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CIVIL RIGHTS OF THE MENTALLY ILL AND

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Studying the civil rights of mentally ill and mentally retarded persons in Oklahoma was an idea which occurred to this student before a dissertation subject was needed for a doctoral program in political science. As an employee and consultant in institutions which care for such individuals and as a member of a profession which is intimately concerned with mental health, these rights elements seemed to me to be only occasionally discussed and seldom mentioned in the literature, despite what seemed to be their great significance.

In February, 1964, an article by Dr. Thomas S. Szasz appeared in Harper's Magazine which articulately raised these issues.[1] This article along with many of Dr. Szasz's other books and articles, which it led me to explore, stimulated my interest and was probably the most significant single source of my interest in this study.

During the two years since my interest in the material became focused and a dissertation began to take form, many miles have been travelled, many conversations held, and many pages turned. By necessity, many persons were involved in my interest through interviews, letters and efforts to test my ideas against their experiences and attitudes. In this connection, I am particularly indebted to Dr. Albert

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[1]Thomas S. Szasz, M. D., "What Psychiatry Can and Cannot Do", Harper's, Vol. 228, No. 1365, February, 1964.

Glass, Director of the Oklahoma Department of Mental Health and his associate, John Holt, both of whom provided answers to complex questions, supplied me with written materials, and helped me arrange interviews with the superintendents of all four state hospitals for the mentally ill. Of course, my thanks go, too, to those superintendents, each of whom is quoted in the body of this report.

Similarly, my thanks go to Lloyd E. Rader, Director of the Oklahoma Department of Public Welfare, and his staff for the assistance provided through written materials and personal interviews with the superintendents of the state schools for the mentally retarded.

The county judges of Cleveland, Kingfisher, and Tulsa counties, were most co-operative in allowing research in their mental health case files, providing comfortable facilities for conducting such research, and granting personal interviews.

During the summer of 1965, I visited Syracuse, New York, to interview Dr. Szasz. He was gracious in answer to my request for a conference, quite helpful, and encouraging in connection with my proposals and plans. Although many persons toward whom I feel equal affection and respect disagree strongly with Dr. Szasz, I consider him both helpful to me in this work and an authentic social philosopher of significance to the twentieth century. He is controversial but so are most people with meaningful messages.

Other individuals were kind in providing interviews and they, along with all those who were interviewed in connection with this research, are cited in the bibliography.

My colleagues on the faculty of the School of Social Work of the

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Wives and children who live with those who are preparing dissertations require inordinate tolerance. My wife, Micki, has both that quality and a background in English, which was helpfully applied to my grammatical and editorial problems. Bobby, Michael, and Meryl Sue, have helped when they could, but, fortunately, they never ceased their efforts to induce my joining in their activities.

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CHAPTER I

INTRODUCTION

This is an examination of the civil rights of persons in Oklahoma who are alleged to be mentally ill or retarded or institutionalized because they are designated as such. Also examined are a number of other matters which are not technically civil rights. Voting, driving an automobile, and other activities which may be desirable in a free society are discussed as human freedoms of which the mentally ill or retarded individual may be denied. The methods and procedures used by institutions in caring for mentally ill and mentally retarded persons, as part of the institution's in loco parentis responsibilities are also studied. These responsibilities charge the institution with the role of functioning in the place of a parent for the patient or pupil.[1]

Three approaches to the question are used. First, the statutes and common law which bear upon the relationship between the mentally disabled and the state are examined, to determine the nature of the context in which the two parties interact. Second, an effort is made to describe the manner in which the regulations governing mental illness and retardation are applied, from the point of view of both commitment procedures and practices within institutions. Third, material describing practices in other states and expert viewpoints is utilized to assess

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[1]Henry Campbell Black, Black's Law Dictionary, Fourth Edition, p. 896.

Oklahoma's position in this field. Although these are the approaches, the content is organized around specific issues. Material based upon each approach is utilized in discussing each issue. Thus the legal, the actual, and the comparative, are each a part of the discussion of each issue.

The universe or scope of this study is the mentally retarded and mentally ill population of Oklahoma, defined as those who appear before county courts for sanity proceedings and those who are voluntarily or involuntarily committed to state and private institutions for the mentally ill or retarded in civil proceedings. Major attention is given to the civil rights of these individuals during commitment proceedings, while they are institutionalized, and once they are released.

Method

Material for this study was gathered from three principal sources, in three ways.

Much of the data comes from personal interviews, many of them recorded on magnetic tape, with persons directly involved in the commitment and hospitalization processes. These include all of the superintendents of the hospitals for the mentally ill in Oklahoma and the schools for the retarded in the state, administrative officials in the Department of Mental Health and the Department of Public Welfare, which are the agencies responsible for the public institutions, three county judges, and other experts. A complete list of those interviewed may be found in the bibliography. The outline used in conducting these interviews may be found in Appendix B.

As a part of the study, commitment practices in three counties

were examined in a statistical manner according to a design which may be found in Appendix A. The three counties were chosen in accord with pre-determined criteria. Cleveland County was chosen as a medium size, urban area which commits patients to Central State Hospital. Tulsa County was utilized as a metropolitan county which sends its patients to the Eastern State Hospital. Kingfisher County is rural and commits to the third hospital, Western State. Fifty cases each were studied in Cleveland and Tulsa counties and were chosen to reflect the current or most recent practices in a random manner. The Cleveland County sample was drawn from cases numbered 1900-2076 and handled between May, 1962, and August, 1964. Because Tulsa County handles several times as many cases each year as Cleveland County, the period of time covered by the universe from which the Tulsa County sample was chosen is much shorter. The Tulsa County study deals with a random sample of cases handled between August, 1964, and November, 1965, numbered 4958-5458.

In the cases of both counties, all of the docket numbers during the period designated were written on slips of paper and placed in a box. The box was shaken and fifty cases drawn from it. These constituted the sample. The procedure provides randomness in that each case in the universe has an opportunity equal to that of each other case to be represented in the sample.

Because Kingfisher County is smaller and commits few patients to mental hospitals, a different procedure was used. For that county, the most recent twenty-five commitment cases, extending over a five-year period, were examined.

Various statistical analysis tools and measures were applied to

the data gathered and the results are discussed in the appropriate chapters.

In addition to this field research, materials for this study were also gathered from various written primary and secondary sources, designated in the bibliography. Although few books are available on the subject of the rights of the mentally ill, there are journal articles, transcripts of the United States Senate subcommittee hearings which dealt with the subject, a detailed study by the Council of State Governments, and another by the American Bar Foundation. These were used and are mentioned in the body of the dissertation.

CHAPTER II

INVOLUNTARY COMMITMENT

Probably the most severe loss of rights associated with mental disability is the loss of freedom to remain in society. Being "locked up" or "put away" is fraught with taboos and anxieties but with little understanding of who may be affected and how involuntary hospitalization operates. No men in white carrying nets and other comic paraphenalia capture happily deranged people who think they are millionaires and carry them quietly off to the sanitarium. In Oklahoma, and most of the other states, a more typical procedure is for a close relative to allege that someone is mentally ill. Upon the allegation being made, a sheriff or his deputy picks up the potential patient and places him in a jail for at least one day, to await a hearing on his sanity or mental health. Then he, if he is capable of doing so, appears before a Sanity Commission,[1] consisting of two physicians, who are not necessarily psychiatrists, and one attorney, whose task is to insure that the proceedings are carried out legally and that the alleged mentally ill person is notified of all his rights. The commission asks some questions, fills out a two page form[2] and determines whether or not the person is mentally ill. If he is, the judge issues an order that the

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[1] A detailed discussion of the Sanity Commission begins on page 20.

[2] Appendix C.

person be hospitalized. At the same time, the person loses his legal competency. Then someone, very often a county law enforcement officer, transports the patient to one of four state hospitals for the mentally ill.

This procedure does not apply to persons who are mentally retarded, nor does it apply to mentally ill patients who enter hospitals through one of the two voluntary admission procedures open to them. The methods used with these individuals are discussed in subsequent chapters. This section relates only to those who are hospitalized without their voluntarily requesting such action.

Legal Bases

Oklahoma law defines a mentally ill person as " . . . any person afflicted with a mental illness to such an extent that he is incapable of managing himself and his affairs, and for his own welfare and the welfare of others it is necessary or advisable for him to be under care."[3] Before 1965, the law specifically excluded from the definition of mental illness epileptics, psychoneurotics, psychopathic personalities, sexual perverts, drug addicts except minors and chronic alcoholics, unless these had a psychosis superimposed. Amendments to the laws in 1965 made the definition more flexible.

The original common law position which made involuntary commitment possible turned on police powers, according to the American Bar Foundation study of The Mentally Disabled and the Law. This meant, however, that the police power could be used only to protect persons or property in the community from imminent danger, possibly resulting from

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[3] 43A O. S. Supplement, 1965, Sec. 3.

the freedom of a mentally ill person.[4] This has since changed in most jurisdictions, including Oklahoma, to a legal position which recognizes involuntary hospitalization as incidental to and necessary for the treatment of some people who are mentally ill.[5] This is, of course, based on the police power, too. According to the study, every state has some form of involuntary hospitalization, although there are wide differences in the procedures for this and for the criteria. Only seven states still require that the committed person be of danger to himself or others. The balance either make the need for treatment an alternative basis for commitment or make this the sole basis.[6] Thus the decision to hospitalize a mentally ill person need be based on no more than the judgment that he is in need of treatment.

Involuntary commitment does not turn on the person's danger to himself or others. In fact, few who appear for commitment proceedings show a history of or an inclination to harm themselves or others. In the study of one-hundred-and-twenty-five commitment cases in three Oklahoma counties, forty-seven persons alleged to be mentally ill had some indication of violent or suicidal behavior. Several of these had only issued threats and many of these were ultimately adjudged not mentally ill and released. For example, one case in Tulsa involved a sixteen year old girl who was apparently an unwed mother, who had a history of retardation, cursed, raged, and tried to kill her infant child.

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[4] Frank T. Lindman and Donald M. McIntyre, Jr., editors, The Mentally Disabled and the Law, p. 17.

[5] Ibid.

[6] Ibid.

She had also attempted to strangle herself. At a younger age she had been sentenced to a girl's training school. The Sanity Commission which heard her case found her not mentally ill and dismissed the case.[7] In the study of cases in Cleveland County some of the most violent-sounding people were rapidly released, in one way or another. A forty-two year old man was diagnosed as a possible paranoid, after his wife initiated a hearing on his mental health. He had been drinking excessively, suspected his wife of infidelity, threatened a divorce, and threatened to kill his wife. He was discharged within ten days of his commitment and legally restored to competency.[8] Two other cases of violent persons in Cleveland County described the individuals as dangerous. One had threatened to harm his wife and daughter. He was committed and died one day after his admission to the hospital.[9] The other man was also committed and died within eight days of being hospitalized.[10]

In a statistical examination of the cases studied in Cleveland County, an attempt was made to define the correlation between violent behavior and length of stay in the hospital. A total of seventeen persons were found to be violent, while twenty-seven had no indication of violence in their behavior. There was no indication, one way or the other, for the other six cases in the Cleveland County sample. Used as a measure of length of stay in the hospital was forty-five days, the

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[7]Commitment Study based upon 125 cases in Cleveland, Kingfisher, and Tulsa Counties, Case T-13.

[8]Ibid., Case C-18.

[9]Ibid., Case C-5.

[10]Ibid., Case C-4.

period mentioned at the time by several mental health officials as the average. Using the phi coefficient of correlation, it was found that the correlation of violent behavior with length of stay in the hospital was .41, negatively. This indicated that violence and length of stay were moderately negatively correlated. When the chi square estimate of probability of relationship in a sample was applied, the resulting figure was 7.28. The indication is that if the two elements of violence and length of stay were considered independent, the observed distribution could have occurred only one time or less in one hundred by random sampling from a population such as this one.[11]

Thus the finding is that a committed patient not only need not be violent or suicidal, but he may be released earlier, if one of his problems is violent behavior, than his more docile counterpart. Thus it is clear that involuntary commitment is used to treat mentally ill persons in addition to protecting the person from suicide and the community from violence.

Section fifty-five of the mental health statutes spells out the process of involuntary commitment in great detail. It allows only certain individuals to initiate commitment proceedings against someone who is alleged to be mentally ill. Those persons include close relatives such as parents, spouses, siblings, and children over eighteen. Sheriffs, and other peace officers, and superintendents or physicians in charge of hospitals and other institutions for the care of the mentally disabled are also included. These individuals may prepare

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[11]Harris K. Goldstein, Research Standards and Methods for Social Workers, p. 286.

a petition, which is presented to the County Court for action.[12] Actually, Oklahoma is more restrictive in the matter of who may petition for the commitment of a mentally ill person than other states. Some allow any person to initiate such a petition while others include friends of the alleged ill person or physicians.[13] The balance of this chapter will be utilized in discussing some of the issues arising from the petition.

Notice and Appearance

Nothing illustrates so well the dilemma of attempting to guarantee civil rights to the mentally ill than the early stages of involuntary commitment proceedings when notice of the allegation of mental illness is given to the potential patient and when he is required to appear at something which resembles a trial. Some interpret such events as cruel and unusual punishment for the sick person. Others consider procedures which have the same result without protections such as notice and hearings a severe deprivation of liberty without due process. It is doubtful that there are many people wholly pleased with the procedures as they now exist in Oklahoma. In some ways they appear to be a compromise between medical methodology and legalistic approaches.

