2,091	384.66
Vermont	300,032	148,297	151,735	51,984	1,054	284.66
Mass.	8,878,673	4,987,045	3,891.628	1,088,840	20,752	427.85
R. I.	774,450	335,494	438,956	10,454	2,524	306.83
Conn.	2,423,421	1,338,912	1,084,509	156,941	7,051	343.70
Middle Atlantic	37,285,252	22,120,469	15,164,783	1,867,786	95,291	391.28
New York	28,192,859	16,874,590	11,318,269	1,520,453	68,487	411.65
New Jersey	3,993,158	2,417,066	1,576,092	150,711	10,365	385.25
Penn.	5,099,235	2,828,813	2,270,422	196,622	16,439	310.19
E. N. Central	21,055,672	11,180,286	9,875,386	5,251,206	72,491	290.46
Ohio	3,676,920	1,711,532	1,965,388	325,227	18,991	193.61
Ind.	1,570,294	674,224	896,070	1,028,805	7,764	202.25
Ill.	7,302,829	3,986,291	3,492,360	3,167,521	28,802	259.66
Mich.	7,478,651	4,246,760	3,056,073	678,522	14,865	491.28
Wis.	1,026,978	561,479	466,499	51,131	2,069	496.36

TABLE 26 - Continued

Division and State	Total	Wages	Supplies	Additions	Av. Daily Resident Patient Population	Per Capita Expenditures for Maintenance
W. N. Central	$ 8,182,251	$3,459,436	$4,722,815	$1,513,642	36,278	225.54
Minn.	2,011,032	1,036,992	974,040	194,853	9,594	209.61
Iowa	1,288,201	483,646	804,555	359,952	6,637	194.09
Mo.	2,026,767	799,447	1,227,320	219,888	8,058	251.52
N. Dak	596,583	248,942	347,641	89,479	1,854	321.79
S. Dak.	425,432	171,452	253,980	149,861	1,624	261.97
Neb.	867,928	332,718	535,210	376,585	3,855	225.14
Kansas	966,308	386,239	580,069	123,024	4,656	207.54
S. Atlantic	12,530,101	5,827,917	6,702,184	1,502,544	47,829	261.98
Del.	437,349	212,835	224,514	4,259	1,115	392.24
Md.	1,559,062	673,221	885,841	587,213	6,224	250.49
D. of C.	3,771,957	2,523,335	1,248,621	255,264	5,723	659.09
Va.	1,366,122	515,904	850,218	132,950	8,799	155.26
W. Va.	678,563	277,669	400,894	105,804	3,836	176.89
N. Car.	1,152,467	397,104	755,363	37,805	6,500	177.30
S. Car.	1,116,368	414,941	701,427	25,282	4,171	267.65
Geo.	1,317,444	532,846	784,598	118,045	7,187	183.31
Fla.	1,130,769	280,062	850,707	235,922	4,274	264.57
E. S. Central	3,165,639	1,231,079	1,934,560	155,002	21,061	150.31
Ky.	744,031	305,765	438,266	2,760	6,315	117.82
Tenn.	909,887	304,833	605,054	23,011	5,316	171.16
Ala.	921,502	362,106	559,396	107,768	5,408	170.46
Miss	490,219	258,375	331,844	21,463	4,022	146.75

TABLE 26 - Continued

Division and State	Total	Wages	Supplies	Additions	Av. Daily Resident Patient Population	Per Capita Expenditures for Maintenance
W. S. Central	$ 6,346,241	$ 2,367,180	$3,979,061	$1,433,023	29,192	$ 217.40
Ark	808,519	281,868	526,651	28,469	4,173	193,75
La.	1,153,859	477,258	676,601	21,490	5,708	202.15
Okla.	1,616,589	550,329	1,066,260	248,308	7,211	224.18
Texas	2,767,274	1,057,725	1,709,549	1,134,756	12,100	228.70
Mountain	2,492,117	1,181,265	1,310,852	436,876	10,093	246.92
Mont.	366,070	152,614	213,456	17,120	1,897	192.97
Idaho	230,661	83,321	147,340	283,796	925	249.36
Wyo.	124,680	56,153	68,527	---	553	225.46
Colo.	976,272	501,948	474,324	37,774	3,687	264.79
N. Mex.	203,124	75,644	127,490	20,904	786	258.44
Ariz.	240,779	120,779	120,000	14,893	863	279.00
Utah	266,619	149,658	116,961	22,690	1,016	262.42
Nev.	83,902	41,148	42,755	39,699	366	229.24
Pacific	7,817,659	4,502,017	3,315,642	977,504	31,286	245.64
Wash.	1,469,018	740,992	728,026	564,961	6,089	241.26
Ore.	679,924	316,333	363,591	102,401	3,916	173.63
Cal.	5,668,717	3,444,692	2,224,025	310,142	21,281	265.37

CHAPTER VII

CONCLUSION

A study of state expenditures shows the mental hospitals receiving a very small part of the total.[1] Within the last few years state government has accepted a number of new functions each costing a great deal. These will probably be continued and accepted as part of the ordinary functions of government by future generations.

The tendency in our various divisions of government has been for the legislative bodies to appropriate money to its various departments and institutions more on a basis of which has the strongest pressure bloc than on what the needs of the institution or department actually are. While this state of affairs may be characterized as deplorable, there is little likelihood that a change is apt to occur in the near future. Mental hospitals have never had a powerful lobby. It would seem logical to assume that these institutions are not apt to receive any substantial increase in their appropriations even though these are badly needed if they are

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[1] State expenditures of 1938-39 are presented in Table 27, page 140.

TABLE 27

STATE EXPENDITURES 1938-1939 *

Purpose	Amount	Per Cent of Total
State Educational Institutions	$ 9,047,184.22	10,47
Aid to Common Schools	16,032,627.67	18.54
**Hospitals	3,519,934.90	4.07
Penal Institutions	2,095,587.80	2.45
Departments of State Government	6,906,888.19	7.99
Construction of State Highways	14,033,633.87	16.23
Construction of County Highways	8,166,389.43	9.45
State Homes	376,264.63	.43
Regulatory Boards	11,829.97	.01
Legislative Expenditures	323,167.59	.37
Pensions and Aid to Dependent Children and Blind	18,176,695.41	21.03
Judicial Expenditures	553,036.08	.64
Relief to Unemployed	1,798,090.85	2.08
Unemployment Compensation Insurance	2,820,995.30	3.19
Miscellaneous Expenditures	998,339.23	1.01
Amount Paid on State Debt	1,602,349.40	1.85
Total	$86,463,014.54	99.81
** Cost of Mental Institutions	1,933,211.43	2.24

*Biennial Report of the State Auditor for the Period Ending June 29, 1940, p. 5.

expected to continue in their present vein and achieve any noticeable success. It therefore becomes increasingly evident that these institutions must reorganize on the money now available to them and do a better job than they are now doing. This is not an impossibility.

Careful study of present institutional methods in this and other states brings to light a number of ideas, which if incorporated, should bring about a more effective and perhaps more economical method of dealing with mental patients. These are:

Education of the People

An intensive propaganda program having as its purpose the educating of the people to the fact that mental disease is often curable and that it is almost always possible to rehabilitate the individual to a point where he can be of some use to society.

Various methods such as radio, newspapers, speeches, reports, lectures and trips through the institution should be made with the above point in mind. It might not even be considered unwise to employ a publicity director to sell such an idea to the general public.

The old idea that the primary purpose of a mental hospital is protective custody is no longer true. However, this fact must be thoroughly impressed on the minds of the general public. Any fears and doubts that they may have must

be dispelled. When the true situation is known and clear to them, improvements in these institutions will follow in rapid succession.

The Elimination of Politics

The elimination of politics from the mental institutions may seem like an idle statement to make in Oklahoma, however, it must be done.

Personnel should be chosen on a merit basis. That is, certain minimum requirements should be set forth for each type of job and all employees required to qualify.

To secure and retain a good grade of employees salaries must be increased to a point where an individual may enjoy a comfortable and decent standard of living. Also working hours must be reduced from twelve to eight per day, and the employee must be given one day off each week.

The employee must be guaranteed job security. He must not be haunted by the fear that he may be let out for political reasons.

Provision must be made whereby an employee may be retired on an ample pension after a reasonable number of years of satisfactory service.

The employee must be allowed an annual vacation, if possible at the time of year the employee wants off. In addition provision should be made for sick and other types of leave.

Suggestion boxes should be set up and employees encouraged to state their ideas on ways and means of improving phases of the institution. This will allow all employees to get steam off of their chests, to have their thinking straightened out, and occasionally a good idea will be presented.

Employees under this type of a system can be expected to put whole-hearted efforts in their work. When this is done the hospital will function a great deal more smoothly and effectively.

In Service Training

When an employee is first hired he should have certain basic qualifications. Even then he cannot be considered as a well qualified employee. He needs seasoning. This is properly gained in two ways. The first is experience, and the second, while closely allied, may be called in service training. In order to receive the latter he should be sent to a school maintained by the hospital. Lectures, followed by examinations on which a passing grade is required, should be given on the functions and duties of the institution, with special emphasis being placed on the type of work that he has been employed to do. All promotions and demotions should be largely based on this type of training and the employees' reactions.

Training of this type gives the employee a better insight into the policies of the institution, therefore enabling him to do a more efficient type of work.

Revision of the Committing Procedure

The committing procedure must be so revised as to allow only mentally ill persons to be committed to the institution.