Oklahoma law on notice to the alleged mentally ill person requires the setting of a date for a hearing and notification of the person involved at least one day prior to the hearing. In addition,

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[12] 43A O. S. (1961) Sec. 55.

[13] Lindman and McIntyre, Jr., op. cit., pp. 49-51.

his close relatives must be given notice of the hearing:

> Upon receiving such petition the court, or the judge thereof, shall fix a day for the hearing thereof, and shall forthwith appoint a Sanity Commission, as defined in this Act, to make an examination of the alleged mentally ill person, whose certificates shall be filed with the court on or before such hearing. Notice in writing of such petition and the time and place of hearing thereon shall be served personally at least one (1) day before the hearing, upon the person alleged to be mentally ill, also upon the father, mother, husband, wife, or in their absence someone of the next of kin, of full age, of the person alleged to be mentally ill, if there be any such known residing within the county, and upon such of said relatives residing outside of the county and within the State, as may be ordered by the court, or the judge thereof, and also upon the person with whom such alleged mentally ill person may reside, or at whose house he may be, and the person making such service shall make affidavit of the same and file such notice, with proof of service, with the County Court. This notice may be served in any part of the State . . . .[14]

Obviously, the purpose of giving notice and delaying court action at least one day is to protect the allegedly mentally ill person and allow him time to defend against the action. However, it is this delay which causes many persons who are alleged to be mentally ill to spend one or more nights in a jail. As Dr. Albert Glass, Director of the State Department of Mental Health, puts it, "Is it due process to land the guy in jail for a weekend?"[15] As will be developed in this discussion, the psychiatrists tend to find this waiting period unnecessary. Many think that giving notice and providing for appearance in court is demeaning and medically unsound. The judges and attorneys tend to think these procedures are important. There are exceptions

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[14] 43A O. S. (1961) Sec. 55.

[15] Interview with Dr. Albert Glass, November 18, 1965.

among both groups and these will be discussed. However, this points to the essential dilemma. That is, involuntary commitment is both a medical and legal matter. In many ways, the interests and beliefs of these two professions are divergent. Some of the reforms proposed by medical people are really measures which would make the procedure almost exclusively medical. Some legal experts want the procedures to be exclusively legal.

When the Oklahoma Mental Health Planning Committee asked the county judges if they thought the twenty-four hour mandatory holding period served a useful purpose, all but twenty said that it did. Of the twenty who felt it was unnecessary, sixteen were judges of rural counties.[16]

The report says:

> Most judges who felt that the holding period encumbered legal action felt that the Sanity Commission was capable of determining the mental status of the respondent and that the mandatory waiting period merely delays treatment. Both rural and urban judges agreed on these two reasons. One rural judge said the mandatory law was useless because of awkwardness of setting up and the functioning of the Sanity Commission. The remaining rural judge gave no reason as to why he thought the law was unnecessary.[17]

When the judges[18] who favored the mandatory holding period were

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[16]Oklahoma Mental Health Planning Committee, Report Number Three, p. 11.

[17]Ibid.

[18]The planning committee defined a metropolitan county as "...one having at least one incorporated concentration of 50,000 or more people." An urban county is one with an incorporated concentration of 10,000-50,000 population, and a rural county is one with no incorporated concentration of as many as 10,000 people. Report Number Three, p. 3.

asked why they supported it, they responded in the manner indicated in Table 1.

The issue of giving notice to the person alleged to be mentally ill is, in itself, a controversial one. "Numerous psychiatrists have decried the traumatic effect of personal notice on a person who is mentally ill. Legal papers are said to produce only anxiety and confusion

TABLE 1

REASONS GIVEN FOR USEFULNESS OF MANDATORY HOLDING PERIOD

Reasons	Judges		
	Metropolitan	Urban	Rural
a. Due process of law	1	6	10
b. Notification of family and relatives	2	4	7
c. Alcoholic drying-out period		3	
d. Prevents improper commitments		3	6
e. Observation and arrangement time		4	7
f. No reason given		2	1

[19]

in a sick mind."[20] Others wonder if this is any more traumatic than finding oneself in a mental hospital without prior notice.[21] The issue of notice and appearance was of importance at the Senate subcommittee

[19] Ibid., p. 12.

[20] Lindman and McIntyre, Jr., op. cit., p. 25.

[21] Ibid.

hearings. Dr. Winfred Overholser, Superintendent of St. Elizabeth's Hospital, in Washington, D. C., said, in describing the current practices in his area:

> There still is formal notice. There is summoning of witnesses. The witnesses must testify in the presence of the patient, and this is an extremely traumatic thing both for the patient and for his family. It is one thing which, all by itself, tends to make families hesitate greatly about sending a patient or proceeding for his commitment . . . .[22]

Dr. Overholser also said, " . . . . hospitalization procedures in the District of Columbia are cumbersome, unduly legalistic, unnecessarily distressing to the patient, and tend to delay rather than to facilitate hospital care."[23]

A statement of the other side of this issue was used by Hugh J. McGee, chairman of the Mental Health Committee of the District of Columbia Bar Association, to rebut Dr. Overholser's testimony:

> Dr. Overholser in his testimony referred to legalisms, and psychiatrists do frequently use that term 'legalisms', and after he used the term 'legalisms' he said 'such as' and gave as examples notice, subpenaing witnesses, which are two of the principal elements of due process without which you have nothing. Without notice and witness being called in your behalf, due process amounts to a farce.[24]

But Mr. McGee recognized the dilemma and showed some understanding of the psychiatrist's position. "They don't want a sick person to be notified of his condition. There is no way you can get around it. You

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[22]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, Hearings, Constitutional Rights of the Mentally Ill, Part 1, Civil Aspects, 87th Congress, 1st Sess., 1961, p. 22.

[23]Ibid.

[24]Ibid., p. 58.

can put it on a flowery piece of paper, but if you put it in small print, then you are depriving him of notice. If you don't formally advise him of what is taking place, then there is no due process . . . On the other hand, if he is sick, the notification might have in some few cases a traumatic effect."[25] He told the committee that the problem was being worked on but that it posed no small problem. Satisfying what the lawyers consider due process and that which the psychiatrists may think of as adequate treatment poses a difficult problem for both.

In his appearance before the subcommittee, Albert Deutsch, a great reformer in the mental health field, objected to the criminal-like aspects of commitment practices. Apparently aligning himself with the point of view expressed by many psychiatrists, he said:

> The combination of police, jail, and court can do incalculable harm to the patient, gravely impeding his chances of recovery. It often reinforces the delusions of persecution in some and the morbid feelings of guilt in others. Psychiatrists generally are appalled by the cumbersome, callous, and sometimes brutal legal machinery that 'processes' sick people as though they were criminals.[26]

Dr. Francis J. Braceland, who represented the American Psychiatric Association and the National Association of Mental Health before the subcommittee expressed much the same opinion:

> We find ourselves throughout history taking issues, it seems, with laws and procedures which govern admission and treatment and discharge of patients to mental hospitals, not because we are any less law abiding, but because we come at this problem from a different angle.

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[25] Ibid., p. 59.

[26] Ibid., p. 43.

> From a medical point of view sometimes these procedures delay and impede treatment, and sometimes they resemble criminal proceedings with a certain amount of stigma attached to them and we feel badly about it. Judges commit people to prison and mental hospitals.
>
> Now we are absolutely in accord with everything that will protect the patient. We bow to no one in our interest in them. But, in addition to due process of law, a patient is entitled to due regard for his dignity and for humane treatment and for proper care.[27]

This presents rather well the psychiatrist's core attitude on notice and other proceedings. That is, due process is not opposed. However, many psychiatrists believe that some of these procedures interfere with the real necessity which is not due process, but treatment. Perhaps the basic psychiatric attitude is, "These are sick people and we are medical men. We will not deprive a person of liberty unless it is necessary and we will release him as soon as it is possible. Why do legal officials and professionals consider themselves the only people who can guarantee freedom?" While this does not represent the thinking of all psychiatrists on the issue of commitment procedures, it is reflected in the statements many made to the subcommittee and to this researcher. As Dr. Bedford Peterson, Superintendent of Eastern State Hospital, put it, no psychiatrist is going to hold someone who doesn't need treatment.

Dr. Peterson also suggested as an alternative to the current system that hearings on mental health be held on the same day that the petition is presented to the County Judge. This would eliminate, at

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[27] Ibid., p. 64.

least, the necessity for holding the person in jail.[28]

Of course, it is not only psychiatrists who support this position. Senator Sam J. Ervin., Jr., chairman of the subcommittee, said:

> I have seen some hearings and thought that any person who was not mentally sick at the time the proceedings started, he would certainly be in that state by the time they were through.
>
> I think that this is an area that certainly warrants study and action, but at the same time we can make it certain that a person doesn't suffer deprivation of any of his constitutional rights.
>
> This is a very difficult problem and I am satisfied, that from my own observation the practice of law, that sometimes a person is injured, insofar as his mental recovery is concerned, by the very process of lawyers seeing to it that he has his constitutional rights.[29]

Also expressing the treatment objective rather than the civil rights protection viewpoint to the subcommittee was Dr. Jack Ewalt, who represented the American Psychiatric Association before the subcommittee. His thought was that inadequate hospital facilities constituted a greater deprivation of patient rights than any neglect of procedural due process:

> Now I don't care how many notices you give him, if you are going to take him to this place, and if you hold him there where the treatment facilities and the examination facilities are inadequate, unhygienic, and unsafe, I think his rights have been involved more than if somebody had forgotten to hand him that piece of paper.[30]

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[28]Interview with Dr. Bedford Peterson, December 21, 1965.

[29]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 70.

[30]Ibid., p. 76.

No matter how sincere or patient-oriented such a statement might be, it is likely that psychiatrists who refer to matters of due process as "handing pieces of paper" disturb attorneys and judges who develop even stronger convictions about the need for protections. Of course, the legal professional is deeply concerned with those pieces of paper, while the psychiatrist may be more interested in treatment facilities.

In the formal statement prepared by Dr. Ewalt and Dr. Braceland, these issues were brought into sharp focus:

> From a medical point of view, the worst features of the commitment laws of the past (and some of these features are still with us in some States) are such requirements as these: That the patient must be given 'notice' that he is to be committed; the insistence that the patient appear personally in court with consequent exposure of his problems to the public; the frequent identification of mental illness with criminality as a result of court procedures . . . .
>
> In general, psychiatrists favor a simple commitment procedure entailing an application to the hospital by a close relative or friend, and a certification by two qualified physicians that they have examined the subject and found him to be mentally ill. If judicial procedures must be brought into play at all, the court should have discretionary power to eliminate notification to the patient and not to require the patient to be present in person at a hearing . . .[31]

As will be discussed in the section on reforms of the involuntary commitment procedures proposed by Oklahoma mental health officials, this seems to represent a widespread psychiatric viewpoint.

A statement of the lawyer's point of view, in almost pure form, was given by Charles Halleck, an attorney in Washington:

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[31] Ibid., p. 81.

> I submit it is the lawyers who are going to have to make this work and it is the courts who are going to have to make it work, and it must be made to work within the framework of the Constitution. There is no excuse, ever, for abridging the constitutional rights of any citizen on the theory that what we are going to do is to protect him from himself, or protect him from the traumatic experienc (sic) of being served with a paper.
>
> As I am sure you Senators are well aware, when the U. S. marshal comes around with a summons in a civil action when somebody sues you for running over them, they don't worry about the traumatic experience in serving papers. And when you go to the hospital and they ask you to sign papers, and they always seem to extract the statement about, 'We promise to pay,' and the doctors are permitted to do this and that and the next thing, if they think it is reasonable, they don't worry about the traumatic experience then. But now these medical men come in and talk about this poor man, this poor mentally ill patient and tell us, 'We are going to do away with some of the constitutional rights in order to protect him.'
>
> They would whittle down his rights on the theory that they are going to protect him.
>
> Somehow that falls on deaf ears when I hear it.[32]

As has been indicated, Oklahoma statutes presently require notice be given to the alleged mentally ill person. Of course, this does not always mean that the notice is given directly to the alleged mentally ill person. If he is under guardianship of any kind, the notice may be served upon the guardian.[33]

In terms of appearance in court, Oklahoma statutes require it unless there is ample reason for the alleged mentally ill person to be excluded from his hearing. Specifically, the statute says:

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[32] Ibid., p. 110.

[33] 58 O. S. (1961) Sec. 810.

> The alleged mentally ill person shall have the right to be present at such hearing unless it shall be made to appear to the court, either by the certificate of the superintendent of the hospital, or the physician in charge of such hospital, home or retreat to which he has been temporarily admitted, or by the certificate of the Sanity Commission, as defined in this Act, that his condition is such as to render his removal for that purpose or his appearing at such hearing improper and unsafe.[34]

Appearance is an issue which is taken rather seriously, it would seem, by many of the county judges. Tulsa County Judge Whit Y. Mauzy said that he requires everyone who comes before a sanity hearing to appear before him, unless, as the law says, it would be improper, dangerous, or unsuitable, for such an appearance to be made. If appearance is not made, Judge Mauzy demands an explanation and evidence from the attorney who serves on the Sanity Commission.[35] There were examples in all three counties studied, for the commitment study done in connection with this research, of individuals who did not appear before the judge. Some of these were considered dangerous, others were unable to give any information, because of their illness.

It should be re-emphasized that the issues of notice and appearance are not involved in the institutionalization of mentally retarded people in Oklahoma or in voluntary mental illness commitments.

The Sanity Commission

Crucial in the involuntary commitment process is the appointment, composition, and functioning of the Sanity Commission. It is described

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[34] 43 O. S. (1961) Sec. 55.

[35] Interview with Judge Whit Y. Mauzy, November 16, 1965.

by statute and its functions are outlined:

> (a) Upon the filing of a petition for the commitment of an alleged mentally ill person as provided in Section 55 of this Act, the County Court or the Judge thereof shall in each case appoint a Sanity Commission composed of two qualified examiners as provided in this Act and one licensed and actively practicing attorney who shall make a careful personal examination and inquiry into the mental condition of the alleged mentally ill person and execute a certificate of their findings as provided in this Act.
>
> (b) The certificate executed by such Sanity Commission shall contain adequate reasons why the alleged mentally ill persons should be received in a hospital for the mentally ill, and the examiners shall furthermore answer, as far as practicable, from their personal knowledge and from information furnished by competent persons, the interrogatories prescribed by law in the Examiner's certificate. By virtue of the certificate of mental illness and urgent need of custody and treatment and of the petition, the alleged mentally ill person may be received and detained in a hospital, for the care and treatment of the mentally ill. The Sanity Commission form shall be printed or written on eight and one-half inch by eleven inch (8-1/2 x 11") sheets of paper and shall be substantially as follows: (see Appendix C)[36]

A qualified examiner for these purposes appears to be ". . . a licensed doctor of medicine or osteopathic physician who is duly licensed to practice his profession by the Oklahoma State Board of Medical Examiners or the Oklahoma Board of Osteopathic Examiners and who is not related by blood or marriage to the person being examined or has any interest in his estate."[37]

It is in the Sanity Commission and its deliberations that some of the most significant problems seem to develop. This is not a suggestion of malice on the part of the commissions or their membership. It

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[36] 43A O. S. (1961) Sec. 54.

[37] 43A O. S. (1961) Sec. 553.

is probable that they are as honest and well-meaning as any other group of qualified professionals. The three members are compensated for their efforts in a manner that would appear to be adequate, though not lavish. The law authorizes payment of up to twenty dollars for each of the physicians and the attorney plus ten cents per mile for transportation and any other expenses authorized by the judge. In Tulsa County, Judge Mauzy has arranged payment of only fifteen dollars per commitment for the three members of the commission.[38]

The issue that may raise cause for concern is the uneven nature of the Sanity Commission deliberations from county to county and the variation in abilities to diagnose and assess mental illness. In most counties, alleged mentally ill persons are examined by physicians who are not psychiatrists. There are so few psychiatrists in Oklahoma that few are available to serve on sanity commissions in most areas of the state. In the larger cities, such as Tulsa, it is likely that two psychiatrists will serve on the commission. This is not to imply that psychiatrists are inherently better able to identify mental illness than other physicians. Although such an assumption would tend to have a ring of truth about it, it would have to be proven with empirical evidence before it would be acceptable as fact. However, being examined by an osteopath who specializes in orthopedics, which is possible under the law, does not seem to be the same as being examined by a psychoanalyst, which is also possible, when mental illness is the supposed problem. Stated another way, it would seem irrational to visit a psychiatrist for the emergency treatment of a broken limb.

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[38]Interview with Judge Whit Y. Mauzy, November 16, 1965.

This concern is not a matter of conjecture alone. The study conducted of commitment practices in three counties indicated that it was possible mental illness meant different things in each community. In fact, the whole notion of defining mental illness is so ambiguous that one of the more articulate statements by a psychiatrist on the subject calls it a "myth."[39]

The issue of variations in sanity commissions is also of concern to the superintendents of the state hospitals, some of whom find themselves regularly returning committed patients to the county, restored, as the superintendents view them, to mental competence, within a few days of their admission. Dr. Harold B. Witten, Superintendent of Western State Hospital, suggested that many of the physicians who serve on sanity commissions lack psychiatric training. Some know about as much on the subject of mental illness as medical school freshmen, he said.[40] Dr. Witten saw this lack as an important indication of the need for an attorney on the Sanity Commission.[41] When Dr. E. P. Henry, Superintendent of the Taft State Hospital, was asked if he thought the physicians on the sanity commissions were as careful as they might be in recording information, he said that it was doubtful.[42] Dr. Eugene Pumpian-Mindlin, acting chairman of the University of Oklahoma School of Medicine Department of Psychiatry, said that Oklahoma physicians have little psychiatric

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[39]Thomas S. Szasz, The Myth of Mental Illness; Another psychiatrist, Dr. William Glasser, has written in Reality Therapy, that he does not accept the concept of mental illness, (p. 44.)

[40]Interview with Dr. Harold B. Witten, December 21, 1965.

[41]Ibid.

[42]Interview with Dr. E. P. Henry, December 21, 1965.

training and that there ought to be at least two psychiatrists on sanity commissions. Even this, he suggested, did not guarantee an adequate examination of the patient, simply because of the press of cases. An adequate medical history ought to be taken by the commission before it reaches a decision.[43]

Some of the difficulties with the Sanity Commission appeared evident in the commitment study done for this research, which involved the examination of the County Court records only. In Cleveland County, fifteen of the cases had no indication of a specific diagnosis or else the diagnosis was undetermined. For the rest of the cases, a myriad of diagnoses were offered. These included toxic psychosis, mental defective psychotic episode, immature reaction, psychoneurotic anxiety state, nervous, schizophrenia, psychogenic disorder, possible organic brain disorder, possible glandular disorder, dementia praecox, involutional psychotic reaction (melancholia), possible simple schizophrenia, possible paranoia, paranoid schizophrenic, schizoid reaction, manic-depressive, possible simple praecox, psychosis-suicide tendencies, menopause-psychosis, manic depressive psychosis, arteriosclerosis, arteriosclerosis-paranoid tendencies, arteriosclerosis-psychotic, and defined-general confusion. Several of these diagnoses appeared to apply to the same clusters of symptoms. It would seem that similar conditions are called different names, depending upon practices in the county and the backgrounds of the examiners. Other diagnoses, particularly dementia praecox, are no longer

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[43]Interview with Dr. Eugene Pumpian-Mindlin, January 31, 1966.

used in psychiatry, having been replaced by different terms.

As indicated earlier, psychiatric diagnosis is less than an exact science for the most skilled psychiatrist and other physicians simply do not have training as mental health specialists. In addition, there probably are a large number of conditions which may be defined as mental illness and each may be somewhat different. The problem is in the naming. Many of the words used to describe these individuals have most frightening implications. Psychosis, schizophrenia, and paranoia, may mean all sorts of things. And even if the person goes to the hospital and is cured (or found to be not ill after all) and returned to the community, for the rest of his life there will be a legal paper filed in the Cleveland County Court House calling him one of those names.

Dr. Thomas S. Szasz, Professor of Psychiatry at the University of New York Upstate Medical Center in Syracuse, New York, and a qualified psychoanalyst, tends to think of all public psychiatric diagnosis as something of a power game. When he was interviewed, Dr. Szasz discredited all of the public health data on mental illness as misleading. Schizophrenia, which is probably the most common diagnosis of hospitalized mental patients, may be an objective fact, he said. That is, there may be such an illness which randomly strikes members of the population. However, schizophrenia as it is used in the United States, he said, is a political or power term. That is, it is a term used by the strong against the weak. He compared it to calling someone a "nigger." Both terms, he said, justify social control.[44]

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[44]Interview with Dr. Thomas S. Szasz, August 10, 1965.

The thought that using the proper word in defining a person is more an issue of power than one of diagnosis seemed to be verified in the study done of commitments in Tulsa County. In that county, the term is psychosis and no one is committed from Tulsa County unless the Sanity Commission calls the person "psychotic." This researcher asked Judge Whit Y. Mauzy why that diagnosis seemed to always be applied to those who were committed from his court, while those who were not committed were clearly designated, "not psychotic." He replied that psychosis was the term used by physicians in Tulsa County to describe people who are mentally ill in the meaning of the mental health laws or unable to care for themselves within the meaning of that law.[45] The Tulsa County Deputy Court Clerk confirmed that Judge Mauzy committed no one who was not designated "psychotic."[46]

It would appear that the term is used in Tulsa County commitments almost as a code. No matter what else is written on the report of the Sanity Commission, if it says "psychotic," the patient is committed. If it says "not psychotic," the patient is not committed and dismissed as being not mentally ill. The two terms are often underlined or circled on the report. All of those committed from Tulsa County were called psychotics; all of those whose cases were dismissed were called not psychotic or without psychosis. And a variety of problems, ranging from drunkeness to child beating, were represented in the sample. This would tend to confirm the thought expressed by Dr. Szasz.

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[45]Interview with Judge Whit Y. Mauzy, November 16, 1965.

[46]Interview with Pat Williams, Tulsa County Deputy Court Clerk, November 16, 1965.

Calling someone the proper name in the proper place leads to social controls.

In Kingfisher County, the situation was rather different. Of the twenty-five cases studied there, the sanity commissions indicated no diagnosis for five and called their diagnosis tentative in two other cases. Since four other cases were voluntary or not heard before a commission, it seems that the sanity commissions in Kingfisher County over the past several years were unable to arrive at conclusive diagnoses in one-third of the cases examined. . . This does not mean that alleged mentally ill people were not committed. They usually were. They were simply not diagnosed.

There were other materials in the study of commitments which give cause for concern. For example, in the Cleveland County study, several persons were diagnosed as victims of dementia praecox. For several years, according to Dr. Bedford Peterson and a variety of textbooks on psychiatry, this term has been out of use. It has been replaced, according to Dr. Peterson, by the term "schizophrenia." When this was discussed with Dr. Peterson, he was not distressed by this. He indicated that the term had been generally used until ten or twelve years ago and that physicians without close contacts with psychiatry would be likely to continue using it.[47] It appeared to this researcher that physicians who were serving on sanity commissions ought to be sufficiently informed on psychiatry to know of basic changes in terminology during the last several years.

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[47]Interview with Dr. Bedford Peterson, December 21, 1964.

Another matter was the notation under the heading of "family characteristics" in some of the reports of the commissions that the family was "thrifty." Such a description seemed to be meaningless for a psychiatric diagnosis and far removed from professional assessment or practice. The degree of family thrift would not appear to be the sort of information on family characteristics being sought. In other words, it was as if lay people were talking about their neighbors, rather than professional people rendering a diagnosis.

These variations are crucial for a number of reasons. The commitment may or may not lead to long-term hospitalization. The superintendents of the hospitals said, and the study of commitments confirmed, that some individuals who are inappropriately sent to the institutions are rapidly returned to the community. That is, the superintendents think that they avoid keeping people who do not need hospitalization. However, all of the things which go along with commitment, particularly the loss of civil rights, are not dealt with in a discharge. The hospital may issue a certificate of restoration to competency, but this does not, as is discussed in Chapter V, restore the person to legal competency. Therefore, the effects of commitment may be long-lasting, even when the patient is immediately released from the institution. In addition, being called schizophrenic or psychotic by two physicians in a hearing, the findings of which remain public information forever, can also be damaging.

Serving as the third member of the Sanity Commission is an attorney. His role and the way in which he plays it is pertinent. It would appear from the statutes that the role of the attorney is to insure that the person being examined is afforded due process and that the

person's rights are upheld.[48] Property is also of concern to the attorney, who makes a recommendation on whether or not a guardian should be appointed, an issue which is developed further in Chapter V.

Although it may sound as if the attorney's role is to represent and protect the alleged mentally ill person, this is not necessarily the case. In fact, he is an agent of the state and is appointed by the County Judge. His role is to guarantee that the alleged mentally ill person is dealt with constitutionally so that his commitment, if this is the result, is a valid one. He may be opposed to the position of the potential patient and thus should not be seen as representing that person. Essentially, it would appear that he represents the other members of the commission and the judge, guaranteeing their ability to do what they wish to do. Of course, the issue is not a clear one since protection of a person against denial of due process must also be assumed an effort on behalf of that person.

In Tulsa County, Judge Whit Y. Mauzy described the role of the commission attorney as that of an "officer of the court." He sees that proper notice is given to relatives and that the person is examined by qualified examiners, as specified in the law. The attorney determines that all of the person's rights are explained to him and that he is advised of all of these, including the right to jury trial. Judge Mauzy uses the attorney in highly specific ways to ascertain some of the facts of the case. If the patient does not appear before the court, the attorney must explain why and certify to the judge that such an appearance

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[48] 43A O. S. (1961) Sec. 54.

would be dangerous or unsuitable. If a spouse is the petitioner, the attorney is asked by Judge Mauzy if marital difficulties are the basis of the complaint. Several attorneys are used by Judge Mauzy for this work. He draws from a pool of seven or eight lawyers.[49]

In Kingfisher County, Judge Francis Borelli presented the same sort of opinion. He agreed that the commission attorney does not represent the patient. Rather, he checks on the civil rights issues, guarantees due process, investigates notices, and generally, in the judge's words, "keeps the judge straight."[50]

Oklahoma's position is actually different than that of other states. It is one of only four jurisdictions which includes a non-medical person on the examining committee.[51] It is also a state which uses the Sanity Commission not for a mandatory final decision but for a recommendation to the County Judge, who is the only person who may commit the patient to a hospital.[52] It is also a state which does not specify the place of the hearings. That is, the proceedings for commitment of a person to a hospital need not be carried out in court.[53] In fact, most of the hearings in Cleveland County take place at the Central State Hospital, where patients are detained on an emergency basis.