At the present time any individual may be legally committed as insane upon the recommendations of two general practitioners, many of whom know very little about mental illness. In some counties it has been the practice of some of the county judges to commit as insane all of the habitual drunks, drug addicts, indigent seniles, and mental defectives that are too bright to be sent to the feeble-minded hospital. These institutions were not originally set up, and are not now prepared to take care of these types of people. According to Dr. D. W. Griffin, Superintendent of the Central Oklahoma State Hospital, fully twenty-five per cent of those admitted to that institution have no business in a mental institution.[2] It is not the purpose of this paper to say where or what should be done with these types of people, however, it must be reiterated that they do not belong in a mental hospital.

An ideal committing procedure would allow the patient to be sent for by the hospital authorities and conveyed to the hospital by them. Many individuals who have suffered a nervous breakdown have sank even further into the depths of mental

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[2]Information given in an interview on September 1, 1941.

illness because they were delivered to the hospital in the same fashion that a common criminal is taken to a penal institution. After all being mentally ill is not a crime. Upon being received the patient should be placed on a ninety day[3] observation basis, during which time he should be given all types of physical and mental examinations that the staff doctors believe advisable. In this way many patients who are not proper hospital cases could be found out. Then, and only then, should a patient be formally admitted to the hospital. In those cases where the individual is not considered by the hospital authorities to be a proper case for the hospital the county authorities should be required by law to reposses the individual.

Psychiatric Social Workers

The installation of large numbers of psychiatric social workers to assist in various in and out departments of the hospital. Employees of this type could adequately perform the following functions:[4]

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[3]More or less, dpending on the individual case.

[4]Lois Meredith French, Psychiatric Social Work, (New York: The Commonwealth Fund, 1940), p. 53:

In 1926 the functions of the psychiatric social worker were outlined by the staff of the United States Veterans' Administration as follows:

a. To secure complete and trustworthy social histories on neuro-psychiatric cases, both for the use of the regional office and the hospital to which a patient is admitted.

b. To assist the neuropsychiatrist in affording satisfactory treatment to neuropsychiatric patients by solving social problems which interfere with such treatment.

c. To investigate the home environment of neuropsychiatric beneficiaries not under hospitalization as well

(1) Go after all patients who are to be admitted to the hospital and bring them in. While at the patient's home they could compile a case history. This would include an evaluation of the environment, the financial set-up, family connections, the social atmosphere, and the patient's abilities and inabilities to adjust himself to them; where the patient is young a study of school adjustments should be made. If possible the psychiatric social worker should ascertain the cause of the breakdown. This type of information is of great value in the treatment of mental disease.

(2) After admission:

a) Assist the physician by getting the case history from the social angle and the patient's adjustments.

b) Look after contacts with relatives. Keep a file of their addresses. Encourage visits and correspondence. Describe the condition of the patient to relatives whenever

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as those whose parole from the hospital is under consideration, and to cooperate with the Guardianship Officer in ascertaining and promoting the social adjustment of incompetent patients in their communities.

d. To contact, cooperate with, and whenever possible, to secure the aid of social service agencies in the respective regional territories, such as state, county or city organizations, and the American Red Cross, utilizing whenever possible the facilities available through such agencies for the adjustment of domestic and economic obstacles to the recovery of neuropsychiatric beneficiaries.

. . .

e. The function of the social worker in the hospital will be to assist the Medical Officer in Charge in solving social problems pertaining to claimants while they are in the hospital.

they come to visit; it is generally a waste of time for the relative to see the patient's doctor.

(3) Encourage and promote recreation. All recreational therapy should be in charge of psychiatric social workers. It should be their duty to get all patients to participate to the greatest possible extent.

(4) When a patient is sufficiently recovered to be discharged the psychiatric social worker should make advance preparations for his arrival. The condition causing the original breakdown should be eliminated, otherwise the patient may have a relapse.

(5) The psychiatric social worker should follow up the case by correspondence and visits to see that the patient's recovery is complete.

(6) The psychiatric social worker should work in connection with other public and private agencies such as venereal clinics, police departments, and other welfare agencies. Much could be worked out through coordination.

(7) Handle all deportation. Patients who are out of state residents must be returned to their own states.

(8) Out patient clinic--the psychiatric social worker could assist the staff doctor in advising people who feel themselves on the edge of a nervous breakdown, and the parents of problem children.

(9) The psychiatric social worker could find homes

for patients.[5] There are many patients in the mental hospitals who are able bodied, harmless, and willing to work. Undoubtedly many farmers and others need someone to perform odd jobs that they can depend on. Many employers would be willing to accept a patient as an employee if they were sure that he was dependable. In return for his labor the patient would be given his keep plus a small amount of pocket change. Properly trained psychiatric social workers could make advance contacts and prepare the way for this type of patient. After placing the patient it would be the social worker's twofold duty to make periodic visits:

a) To see whether the patient was behaving properly, if not he could be returned to the institution, and

b) To prevent the employer from exploiting the patient.