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[49]Interview with Judge Whit Y. Mauzy, November 16, 1965.

[50]Interview with Judge Francis Borelli, December 20, 1965.

[51]Lindman and McIntyre, Jr., op. cit., p. 24. (The others are Florida, Pennsylvania and the District of Columbia.)

[52]Ibid., p. 25.

[53]Ibid., p. 53.

Right to Counsel and Psychiatric Representation

A right which has increasingly been granted to persons who may lose their liberty because they have committed crimes is the right to counsel. Through a number of court decisions, persons accused of the whole range of criminal activity are more and more often required to be represented in court. Many of the reform measures proposed for the penal system use this as a central concept. Persons who are likely to lose their liberty because someone thinks they are mentally ill are less often represented by counsel and the reforms proposed for procedures involving mental illness focus on making them less judicial.

Richard Arens represented the American Civil Liberties Union before the subcommittee on rights of the mentally ill and summarized the issue concisely:

> The most elaborate safeguards are established to protect the individual accused of crime. Provisions are made to secure arraignment within 24 hours and within Federal jurisdiction within a reasonable period of time, which the courts have interpreted to be less than that.
>
> . . . . Where mental illness is involved, we have proceeded to allow individual psychiatrists a latitude in discretionary power which we have not seen fit to accord to any of our other officials, be they judicial, legislative, or any that you may visualize.
>
> This appears to me to be justifiable solely upon the assumption that psychiatrists are possessed of a virtue which is not available to other mortals . . . .
>
> The mentally ill patient, speeded on his way to his place of incarceration in a mental hospital, has no comparable statutory assurance of a speedy and impartial review, judicial review, that the person accused of a crime has . . . .
>
> I feel very strongly that assistance of counsel is essential to due process, and I feel even more strongly that assistance of psychiatrists not connected with the

> institution to which a given person is committed is essential for the same reason. That does not mean that it need not be a publicly employed psychiatrist; it may well be. But it should not be a psychiatrist whose institution has made the recommendation of commitment.[54]

Oklahoma does not provide for the appointment of counsel for persons alleged to be mentally ill. There is no specific provision guaranteeing the right to employ private counsel but there is a statement in the statutes on mental health which assigns the county attorneys the responsibility of representing the state when alleged mentally ill people do employ personal counsel.[55]

The national position is outlined by the American Bar Foundation study and it seems to indicate that Oklahoma is behind other states in the provision of counsel:

> Only seventeen states provide for the appointment of counsel in all hospitalization cases in which the person alleged to be mentally ill has none. Thirty-five jurisdictions merely provide that the patient has the right to be represented. Seven jurisdictions provide that such appointments may be made at the discretion of the court, and in five states appointment is mandatory in the event the patient requests counsel . . . .
>
> Given ideal conditions, every patient would be represented at the hospitalization hearing by counsel, either personally retained or court appointed. This would be no greater protection than that accorded every indicted felon under the prevailing statutory guarantee. Both groups are subject to a deprivation of liberty through custody or confinement. If a distinction is to be drawn between these two groups, then it is the mentally ill who should be given the benefit of more extensive procedural guarantees. With rare exception, the mentally ill person will be less likely than the

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[54] U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 209-210.

[55] 43A O. S. (1961) Sec. 4.

> felon to comprehend the nature of the proceedings and its consequences . . . .
>
> Counsel must guard not only against scheming relatives but also against incompetent and lax medical judgment and the improper extension of hospitalization requirement to borderline cases.[56]

Not dealt with in the foundation report is the call issued by Mr. Arens for the appointment of a psychiatrist to aid in the defense, along with a court-appointed, if necessary, attorney. This is a matter upon which Dr. Thomas S. Szasz has expressed himself. In an interview he suggested that the allgged mentally ill person, who is called the "victim" by Dr. Szasz, be represented not only by an attorney but by psychiatrists. And the psychiatrists should be of the same number and the same eminence as those representing the state or the family. He added that few psychiatrists could be found to play such a role. Much like the history of law, when few attorneys would take the case of an unpopular client, the psychiatrist will typically not defend an unpopular case. There should be payment, Dr. Szasz concluded, for psychiatrists who assist in defense.[57]

Dr. Eugene Pumpian-Mindlin said that the practice of having psychiatrists opposing each other in court was a poor one. Ideally, a court-appointed psychiatrist would present evidence in commitment and competence cases. The court would then evaluate that testimony. But psychiatric representation for one side or the other is not desirable, he said.[58]

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[56]Lindman and McIntyre, Jr., op. cit., p. 29.

[57]Interview with Dr. Thomas S. Szasz, August 10, 1965.

[58]Interview with Dr. Eugene Pumpian-Mindlin, January 31, 1965.

It would appear, from research done in connection with this project, that few alleged mentally ill persons in Oklahoma have any sort of representation, other than the Sanity Commission attorney, whose role should not be confused with that of personal counsel. Cleveland County Judge J. David Rambo estimated that one per cent of all the persons coming before his court on allegations of mental illness are represented by an attorney.[59]

In the entire study of one-hundred and twenty-five commitment cases only four persons were definitely, from the evidence, represented by attorneys and all of these had jury trials. These cases represented the only jury trials in the sample. Although one might assume that representation by an attorney would virtually assure better prospects for dismissal of the case, only two of the four who were represented had this occur. The other two were committed.

However, the significance of representation of the alleged mentally ill person in Oklahoma should not be underestimated. It would seem that the person is rarely represented in the state of Oklahoma, particularly if he is interested in not being committed. It is possible for him, in fact, to face a Sanity Commission composed of some persons who have asked for his commitment in the first place. In the Tulsa County sample, there were cases of a psychiatrist determining that a patient of his needed to be committed. He would suggest this to the family and would then turn up, himself, as a member of the Sanity Commission. When this sort of practice was discussed with Judge Borelli

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[59]Interview with Judge J. David Rambo, December 20, 1965.

of Kingfisher he said that he would often appoint the physician to the Sanity Commission who was requested by the petitioner. He explained that a physician who testifies under oath and certifies a person's mental condition in court must tell the truth, as he sees it.[60] While one may readily accept the honesty of physicians, it must also be noted that the physician may have determined the truth long before the Sanity Commission meets. This may mean, and the example is not far-fetched, that a person may refuse to accept treatment for mental illness from a particular physician. That physician may encourage the family to have the person committed, because he is rebelling against treatment. That same person may then face a Sanity Commission with his adversary sitting as a member. Thus a physician may serve as accuser, jury, and judge, for the alleged mentally ill person.

It is likely that physicians who have been involved in cases should not be appointed to the sanity commissions which handle them. It is also likely that those who wish to protest their commitment must be represented by counsel and, ideally, independent, psychiatric experts, if their protest is to have any meaning.

Trial by Jury

According to the American Bar Foundation study, Oklahoma is one of thirteen jurisdictions providing for a jury to decide the issue of hospitalization.[61] State law provides:

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[60] Interview with Judge Francis Borelli, December 20, 1965.

[61] Lindman and McIntyre, Jr., op. cit., p. 28.

> . . . . If the court or the judge thereof shall deem it necessary, or if such alleged mentally ill person, or any relative, or any person with whom he may reside, or at whose house he may be, shall so demand, a jury of six (6) freeholders having the qualifications required of jurors in courts of record, shall be summoned to determine the question of his mental illness, and whenever a jury is required the court shall proceed to the selection of such jury in the same manner as provided by law for the jurors in County Court, and such jury shall determine the question of the mental illness of the alleged mentally ill person. The jurors shall receive the same fees for attendance and mileage as are allowed by law to jurors in the County Court.[62]

Ten states use the system of providing a jury trial only when it is demanded by the patient or someone on his behalf. Only Michigan and Oklahoma provide for the court's requiring a jury trial when this is deemed necessary.[63]

Trial by jury is considered by many to be an archaic and objectional feature of mental health practices. Some, according to the American Bar Foundation report, compare it to asking the neighbors to diagnosis serious physical illnesses. Others say that jury trials do not even reduce the possibility of wrongful hospitalization.[64] The study conducted by the Foundation comments upon some of the questions it raises.

> While one may concede that these points, if true, are damaging to the case for the continued use of the jury system, they are certainly not conclusive. Moreover, some of the criticisms are inaccurate or unjustified. For example, it has been urged that a jury consisting of laymen is not competent to express a viewpoint on the medical condition of the patient. The jury is not ask

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[62] 43A O. S. (1961) Sec. 55

[63] Lindman and McIntyre, Jr., op. cit., p. 28.

[64] Ibid., p. 27.

> asked, however, to diagnose the illness of the patient. It has only to decide on the basis of the medical evidence submitted to it, for the most part by experts, whether the patient's illness is of such a nature that the statute requires his hospitalization.[65]

Part of the reason for the retention of jury trials in some states is the legal history of the state and constitutional provisions guaranteeing trial by jury. Attempts to abolish jury trials would be met in some states with the argument that the right to trial by jury is constitutionally guaranteed.[66] Whether or not this would be the case in Oklahoma would seem to depend upon cases arising out of such an action.

It may be assumed that there is no great enthusiasm for jury trials in Oklahoma mental health procedures, on anyone's part. For example, Judge J. David Rambo of Cleveland County, said that he has had only one jury trial on a mental health case in the three years he has served as County Judge. And that person was committed, by the jury, to hospitalization.[67]

When he was interviewed, Dr. Bedford Peterson, Eastern State Hospital Superintendent, thought that the request for a jury trial might be evidence of one kind of illness, itself. He noted that those with whom he had experience in Tennessee, where he also directed a state hospital, were usually paranoid when they requested such trials.[68]

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[65] Ibid., p. 28.

[66] Ibid., p. 29.

[67] Interview with Judge J. David Rambo, December 20, 1965.

[68] Interview with Dr. Bedford Peterson, December 21, 1964.

In the cases examined for the commitment study, only four involved a trial by jury. All of these were in the Tulsa County sample. Two of these cases ended in a commitment to Eastern State Hospital and two had their cases dismissed. The first of these cases involved a sixty-eight year old retired registered nurse. At the apparent urging of her physician, the woman's daughter initiated commitment proceedings. The Sanity Commission diagnosed her as suffering from an unclassified psychosis. She was belligerent, used bad language, and displayed other kinds of behavior which was disturbing. She demanded a jury trial and was found not mentally ill. Her case was dismissed.[69] The second case involved a sixty-four year old man who was a retired automobile dealer. Also at the urging of his physicians, his wife and daughter initiated commitment proceedings. He was found to be a victim of organic brain syndrome without psychosis, which would mean, in Tulsa County, that he was not mentally ill. He refused to stay in his nursing home, was not able to reason adequately, and felt that his family was mistreating him by keeping him in the nursing home. His case, also, was dismissed.[70]

The two other cases identified in the Tulsa County sample involved a forty-three year old woman who was diagnosed as a victim of Huntington's Chorea by the Sanity Commission and whose daughter, at the suggestion of a physician, was her petitioner, and a thirty-eight year old woman whose brothers petitioned for her commitment and who was diagnosed as a

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[69]Commitment Study, case T-10.

[70]Ibid., case T-11.

schizophrenic with a paranoid psychotic reaction. Both cases went to juries and both persons were found to be mentally ill and committed.[71]

When interviewed, Judge Whit Y. Mauzy said he believed that the majority of juries in mental health cases committed the people who requested jury trials.[72]

Dr. Hayden Donahue, Superintendent of Central State Hospital, noted that he had been involved in writing the new Texas mental health laws, which are considered model examples, and which eliminated the mandatory jury trial for mental illness which had been used in that state. When it was utilized, Dr. Donahue believed, it was somewhat farcical. Typically, a patient would be committed to a hospital. Then a number of attendants would be rounded up to serve as a jury. They would determine whether or not the patient should remain in the hospital. But everyone had a jury trial in Texas![73]

Despite the criticisms of using juries to determine mental illness, it appears that in the sample studied at least one person who did not want to be committed did not have this action taken against her because she had access to a jury. Under these circumstances, there may be validity to the provision. Of course, it can also be used to thwart the decision of the Sanity Commission, by a family that wants a person committed but cannot achieve this through the non-jury proceedings.

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[71] Ibid., cases T-18 and T-28.

[72] Interview with Judge Whit Y. Mauzy, November 16, 1965.

[73] Interview with Dr. Hayden Donahue, November 23, 1964.

Jailing of Mentally Ill Persons

In Oklahoma persons who are alleged to be mentally ill may be held in a jail for as long as thirty days while their mental illness is being adjudicated:

> Pending such proceedings for admission into the hospital, if it shall be made to appear to the satisfaction of the County Court or the judge thereof, upon medical evidence or other competent testimony, that the alleged mentally ill person is violent or his condition is such that he may injure himself or others, then the court or the judge thereof may order to be issued an order directed to the sheriff or other peace officer within the county in which such petition is filed, for the detention of such alleged mentally ill person in some suitable place, until such petition can be heard and determined; provided, however, that the period of such temporary detention shall not exceed thirty (30) days.[74]

The suitable place mentioned in the law typically is interpreted to mean a jail. Dr. Hayden Donahue indicated, when he was interviewed, that the great majority of persons who are admitted to Central State Hospital are sent to a county jail first. Part of this is because of the requirement of notice, (discussed earlier in this chapter) and part because there is no other suitable public facility in most communities. A great effort has been made, Dr. Donahue said, in Oklahoma to convince communities to make other kinds of facilities available for emergency detention. However, these efforts have generally been unsuccessful. The psychiatrists insist, he says, that a jail is not a suitable place for such detention. The "legal people" disagree and insist that there is no other facility which can be used to guarantee the protection of the person and the public.[75]

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[74] 43A O. S. (1961) Sec. 55.

[75] Interview with Dr. Hayden Donahue, November 23, 1964.

The 1965 legislature made it mandatory for persons detained because of mental illness to have the right to contact a friend or relative. Specifically, the statute requires any public or private facility in which a person is detained while awaiting a sanity hearing, examination, or treatment, to provide that person with the right to contact a friend or relative immediately.[76]

Cleveland County is one of the few jurisdictions where alleged mentally ill people are not normally jailed. Judge Rambo objects to the use of the jail for mentally ill people, as do many others, and has arranged for patients to be taken to the Central State Hospital for detention when they are picked up. But, he explained, this is an individual arrangment that he has made with Dr. Donahue. It is an arrangement that Dr. Donahue could terminate at any time. If the arrangement were terminated, Judge Rambo would appear to have no other choice than the jail for the emergency detention of alleged mentally ill people.[77]

Most judicial officials in Oklahoma see the use of jail as a direct result of there being no other suitable place for emergency detention of mentally ill people. Judge Whit Y. Mauzy of Tulsa County indicated that this is considered a significant issue but that there is simply no money for hospital rooms, which may cost as much as thirty dollars a day. Persons who have sufficient funds are taken to other kinds of facilities, such as psychiatric wards of general hospitals.

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[76] 43A O. S. Supplement, 1965, Sec. 451.

[77] Interview with Judge J. David Rambo, December 20, 1965.

A special section of the Tulsa County jail is set aside for mental patients awaiting their hearings. They are separated from those accused of or serving time because of criminal acts. Judge Mauzy considers these facilities inadequate but notes that there are insufficient funds for any other arrangement.[78]

Dr. Bedford Peterson suggested some solutions for the current practice of incarcerating mental patients. One, he noted, would be the elimination of the waiting period, which was the practice in Tennessee and which allowed for an inquisition on the same day. Another solution might be immediate detention of the patient at Eastern State Hospital. County judges could then come to the institution and hold the hearing. Judges from larger communities, which have a large number of commitments, could visit the hospital once each week and conduct hearings. There are no legal reasons why such a plan could not be utilized, Dr. Peterson said.[79]

Of all the issues related to the civil rights of the mentally ill, that of jailing patients has probably had more recent attention than any other. Some newspaper articles have been devoted to it, along with two reports of the Oklahoma Mental Health Planning Committee. The surveys done on the subject by that committee provide some interesting data but, judging from the reports themselves, it would probably be unwise to use them as a basis for fact. The two reports indicated are those on views expressed by county judges and the report on Detention of the Mentally Ill, based upon a questionnaire mailed

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[78]Interview with Judge Whit Y. Mauzy, November 16, 1965.

[79]Interview with Dr. Bedford Peterson, December 21, 1964.

to sheriffs throughout the state. For a variety of reasons, these reports can only be assumed to reflect the attitudes of those sheriffs and judges who answered their respective questionnaires. The survey does little more than tabulate and list these answers. There was apparently no effort to cross-check these responses with field data from the counties, although some of the questions reflect the results of some data-gathering which was done in 1962. It would seem that there is real question about the wisdom of accepting as valid answers given by sheriffs and judges. Actually, statistics are not kept by county officials. Rather, each case is an entity and is entered in a docket and filed as a case. In the research done for this study, this student found the judges to be less than ideal generalizers. Their tendency seems to be one of thinking on a case-by-case basis. In fact, the law and law enforcement officers are probably more inclined to specify than generalize. One does not find great interest in mores, norms, and other social science concepts among judges and sheriffs. This is substantiated by the discrepancies between the notions expressed by judges about the people who appear before them for commitment and the data uncovered in the study of commitments.

Another matter which raises question about the validity of the planning committee reports is an obvious bias. For example, the introduction to the report on county judges' views begins, "The detention of mentally ill patients in jail prior to their commitment is one of the most regrettable problems of our age."[80] This is despite

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[80]Oklahoma Mental Health Planning Committee, Report Number Three, p. 1.

the fact that the report says nothing in its title about using the issue of jailing patients as a core issue. More likely, this was an issue of great concern to the persons involved in designing and presenting the report. There are other sides to this question as there are to most. For example, one could call a couple of days in jail insignificant to someone who is about to spend an indeterminate period, perhaps against his will, in a mental hospital. On that basis, any uproar about jailing mentally ill people could be termed a phony issue, designed to hide the gross deprivations arising out of commitment itself. Another viewpoint might be that this reflects on the inadequacy of Oklahoma jails, rather than mental health laws. Public detention facilities should, perhaps, be adequate for detaining mentally ill people. If they are not, it is probably because they are inhumane for any group of persons, including law offenders. Some writers who are interested in the issue of criminal responsibility and mental illness tend to believe that some recent redefinitions of persons once deemed evil as sick, instead, suggest that the primary reason for this is the unwillingness of some officials to send anyone to prison. It is more humane, they believe, to define someone as sick than to convict him of a crime. For the former, he becomes a patient in a hospital which is far superior to becoming a prisoner in a jail.[81]

With these limitations plus the recognition that the committee's research methodology and analysis is less than sophisticiated, there may be some meaningful data in the various reports.

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[81]Thomas S. Szasz, M. D., The Myth of Mental Illness and Law, Liberty and Psychiatry.

One question asked the county judges what percentages of their commitment cases were detained in jail while awaiting a hearing. Most of the judges indicated that less than twenty-five per cent of all those awaiting commitment hearings were detained in jail. Both metropolitan judges, nine of the urban judges, and twenty-seven rural judges used this estimate. Five urban judges and five rural judges said that between one-fourth and one-half of their cases spent some time in jail, while two urban judges and one rural judge indicated that between one-half and three-quarters of all their cases were jailed. Four rural judges said that more than three-quarters of the cases spent time in jail and two judges did not comment.[82]

Materials gathered in the commitment study done for this research seem to indicate that the percentage of persons detained in jail or those who would have to be in jail if there were not other facilities, is higher than indicated. In Tulsa County, which the planning committee would call a metropolitan county, nineteen of the fifty cases studied involved detention in prison. In Cleveland County, thirty-eight of the fifty cases studied were detained at Central State Hospital. Were it not for the special arrangement between the Cleveland County Judge and the hospital, it is presumed that most of these would require detention in a jail. In Kingfisher, six of the twenty-five cases studied involved jail detention. Only Kingfisher County has the relatively small percentage of detentions indicated in the planning committee's report. It would seem apparent from the data gathered in Tulsa

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[82]Oklahoma Mental Health Planning Committee, Report Number Three, p. 7.

and Cleveland counties that a relatively large number of patients require detention, according to the definitions of those requirements in the law. In Tulsa County more persons were detained in hospitals than in jail. However, this reflected two special characteristics. First, several of these were in a hospital when the commitment was made and, second, those who were detained in a hospital had sufficient funds to pay for this kind of detention.

TABLE 2

DETENTION OF ALLEGED MENTALLY ILL PERSONS

Place of Detention

County	Jail	Public Hospital	Private Hospital	No Detention Indicated	Per Cent Jailed
Tulsa	19	0	21[a]	10	38%
Cleveland	0	38	0	12	0[b]
Kingfisher	6	0	4[a]	15	24
	25	38	25	37	

[a]Include patients in nursing homes.

[b]Due to special arrangement with Central State Hospital.

Another question asked the judges related to the number of "emergency hearings" conducted during 1962. Their point seemed to be that emergency hearings could be held to provide for hospitalization quickly and avoid the necessity of jailing the patient. Their report says, "The interpretation of 'emergency' ranged all the way from

including all sanity cases before the judge to the assertion that no such situation existed."[83] The committee says that the question caused misunderstanding. The reason for this may be that there is no provision in the law for any emergency commitment. The hearing must be held after at least one day's waiting period and before thirty days have elapsed. There is provision for emergency detention.[84] The judges answered the question anyway, although twenty-one of the fifty-seven who responded to the survey indicated that they held no emergency commitments. One said that the court calendars are set up to handle these cases speedily.[85] The judges went on to answer more questions about the reasons for emergency hearings and the reasons for detention of three to five days.[86] However, these responses would seem to lack meaning since there is no such thing as an emergency hearing in Oklahoma and since most judges tend to hold hearings on mental health rather promptly.

Another question raised by the committee asked why mental patients are kept in jails rather than hospitals. Twenty-one judges said that the hospitals would not admit such patients, eighteen indicated that no other facilities were available, fifteen said there were no funds available to pay for hospital care, thirteen said they relied on prompt hearings and transfer to state hospitals, rather than using local

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[83] Oklahoma Mental Health Planning Committee, Report Number Three, p. 8.

[84] 43A O. S. (1961) Sec. 55.

[85] Oklahoma Mental Health Planning Committee, op. cit., p. 8.

[86] Ibid., pp. 9-10.

facilities, six said that the county lacked a hospital, three said that the family lacked sufficient funds for hospital care (one of these was a metropolitan judge), three said the county did not detain patients in jail, two said they had access to a state hospital for the mentally ill, and one said he was unable to induce the doctor to hospitalize the patient. Five judges did not comment.[87]

The Oklahoma Mental Health Planning Committee's study of the practices followed by county sheriffs in detaining mentally ill persons and persons alleged to be mentally ill also seemed to seek the answers to highly specific questions. Some of these reflected upon the quality of the work done by the sheriff and would not, perhaps, elicit candid answers.

First of the questions asked the sheriffs was whether persons who were awaiting hearings and transfers to state hospitals were held in jail or hospitals, or both. Of the fifty-one sheriffs who answered the questionnaire, thirty-five said that they used the jail as the emergency detention facility, one said that a hospital was used, and fifteen indicated the use of both kinds of facilities.[88]

The second question asked, on the basis of other research and reports, how many deaths and suicides there had been among mental patients who were awaiting transfer to state hospitals. Based upon the survey, the committee found: " . . . . that there is no apparent problem in connection with deaths and suicides among mental patients awaiting

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[87] Ibid., p. 16.

[88] Oklahoma Mental Health Planning Committee, Report Number Three, p. 6.

transfer. Only one sheriff reported a death during the past year and this death was due to a heart attack. There were no suicides reported and only one sheriff indicated that there had been an attempt at suicide."[89] After reporting this conclusion and recording it on a three-by-three table, the report says:

> The reported mortality and morbidity rate may not be the accurate figures. A partial survey of newspaper articles published during the time period of the survey indicates that five deaths occured among mentally ill persons in jail.[90]

The third question asked for similar data for the past five years:

> The results of question 3 served to substantiate the conclusion drawn from the responses to the previous question that there is virtually no problem with respect to mortality among mental patients awaiting transfer. The sheriffs reported that, within the past five years, there were only two deaths and one suicide. There were three attempted suicides reported and one sheriff indicated that statistics in his county are 'not known.'[91]

Question No. 4 asked for the number of mental patients who have had serious physical illness or injury while in custody during the last year.

> Taking into consideration the large number of respondents and mental patients and the number of days they await commitment or transfer to a mental hospital, the replies to this question would indicate that sheriffs experience very few problems in connection with serious illness or injury with persons under their custody. One metropolitan sheriff simply stated that 'some were' without including an exact figure. No cases of illness or injury were reported from the urban counties.[92]

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[89] Ibid.

[90] Ibid., p. 7.

[91] Ibid.

[92] Ibid., p. 8.

Since the committee says that twenty-six sheriffs, or thirty-four per cent did not reply to the questionnaire,[93] it is possible that those who did experience deaths or injuries among the mentally ill did not answer the survey. Although a sixty-six per cent response to a mail questionnaire may be considered good and capable of providing valid information, this would not necessarily be true if the non-responding counties included some where such deaths or injuries did occur.

This material would tend to indicate serious gaps in the data. Despite this, however, the committee refers to the results as "encouraging"[94] and concludes:

> The problem of serious illness or injury among mentally ill persons in detention, over the past year, is also quite low but, the need for conscientious care and supervision is great. The mortality and morbidity rate among mentally ill persons may not be complete as reported.[95]

It would appear difficult to justify a conclusion that the results are encouraging along with an admission that mortality and morbidity rates may not have been completely reported. This is particularly true when such reports do not correspond to the committee's own findings in examining newspaper stories.

The latter part of the report on practices of sheriffs allowed for the sheriffs to respond, at will, to open-ended questions. Most of the responses indicated that the sheriffs were unhappy about having to jail mental patients, although most acknowledged that there was no better

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[93] Ibid., p. 2.

[94] Ibid., p. 8.