> To set up a family care system four steps are essential: legislative authority; appropriations adequate for competent, well-staffed psychiatric social service departments; preparation of communities to receive patients by direct or indirect publicizing; discovery of suitable homes, preferably near the hospital.[6]

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[5] There are about 2,650 patients now in family care in five states (New York, Pennsylvania, Massachusetts, Maryland, and California). Utah and Illinois have enacted permissive legislation. Families have had mentally ill boarding with them for six centuries in Gheel, Belgium. Scotland, France, Hungary, Germany, Norway and Switzerland also have had systems of this type for a long time. Edith M. Stern, "Family Care for the Mentally Ill," Survey Graphic, Vol. XXXI, No. 1, (January, 1942), pp. 31-32, 42-44.

[6] Ibid., p. 32.

Dr. D. W. Griffin recently made the statement that there are around 500 patients in the Central Oklahoma State Hospital that could be paroled under favorable conditions such as these outlined above.[7]

Home for Chronic Patients

Many patients in mental hospitals are known as chronic patients. They require a certain amount of supervisory care but very little medical attention.

In the present type of mental hospital, they spend their days sitting around doing nothing, for there is nothing for them to do. They are locked in ward buildings, and watched day and night. They contribute nothing toward their upkeep, and are a total loss to society.

In Wisconsin a plan is now in operation where chronic patients who are harmless are sent to county homes. There they are given ground privileges and allowed to perform various chores and other activities that tend to keep maintenance costs down. They are allowed to be out in the fresh air for many hours each day and to enjoy life to a greater extent than is possible for patients locked in a custodial ward of a state hospital. These county homes are in charge of an industrial supervisor, who is assisted by a small staff of attendants or group leaders. Costs of these institutions are

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[7]Information obtained in an interview on September 1, 1941.

met on a fifty-fifty basis by the state and the counties.[8]

It is neither feasible nor economically wise to suggest that Oklahoma should establish seventy-seven homes of this type. This states does not need that many homes, and many Oklahoma counties are already in a state of bankruptcy. However homes could be established in each of the congressional districts. These would be ample for all the needs of this state for many years. Dr. D. W. Griffin recently estimated that there were between five and six hundred patients in the Central Oklahoma State Hospital who could be placed in homes of this type.[9]

Incorrigible Patients

A certain number of patients may be thought of as incorrigible. There is only one method of treatment now known. That is a close form of custody. They must be kept in heavily barred buildings and watched at all times. Full faith and trust can never be put in them. Perhaps at some future date a method of rehabilitating them may be discovered, however until that time they must be kept in locked wards. This type of patient is but a small part of the total institutional population. Buildings of the proper type should be provided

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[8]Mental Hospital Survey Committee, A Survey of the Care and Treatment of the Mentally Ill of Wisconsin, 1938, New York.

[9]Information obtained in an interview on September 1, 1941.

where they can be properly taken care of by employees versed in the handling of this type of patient. They need only a daily visit of a medical doctor to take care of their occasional ills and hurts.

Intense Treatment for Hopeful Cases

The remainder of the patients constitute the group for whom medical science offers the greatest chance of recovery. These patients must receive highly specialized individualized treatment. From the time they are admitted until they are discharged they should be surrounded with ample numbers of doctors and technicians. In this type of service the ordinary attendant should be replaced with medical orderlies.[10] Each activity of the individual should be planned and supervised by competent personnel. It is highly important that these patients have good living conditions and the proper diets, because good physical health is the foundation on which psychiatry builds. It is also important to have trained personnel because they are not apt to mishandle patients thereby impairing their chances for recovery.

The hospital should establish an admitting department. Here all entering patients could be carefully studied, case histories, worked up, various types of examinations and

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[10] A medical orderly is an individual who has considerable training and experience in medicine. As a rule they are directly under the authority of a registered nurse. It is their job to take care of all the rough work.

interviews given, and a tentative diagnosis made. Many patients could be shuttled to chronic wards. Only those patients who offer possibility of cure under treatment would be sent to the hospital proper.

The suggestions listed above constitute a gathering together of some of the better plans and ideas for the care and treatment of mental patients. There is no state in the union that has yet incorporated all of these ideas into the administration of their mental hospitals. Various states have part of these ideas in operation. Some of the ideas have been suggested by writers and others gained in conversations with various officials.

All of these ideas are sound. It is probably impossible to install all of them at once, and it would perhaps be unwise to do so. However, it is possible and feasible to place them in operation on a piecemeal basis. Certain phases will call for large expenditures, others will require very little money. Any of them will increase the effectiveness of the institution. In the long run their installation will save the state considerable sums of money, as well as provide better service for the mentally ill.

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