[95] Ibid., pp. 20-21.

way to handle them. Several expressed their pleasure at the co-operation given them by doctors and hospitals, although most said they could not have patients admitted to the hospitals because of hospital policies or charges. Some were pleased that physicians would help them by giving patients shots to quiet them, either in the hospitals or at the jail. Some of the comments are:

> We think here jail is no place for a mental patient because we are not fixed for taking care of them. I believe jail scares the patient and makes them worse.
>
> It works a hardship on law enforcement to handle mental patients when we do not have the facilities to do so.
>
> We are not really equipped to take care of mental patients but have kept them in the past without any serious trouble except for some damage to cell equipment.
>
> It has been a wonder that we have not had some serious problems since we just have two big cells to hold our prisoners. When we get ready to send them off we have to run them down in a big enclosure . . . .
>
> About the only problem we have is the lack of facilities such as a padded cell, etc.[96]

Apparently, the research done with the sheriffs was also geared to make a point -- that mental patients should not be jailed and that hospitals would be more adequate. The sheriffs were willing to agree that jail is an inappropriate detention facility for the mentally ill but the committee seemed unable to gather data which would justify the conclusion. All the committee arrived at was that a county jail is an undesirable place. This was not in dispute before the study was made.

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[96] Ibid., pp. 10-19.

Some of the committee's conclusions do have significance:

> The majority of counties make use of the facilities of the county jail as the main means of detention while a smaller number use both the jail and a local hospital . . . .
>
> Detention in the local jail is far from the ideal approach to the problem. Strong support exists for additional facilities in the local hospitals where it is felt more adequate care could be provided with a minimum danger of personal injury to the individual patient or to others.[97]

Oklahoma is not the only state faced with the problem of jail being used for the detention of the mentally ill. The American Bar Foundation report says that "The jail is apparently a permissible place of detention for the mentally ill in most states."[98] The report notes that some states have prohibited the practice of jailing mentally ill people or established that jails may be used only when they have special facilities for the mentally ill. But many of these laws are ineffective. "In Indiana, for example, ten years after the passage of a statute prohibiting the detention of the mentally ill in jails, a special committee was established to study methods for the enforcement of the law."[99]

Several things may be concluded from this information. Oklahoma -- and most other states -- uses jails for the emergency detention of the mentally ill. The reasons for this are varied but most of them seem to turn on the dual lack of facilities and funds. In value terms, this is probably undesirable. Most would agree that jailing persons who have

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[97] Ibid., pp. 20-21.

[98] Lindman and McIntyre, Jr., op. cit., p. 39.

[99] Ibid.

not committed a crime is less than ideal. The great concern over this issue, however, would seem as much a reflection on the quality of the jails as on mental health practices.

The whole issue of jailing would appear to only highlight the essential question of involuntary commitment. That is, should persons who have not committed a crime be denied their liberty? Whether it is deprivation of liberty in a jail for a few days or deprivation for a lifetime in a mental hospital would seem irrelevant to the basic issue.

Transportation to the Hospital

A rather specialized issue was mentioned by Dr. Harold B. Witten, Superintendent of Western State Hospital, when he was interviewed. Although it is not required by law, he said, most counties seem to use peace officers, such as sheriffs, to transport their committed patients to the institution. This goes further than the law demands in treating the mentally ill as if they were offenders.[100] The only legal requirement is:

> . . . . The court or the judge thereof may appoint a proper person or persons to take such mentally ill person to the hospital, home or retreat, who shall each receive, as pay for such services, the sum of Three Dollars ($3.00) per day, together with necessary expenses.[101]

So transportation for a committed patient may be provided by anyone designated by the court.

Special protection is given women being transported to institutions

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[100] Interview with Dr. Harold B. Witten, December 21, 1965.

[101] 43A O. S. (1961) Sec. 55.

and between institutions in Oklahoma. The law requires the assistance of females with female patients and this is an allowable expense.[102]

There are special provisions in Oklahoma law for the transfer of patients from institution to institution, although this relates primarily to transfers to federal hospitals, the return of patients to the state of their residence, or the acceptance of patients from other states, into Oklahoma hospitals.

The issue of transfers is handled in the laws on mental health[103] and in the Interstate Compact on Mental Health, of which Oklahoma is a member state.[104] The compact provides for some protections such as notice before a transfer is made to the patient's family, treatment of persons in one member state if they are citizens of another member state, and an admonition that jail be used only when it is impossible to detain patients elsewhere.

Unwarranted Commitment

It is a misdemeanor in Oklahoma for anyone to participate in the involuntary commitment of a person who is not mentally ill, if that person's actions are willful, negligent, or conspiratorial:

> Any person who shall knowingly contrive or conspire to have ordered or admitted any person to an institution for the mentally ill, or mentally retarded, unlawfully or maliciously shall be guilty of a misdemeanor, and upon conviction, shall be fined not to exceed One Thousand ($1,000.00) Dollars or con-

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[102] 43A O. S. (1961) Sec. 100.

[103] 43A O. S. (1961) Sec. 71, 72, 188.

[104] 43A O. S. (1961) Sec. 501-506.

> fined in jail not to exceed one (1) year or both.[105]

Physicians are dealt with specifically in the statutes:

> Any physician who falsely certifies to the mental illness or mental retardation of any person, or whose false certificates as to mental illness or retardation of any person is proved to be the result of negligence or deficient professional skill, or who signs such a certificate for pecuniary reward, or promise thereof, or other consideration of value or operating to his advantage, other than the professional fee usually paid for such service, shall be guilty of a misdemeanor, and upon conviction thereof, shall be sentenced to pay a fine not to exceed Five Hundred ($500.00) Dollars, or to imprisonment not to exceed one (1) year, or both.[106]

According to the American Bar Foundation, twenty-eight states provide for this sort of protection, nineteen making the crime a misdemeanor and nine a felony.[107] The report also notes that patients who are so committed have recourse to common law remedies:

> The essential element of such an action is that the defendant must be shown in some way to be responsible for the unlawful confinement of the plaintiff; however, confinement authorized by process regular on its face and issued by a court of competent jurisdiction is lawful and cannot result in an action for false imprisonment even though process was erroneously or improvidently issued.[108]

There appears to be a rather widespread feeling that improper or unwarranted commitment of a malicious kind is unusual. When asked if he had had experiences with "railroading" mental cases, Dr. Francis J.

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[105] 43A O. S. (1961) Sec. 131.

[106] 43A O. S. (1961) Sec. 139.

[107] Lindman and McIntyre, Jr., op. cit., p. 153.

[108] Ibid.

Braceland, who represented the American Psychiatric Association and the National Association of Mental Health before the Senate Subcommittee on Constitutional Rights of the Mentally Ill, said, " . . . I may lead a protected life but I really haven't really run into that."[109]

Dr. Manfred Guttmacher of the Supreme Bench of Maryland told the committee:

> Too often the concern of those who would protect society is centered upon the fear of an individual being committed to a hospital when there is no justification of it. The horror generated in the minds of most persons at such a happening must be in part due to the images of ancient Bedlam which are so frequently conjured up, and to the analogy between false commitment and false imprisonment for crime.
>
> As reprehensible as being improperly committed to a psychiatric hospital may be, it is a wrong to which there exists prompt and ready redress legally, and this is a much more cumbersome and difficult problem in the case of false imprisonment.[110]

He added that the real problem was the provision of adequate care for the sick.

The Oklahoma Mental Health Planning Committee asked the county judges if they had ever experienced attempts at improper commitment and further asked the judges to describe one of these. The answers ranged from recollection of more than one hundred cases to indignant comments. Keeping in mind the limitations on the validity of these reports, the responses of the judges are interesting:

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[109] U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 70.

[110] Ibid., p. 150.

> Responses . . . show that twenty-three Rural judges recalled no such incidents. Fourteen judges reported attempts of improper commitments; none of these reported more than five such cases; four of these stated no specific number, and four reported only one such personal experience.
>
> The Urban county judges reported a total of forty-nine attempts. Forty of these were reported by one judge; another judge reported six cases. Nine judges reported no experience of attempted 'railroading' of persons by commitment to a mental institution.
>
> The judge reporting forty attempts at improper commitments indicated that these were attempts to abridge the civil rights of an individual rather than an attempt to take over personal property.
>
> The Metropolitan judges gave a combined total of one hundred and one instances of attempts at improper commitments. One judge estimated experiencing one hundred of these attempts. The major cause was felt to be due to marital difficulties coupled with a falsified medical history. This reason was prevalent in all three types of counties.
>
> It was felt that at least six judges saw this question as an attack upon the integrity of the court. Half of these were Rural judges and half were Urban judges. These responses ranged from 'Never' to 'I do not allow such cases into my court.'; in either instance, the simple 'Yes' or 'No' reply was avoided.[111]

Since the definitions of improper commitment are so precise in the statutes, it would seem difficult for anyone to arrive at any statistics on improper commitment, without counting convictions under those statutes.

Proposals for Reform

There are probably as many criticisms of involuntary commitment

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[111]Oklahoma Mental Health Planning Committee, Report Number Three, p. 13.

practices as there are practices. While no attempt will be made to cover all of these, a discussion of those suggested by Oklahoma mental health officials and the proposals offered by Dr. Thomas S. Szasz is in order.

Abolition of Involuntary Commitment

Dr. Thomas S. Szasz of the University of New York School of Medicine has been suggesting for several years that involuntary hospitalization of the mentally ill be abandoned. Understanding the basis of his thinking requires some examination of his whole theory, which is contained in a number of books and articles. He also expressed himself to the Senate subcommittee and to this student in a personal interview. The root of his thinking is that mental illness is a myth and metaphor. "Let us launch our inquiry by asking, somewhat rhetorically, whether there is such a thing as mental illness. My reply is that there is not."[112]

With precision, Dr. Szasz dismisses all of the contemporary definitions of mental illness in a manner which a brief exposition such as this cannot do. However, he suggests that those who imply that brain disease is a form of mental illness are misleading. "If they mean that people so labeled suffer from disease of the brain, it would seem better, for the sake of clarity, to say that and not something else."[113] Many others, says Dr. Szasz, refer to mental illness as a problem in living--an inability to function adequately

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[112]Thomas S. Szasz, M. D., Law, Liberty, and Psychiatry, p. 11.

[113]Ibid., p. 13.

within a society. He agrees that not all people are able to conform to all norms. There are problems in living. However, calling these problems mental illness " . . . creates a situation in which it is claimed that psychosocial, ethical, and/or legal deviations can be corrected by medical action. But is this rational?"[114] Thus he does not deny that problems exist. His criticism is of the practice of labeling these as "mental illness," or making medical problems that are moral or social.

Dr. Szasz believes that people have the right to be mentally ill. He was questioned about this by the Senate subcommittee counsel who wondered " . . . doesn't the term 'mentally ill' of itself imply a lack of capacity to make the determination of whether one wants to be mentally ill?"[115]

He answered:

> You have gone right to the heart of the problem. This whole business of mental illness, diagnosis, and treatment is in some ways, if you will excuse the homely analogy, like a dog chasing its tail. The definition of one term depends on the definition of another term, round and round.[116]

Szasz believes that mental illness is a name applied to human behavior that is socially unacceptable. The analogy between mental illness, then, with crime is perhaps more valid than an analogy of mental illness and physical illness. Dr. Szasz told the Senate subcommittee that as

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[114] Ibid., p. 16.

[115] U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary., op. cit., p. 261.

[116] Ibid.

recently as two hundred years ago no distinctions were made between prisons and mental hospitals. People who committed crimes were imprisoned. Another of Dr. Szasz's core beliefs is that people should not be denied liberty if they have not committed crimes. This is why he would prefer the abolition of the dual system of prisons and hospitals, one used, he would say, to punish crimes, the other used to incarcerate those whose behavior is unacceptable. He said:

> I don't see why people have to be put in a mental hospital to be treated. If you have an acute appendix if you are in Sing Sing you get treated. The same thing could go for psychiatric illness if this is what psychiatric illness is and these people who do not violate society should be left alone.[117]

Another rationale for involuntary commitment to hospitals is the protection of the person against himself, to avoid suicide. When asked whether or not this prevention is possible, Dr. Szasz responded:

> . . . a certain proportion of people who want to kill themselves do so. And while I certainly don't want to appear peculiar or callous about this, it seems to me that we must recognize that ability to kill oneself is one of the opportunities which one has in a free society and there is absolutely no way of eliminating this completely . . . I certainly would not think it reason to restrain somebody for a long time just because he might kill himself.[118]

This position should be seen as a libertarian one. When interviewed by this researcher, several questions were asked Dr. Szasz in relation to his notion that mental illness is a myth. When asked about the studies which have identified substances in the brain fluid of schizophrenics that are not found in nonschizophrenics, Dr. Szasz said that

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[117] Ibid., p. 271.

[118] Ibid., p. 272.

the studies were inaccurate and based upon faulty data. First, he said, all of the findings were uncorrelated--each study finds something else. Second, the definitions of schizophrenia are inadequate. There may be something like schizophrenia which exists as a disease entity and which is randomly distributed in the population. But schizophrenia, as it is used in the United States, is a power term instead of or in addition to an objective fact. The stronger call the weaker "schizophrenic" and this justifies social control. The use of the term carries social implications and justifies controls that would not be justifiable without it. Most studies are of hospitalized mental patients. Any valid study of schizophrenics, he said, would have to include some capitalists, some senators, and other members of the population who are not hospitalized. This, like all involuntary commitments, is an example of class conflict, something that is largely repressed in the United States. Involuntary hospital commitments are examples of the upper classes oppressing the lower classes. For example, alcoholic United States Senators go to hospitals for treatment. Most acute alcoholics are committed to jails or mental hospitals.

Dr. Szasz, as a qualified psychoanalyst and psychiatrist, opposes involuntary commitment on other grounds, too. He says that there is no possibility of effective mental treatment in an involuntary situation. His wish, he says, is for the augmentation of free choices in a free society. He is not opposed to state-supported hospitals or state-supported psychiatry. Low-cost or free services to persons with problems would not be contradictory to his views on either liberty or psychiatry. His opposition is to involuntary institutions for the mentally

ill. He agrees that the practices of these institutions and their facilities have been improved. Only the most cruel of all the tortures--involuntary deprivation of liberty--has been retained.

One reason for Dr. Szasz's lack of popularity with psychiatrists is, it would seem, the attack he makes on psychiatry, which has a vested interest, he says, in maintaining involuntary commitments. There are few psychiatrists, he notes, in full time private practice. The psychiatric lobby has a vested interest in maintaining the system because most psychiatrists would not be employed as psychiatrists without the existence of coerced treatment. This has nothing to do with the competence or incompetence of the psychiatrist. It is related to the unpopularity of psychiatric treatment. Voluntary requests for treatment are very few, he says, and much of what is called voluntary is, as is discussed later in this study, a product of coercion and threats, rather than a genuinely voluntary expression.

But Dr. Szasz is also attacked by those who ask what he would do with patients who are completely out of contact. His suggestion is that they be treated as if they were provisionally sick and treated in medical hospitals, as one would do with an unconscious accident victim or any other person who has lost his powers. Once they become well-functioning again, they should be released.[119] Dr. Szasz says, in one of his books, that this would eliminate the involuntary hospitalization of persons who may be considered in need of it.[120] Real psychiatric

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[119]Interview with Dr. Thomas S. Szasz, August 10, 1965.

[120]Thomas S. Szasz, M. D., Law, Liberty, and Psychiatry, pp. 226-227.

emergencies are rare and are a small proportion of all involuntary hospitalization cases. Many of those who are hospitalized on an emergency basis are victims of a physical illness, too, and are better placed in medical hospitals.[121]

Dr. Szasz's specific recommendations for reform are clear:

> All provisions for involuntary mental hospitalization should be abolished. Like the institution of slavery, the institution of hospital psychiatry, as we know it, must go.[122]

In his recommendations, he reacts to the American Bar Foundation proposal that the statutes more specifically and clearly define the degree of mental illness which justifies involuntary hospitalization:[123]

> This seems reasonable, but it is not. It disregards the fact that thus far jurists and psychiatrists have been unable to agree on even a qualitative definition of the severity of mental illness. It is therefore unreasonable to ask for quantitative definition of the severity of mental illness precise enough for the purposes of law enforcement.[124]

> Mental hospitals, both private and public, should be restricted to the care of consenting, voluntary, adult patients. Both the hospital and the patient should be treated as independent contracting parties . . . The mental hospital should be a new kind of institution, resembling neither prison nor medical hospital.[125]

The above are seen by Dr. Szasz as long-range goals. In the short-range, he also makes some proposals for change. Some of these are predicated on assumptions about the characteristics of mental

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[121] Ibid., p. 226.

[122] Ibid.

[123] Lindman and McIntyre, Jr., op. cit., p. 40.

[124] Szasz, op. cit., p. 226.

[125] Ibid., p. 227.

hospital patients themselves. Some of these notions are discussed in Chapter IV, based upon material gathered in the study done on Oklahoma commitments.

Among the short-range steps he proposes is a recognition of the conflict between the involuntary patient and the psychiatrist. Likening the political role of the mental patient to that of the American Negro, he suggests that they band together for action on their own behalf.[126]

He also calls for the creation of watchdog agencies to protect the rights of mental patients, independent of the agencies which administer mental hospitals. Persons could call on this agency to protect themselves against commitment, secure releases, and work for the restoration of their rights.[127] Those who are hospitalized should retain as many of their rights as is possible,[128] and involuntary hospitalization, in general, should be discouraged, through education on the alternatives to it which exist.[129] People should also, he says, be told of the dangers of psychiatric hospitalization.[130]

The specific criticisms of Szasz rendered by his psychiatric colleagues tend to center less on what he says about the care of the mentally ill than the way in which he says it. In a paper read to the

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[126] Ibid., pp. 230-231.

[127] Ibid., p. 232.

[128] Ibid., p. 233.

[129] Ibid., pp. 233-234.

[130] Ibid., pp. 234-235.

1965 Annual Meeting of the American Psychiatric Association, Dr. Ralph Slovenko replied to a paper presented by Dr. Szasz called "The Moral Dilemma of Psychiatry: Autonomy or Heteronomy?"[131] Dr. Slovenko admitted that there were evils in the commitment of mentally ill persons but said that psychiatry was not wholly responsible for these matters.[132]

Several hours of the association's annual meeting were devoted to this exchange between Dr. Szasz and his colleagues. The position papers and discussions which followed his presentation were all critical either of Szasz as a person or of his methods of reaching the public, or of the construction of his arguments.

In another commentary, Dr. John Donnelly questioned Dr. Szasz's logic and rhetoric. He said:

> Professor Szasz repeatedly, in his presentation uses . . . loose argumentation. If Professor Szasz is seeking to convince not the lay public but those accustomed to logical discussion, he should be aware that his arguments are themselves, rhetorical, not logical.[133]

Dr. Henry A. Davidson suggested that Dr. Szasz's writing had resulted in making people think psychiatrists are a menace to their patients.[134] He quoted statements Szasz had made which were critical of psychiatrists and which were published in lay publications.[135]

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[131]Thomas S. Szasz, M. D., "The Moral Dilemma of Psychiatry: Autonomy or Heteronomy?" The American Journal of Psychiatry, December 1964, Vol. 121, Number 6, pp. 521-528.

[132]Ralph Slovenko, Ph. D., "The Psychiatric Patient, Liberty, and the Law", Ibid., pp. 534-539.

[133]John Donnelly, M. D., Ibid., p. 546.

[134]Henry A. Davidson, M. D., "The New War on Psychiatry", Ibid., p. 529.

[135]Ibid., pp. 530-531.

Davidson's strongest criticisms seemed to be that Szasz was disloyal to his profession and unwilling to limit his remarks to the professional community.[136]

Dr. Henry Weihofen noted that Dr. Szasz was "playing footsie" with right-wing extremists, who used his writing to prevent needed reforms in the care of the mentally ill.[137]

In an interview, Dr. Eugene Pumpian-Mindlin suggested that Dr. Szasz's basic feelings were shared by many psychiatrists. However, the manner in which Dr. Szasz carries them to their logical conclusions makes them ridiculous and extreme.[138]

Thus the criticisms of Dr. Szasz are based, it would appear, not upon what he says but upon the means he has chosen for saying it. His direct attacks upon psychiatry as the primary group responsible for the inequities also tend to make him unpopular. However, one finds little disagreement with his basic charge which is that commitment procedures are inequitable.

Although they are vastly different than the reform proposals typically made by professionals in mental health, Dr. Szasz's suggestions appear to be well-reasoned and may be useful as ideal models. The strong criticisms of him and his positions and the feelings he arouses would probably make it difficult for psychiatry to objectively discuss these as reforms. In raising basic issues in a dramatic way, Szasz is likely to arouse public concern and psychiatric ire. This is,

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[136] Ibid., p. 533.

[137] Henry Weihofen, M. D., Ibid., p. 548.

[138] Interview with Dr. Eugene Pumpian-Mindlin, January 31, 1966.

perhaps, his dilemma.

Dr. Szasz is not the only psychiatrist generally opposed to involuntary commitment. Dr. Eugene Pumpian-Mindlin of the University of Oklahoma School of Medicine Department of Psychiatry, said, when interviewed, that most reasonable psychiatrists would agree that involuntary commitment is undesirable and while it must be retained for the unusual and exceptional case, it should be the last, rather than the first resort. In a showdown, he said, the faculty of his department would probably favor all voluntary procedures. Much of the stigma of mental illness, he said, results from the legal procedures associated with it. More effective and earlier treatment is also possible if legal barriers are removed. And the person most dangerous to himself and others is one of the most difficult to commit when he refuses to voluntarily seek help.[139]

Use of Social Studies

One reform proposal came from Dr. Bedford Peterson, Superintendent of Eastern State Hospital in Vinita. When he held a similar position in Tennessee, he required that a complete social history be conducted in connection with the admission of an elderly person who was considered for commitment. This had to be based upon a home visit made by a qualified person, either a public welfare social worker or public health nurse. There are many ways other than hospitalization that may be effective in treating an elderly person. In addition, one would need to know something of the person's home life in order to

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[139] Ibid.

reach a sound decision at the time of discharge. Of course, Dr. Peterson said, some people are too sick to permit the use of the time that would be necessary for such a history. They are best admitted immediately.[140]

Non-Judicial Emergency Commitment

Dr. Albert Glass, Director of the Oklahoma Department of Mental Health, sees a need for an end to the judicial aspects of involuntary commitment. It is his contention that mental illness is a medical, not a legal, problem and should be handled accordingly. Specifically, he would propose a ten or fifteen day emergency commitment for non-protesting persons, which could be handled by two physicians. If the family or the patient did not protest, the person would be hospitalized, a term which Dr. Glass considers more descriptive of the process than commitment. He notes that many of the involuntary commitments in Oklahoma are of sick and old people who will not volunteer but do not protest.

The real objective sought by Dr. Glass is for most patients to be voluntary. The few involuntary commitments which remained would best be handled on a medically regulated basis. He notes that the writ of habeas corpus would always remain available to the patient who wanted to be discharged.[141]

This is somewhat similar to a plan utilized in New York, which has recently revised its state mental health laws. There, patients may

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[140]Interview with Dr. Bedford Peterson, December 21, 1964.

[141]Interview with Dr. Albert Glass, November 18, 1965.

be committed at the request of "Spouses, parents, children, relatives, friends, employers or the state itself . . . but every request must be approved by two physicians and one staff psychiatrist. Full commitment does not take place until the patient has spent at least 60 days under observation in a psychiatric receiving center such as Manhattan's Bellevue Hospital."[142]

There are protections in this statute, too:

> Within five days after entering such a center, however, the patient and four of his relatives or friends must be informed of his right to a jury hearing. Any one of them can demand it.[143]

One of the major differences between these provisions and those of Oklahoma is that Oklahoma's are pre-hospitalization procedures, while New York's become operative after the person is in the institution.[144] However, New York retains a system similar to Oklahoma's for persons who object to hospitalization and who have no families or who, along with their families, protest the commitment. This involves a court action, similar to that used in Oklahoma.[145]

But the basic difference between the Oklahoma procedures and those proposed by Dr. Glass and used in New York is that the protections and litigation occur after hospitalization. This eliminates the necessity for jailing patients. However, it may lead to lengthier deprivations of freedom. For example, under the New York law the non-protesting

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[142] Time, September 24, 1965, p. 50.

[143] Ibid.

[144] Letter from Marie Demetry to Dr. Eli C. Messinger, January 20, 1965.

[145] Ibid.

family commitment is in effect for sixty days. At the end of that period, the patient may object and demand a hearing. Under the court certification, the patient may request a hearing after thirty days elapse.[146]

Administrative Hospitalization

Another system which is used for involuntary commitment is that of administrative hospitalization. Although the details of this method vary from state to state, administrative hospitalization usually involves an expert board which examines persons who are alleged to be mentally ill and determines whether or not they are to be institutionalized. The American Bar Foundation study says that the procedures are usually similar to those used in judicial commitment, although the statutes are typically vague about the administrative hearing and its rules.[147]

The basic difference between administrative and judicial hospitalization is that the issue of mental illness is determined by, rather than recommended upon, by a board consisting predominantly of medical specialists. There is no judge and no trial, in the usual sense. The elimination of these elements removes, the proponents of administrative hospitalization suggest, the atmosphere of crime and punishment and replaces it with a treatment approach.[148]

Most states which provide for such procedures provide for

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[146] Ibid.

[147] Lindman and McIntyre, Jr., op. cit., p. 33.

[148] Ibid.

judicial review, a jury trial, or an enlarged habeas corpus proceeding. The American Bar Foundation report suggests that problems similar to those in other administrative actions arise in determining the scope of judicial review of administrative hospitalization.[149]

This discussion of involuntary commitment to public hospitals indicates that there are innumerable variations in commitment procedures. Most of them appear to be compromises between medical and legal approaches. Generally, neither group predominates and both, one way or another, are involved. The interests of the two groups, in the area of involuntary commitment, differ though both see themselves as being concerned with the protection of the patients' best interests. The two dimensions are treatment and civil rights. To generalize, the medical people tend to see themselves protecting the first concern and the lawyers and judges, the second. Reforms seem to be pressed by one of the two groups, alone. Occasional alliances between the two in planning reforms may lead to more adequately planned results.

Private Hospitalization

Much of the foregoing discussion of involuntary commitment has been related to hospitalization in the state institutions. Actually, persons may, in Oklahoma, be committed to private institutions as well as those owned and operated by the state:

> If the relatives or friends of such mentally ill person so request, the court or the judge thereof shall order his admission as a private patient to any institution, home or retreat for the care or treatment of the mentally ill, other than one of the hospitals of

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[149] Ibid.

> the State, upon such relatives or friends complying with the rules and regulations of such institution, home or retreat, for the admission and support of the mentally ill person as a private patient.[150]

Later clarifications of the law provide that a:

> . . . private hospital or institution means any general hospital maintaining a neuropsychiatric unit or ward, or any private hospital or sanitarium for care and treatment of mentally ill persons, which is not supported by State or Federal governments, except that the term shall include the University Hospital Neuro-psychiatric Unit. The term shall not include nursing homes or other facilities maintained primarily for the care of aged and infirm persons.[151]

The proceedings for commitment to a private institution are basically the same as any other, except that some extra activities must be performed.

An attending physician must be designated, who will be responsible for the care of the patient while he is hospitalized. He must have the same qualifications as those legally defined for a qualified examiner.[152] The institution to be utilized must also state that it will accept the patient, if he is accompanied by a valid order for admission.[153]

Because, it would seem, the attending physician takes on some of the same responsibilities as the superintendent of a state institution, the law on his role is rather specific. If the family or petitioner or guardian wishes to change the attending physician, they must notify

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[150] 43A O. S. (1961) Sec. 55.

[151] 43A O. S. (1961) Sec. 182 (A).

[152] 43A O. S. (1961) Sec. 185 (B).

[153] 43A O. S. (1961) Sec. 185 (C).

the court and the name of a new attending physician must be submitted. If the attending physician wishes to withdraw from the case, he must also notify the appropriate people and the court. The new attending physician, in any case, must file a statement with the court, agreeing to be responsible for the patient's care. It is the attending physician who grants leaves, determines whether or not the patient has recovered, and discharges the patient.[154]

Although it is not true in all states,[155] in Oklahoma it would seem that a patient in a private institution has protection of his rights that is equal to that available in a state hospital, with one major exception. That is, a family which does not want a patient released but finds that the attending physician thinks the patient is cured, may dismiss and replace the attending physician.[156] This differs significantly from the state institution, where the superintendent is always the final authority.

Conclusion

As may be evidenced by the length of this chapter, involuntary commitment is the most controversial subject in mental illness practice and is probably the most complex. It provides the basis for the hospital's *in loco parentis* role, in addition to denying freedom to the patient. Despite this, there have been few court cases relating to Oklahoma commitment, itself. A large body of common law has arisen

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[154] 43A O. S. (1961) Sec. 186.

[155] Lindman and McIntyre, Jr., *op. cit.*, p. 114.

[156] 43A O. S. (1961) Sec. 186.

out of some of the consequences of commitment, such as competency, guardianship, and other property-centered issues, which are discussed in Chapter V. No cases arising out of commitment itself were found. This is probably due to the settled nature of the law on commitment, rather than on satisfaction with the procedures. Oklahoma follows all of the typical due process formulae such as notice and right to trial. It may be, however, that the apparent acceptance of the laws as they are applied is a result of the kinds of people who are effected by them. This notion is discussed in more detail in the chapters on discharge, characteristics of patients, and competency.

CHAPTER III

VOLUNTARY ADMISSION

Currently, a majority of mental hospital patients in Oklahoma and all children admitted to schools for the retarded enter the institutions on a voluntary basis. The various meanings of and procedures for voluntary admission are discussed in this chapter, along with some of the opinions on this means of becoming a patient or pupil in an institution.

Voluntary Mental Patients

According to Dr. Albert Glass, Director of the Department of Mental Health, voluntary admissions are constantly increasing in Oklahoma institutions. In July, 1965, the most recent statistics available when he was interviewed, voluntary patients comprised the majority of all admissions. This ranged from less than fifty per cent voluntary at Eastern State Hospital to sixty per cent at Western State Hospital. Central State Hospital admitted some fifty-six per cent of its patients on a voluntary basis.[1]

There are two kinds of voluntary admissions into mental hospitals. One simply permits hospital superintendents to accept for care and treatment persons who want it.

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[1]Interview with Dr. Albert Glass, November 18, 1965.

> . . . The superintendent in charge of any State Hospital or licensed private hospital for care and treatment of the mentally ill may at his discretion receive and retain therein as a patient any person eighteen years of age or over, suitable for care and treatment, who voluntarily makes written application therefor, or any person, suitable for care and treatment at least sixteen years but not over eighteen years of age, with the consent of such person's parent or guardian. A person thus received at any hospital or institution shall not be detained for a period exceeding fifteen (15) days from and inclusive of the date of notice in writing of his intention or desire to leave such hospital or institution . . . The applicant, or someone for him, must give a bond for the cost of care and treatment or pay such cost each month in advance, unless it is determined that the applicant is a poor or indigent person as provided in this Title.[2]

A second kind of voluntary admission is commonly called a "court voluntary" and was passed by the 1963 legislature. It is somewhat more complicated, but binds the hospital to take the person who desires treatment.

First of the steps taken by a person desiring a court voluntary commitment is the written application for this to his County Judge or the County Judge of a county where a state hospital is located. His application gives his name, age, address, and a statement that his decision to accept commitment is based upon medical advice. He also agrees to stay in the institution until the superintendent believes he is sufficiently recovered for release " . . . not exceeding, however, a period of sixty days after . . . (he gives) written notification to the superintendent or his designee of . . . (his) desire to leave the hospital."[3] He then lists his close relatives and their addresses and signs the application.

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[2] 43A O. S. Supplement, 1965 Sec. 53.

[3] 43A O. S. Supplement, 1963, Sec. 552.

This application must be accompanied by a certificate executed by a licensed doctor of medicine or osteopathic physician who meets the standard qualifications and is not a blood relative or a relative by marriage of the person seeking admission. The certificate states that the person has been examined and is mentally ill and recommends, for the welfare of the patient, that he be admitted to the appropriate hospital. He must also sign a document stating:

> I further certify that I have explained to said person that if he/she is admitted to a state hospital for the mentally ill as a voluntary patient, the medical staff may find it necessary or desirable to give a course of treatment requiring an extended period of time, and that it is not the legislative policy of the state to authorize the expenditure of public funds for the commencement of an expensive treatment unless the patient desires to continue that treatment for a length of time that the attending physicians believe is likely to give adequate benefit to the patient; and I have also explained that it may become necessary to give treatment which may temporarily weaken the patient's system so that it would be injurious to his/her health to release him/her immediately upon his/her request; and that therefore the superintendent of the hospital has authority under the law to detain the patient in the hospital for as long as sixty days after said patient gives written notice to the superintendent of his/her desire to leave the hospital.
>
> I further certify that in my opinion said person has sufficient mental capacity to and does understand and comprehend the matters set out in the preceding paragraph . . .[4]

Then the doctor certifies to his own qualifications as a physician and signs the form.

Next, the County Judge must question the applicant for admission. He must satisfy himself that the person understands what he is doing, including the consequences of the admission. In addition, he must assure

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[4] 43A O. S. Supplement, 1963, Sec. 553.

himself that the application is voluntarily made. Once this is done, he issues an order for admission of the patient to the appropriate state hospital.[5]

It is further specified in the law that the patient may not be held against his will for more than sixty days after he formally indicates his desire to leave.[6]

Most important is a provision that "No person shall be presumed to be incompetent by reason solely of his commitment under the provisions of this act."[7] This probably constitutes the primary civil rights difference between voluntary and involuntary commitment, with the exception of the length of hospitalization. The involuntary patient loses his competence and civil rights along with his freedom.

There are some differences in the procedures for admission as a voluntary patient in a private institution:

> A mentally ill person may request voluntary admission to any private hospital or institution as defined by this Act, in the same manner and by the same procedures as any other type of patient that is admitted to said institution or hospital. Minor patients may be admitted on application of parent, guardian, or the person having custody. Patients admitted voluntarily who give notice in writing of their desire or intention to leave said private hospital or institution must be released forthwith; provided, that if in the judgment of the attending physician the patient's release would be injurious to the welfare of the patient or the public, such patient may be detained for so long as is reasonably necessary to initiate the court certification proceedings provided by law; provided that the attending physician shall immediately notify the judge of the county court

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[5] 43A O. S. Supplement, 1963, Sec. 554.

[6] 43A O. S. Supplement, 1963, Sec. 556.

[7] 43A O. S. Supplement, 1963, Sec. 558.

> in which said private hospital or institution is located by telephone or otherwise, confirmed by a written communication, that such patient is so detained, and that such detention shall not exceed three (3) days.[8]

Thus greater protection, in terms of the period of detention, is afforded the voluntary patient in a private institution than the voluntary patient in a state hospital. However, it is this last suggestive set of phrases, indicating that voluntary patients may become involuntary patients with the complicity of the institution and the court, which is the basis for most of the criticisms of voluntary hospitalization.

When he was interviewed and in his statement before the Senate subcommittee, Dr. Thomas S. Szasz was highly critical of voluntary commitment:

> What is called voluntary admission is really not voluntary. It is perhaps quasi-voluntary. What we call voluntary admission to a mental hospital doesn't resemble voluntary admission to a medical hospital, for example for pneumonia. It is rather a kind of voluntary involuntary admission. This so-called voluntary admission to a mental hospital is a procedure, which more often than not, could be paraphrased as follows: It is as if the patient were told: 'If you don't go to the hospital by signing this piece of paper, then we'll get you in by having someone else sign another piece of paper.'
>
> It is the same for release. Voluntary release is really pseudo-voluntary, or sometimes results in no release at all. Requesting release depends on many circumstances, mostly on what kind of doctor he happens to be confronted with. I don't have the facts on this, and I doubt that anybody does. But again, the fact is that the patient may be released after 10 or 60 days, or may be not. Often, while he is waiting for release, forms are made out for involuntary commitment--and the patient's status may thus be changed from voluntary admission to involuntary commitment. Usually, the patient isn't told

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[8] 43A O. S. (1961) Sec. 184.

> about this, and if he is, he is as a rule helpless to do anything about it.[9]

This was a subject of some discussion before the subcommittee. The consensus of opinions expressed seemed to be that it was not really a problem, although it could become one. Dr. Winfred Overholser put it this way:

> I can't think of more than one case in the last 12 or 13 years in which a patient who would come in as a voluntary patient had subsequently been committed to us. We like to play squarely with the patient.
>
> We don't intend to mislead him and we certainly don't want to slip something over on him, so to speak.
>
> When he has come in voluntarily we have told him he may leave voluntarily.[10]

Hugh J. McGee, chairman of the Mental Health Committee, District of Columbia Bar Association, responded to Dr. Overholser's statement. He told the committee that he knew of two cases of involuntary commitment proceedings being instituted against persons who had entered voluntarily and considered this a good record. He also told the subcommittee that he had once wanted to involuntarily commit a client of his who both he and the family considered dangerous. The doctors would not agree to this because the patient had entered voluntarily.[11]

In an appearance before the subcommittee, Dr. Eugene A. Hargrove of North Carolina, where he is Commissioner of Mental Health, described his state's voluntary admission program, under which some thirty-two

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[9]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 265.

[10]Ibid., p. 37.

[11]Ibid., p. 56.

per cent of the patients were entering the hospital at the time. Voluntary commitment there was for thirty days, but the patient, if he seemed to need further treatment, could be committed again for sixty days, involuntarily.[12] Dr. Hargrove indicated that voluntary patients were easier to treat and improve.[13] This seems to bear out Dr. Szasz's contention that voluntary treatment is most effective in the mental health field.[14] This same idea seems to have been suggested by the various mental health officials in Oklahoma.

When Dr. Hayden Donahue was interviewed in late 1964, he indicated that as late as 1953 only four per cent of all admissions to Central State Hospital were by voluntary procedures. This had risen to some thirty per cent in October, 1965, and is now more than fifty per cent. Most had not come voluntarily through the court procedures. Instead they had come directly to the hospital and requested admission. He said that he had talked with many of these patients and that they were not coming to avoid involuntary commitment but were seriously interested in receiving help.[15]

With regard to turning voluntary commitments into involuntary, Dr. Donahue said that this was rarely done, although critics of the voluntary commitment law suggested that it would be a problem. Although there are laws which require the release of the patient within a certain

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[12] Ibid., p. 176.

[13] Ibid., p. 180.

[14] Interview with Dr. Thomas S. Szasz, August 10, 1965.

[15] Interview with Dr. Hayden Donahue, November 23, 1964.

number of days after he writes the superintendent a letter, the hospital practice is to release patients even sooner if they are ready to be released. When such a patient is too ill for discharge, the hospital speaks with the family and suggests that commitment procedures be initiated. If the hospital did this, itself, it would present poor public relations. The word would be disseminated and few people would enter voluntarily.[16]

One of the significant advantages of voluntary commitment is the flexibility it provides the hospital and the patient. The patient loses none of his rights and has no need for a restoration to competency. There are a variety of services available at Central State and these can be provided to the patient as he becomes ready for them, without any entangling legal arrangements.[17]

Judge J. David Rambo of Cleveland County tends to use the voluntary commitment procedures when this is advisable. Family doctors are most helpful in implementing this, he says, because people are very likely to follow a physician's advice. When a physician detects a problem and recommends voluntary commitment, the patient often accepts the advice and enters the institution.[18] The study of commitments in Cleveland County revealed that three cases in the sample of fifty were voluntary. It should be noted that this reflected a time span when voluntary admissions were not yet widely used.

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[16] Ibid.

[17] Ibid.

[18] Interview with Judge J. David Rambo, December 20, 1965.

Judge Francis Borelli endorsed the idea of voluntary commitment. Its primary differences from the involuntary commitment are that the patient is committed for only sixty days and there is no loss of rights or competency involved. Judge Borelli said that most of the voluntaries he had sent to the hospital were alcoholics. "Involuntary commitment would probably be inadequate with alcoholics, he said, since they must be motivated to change for the treatment to work."[19]

Three cases of voluntary court commitments were found in the sample of twenty-five cases studied in Kingfisher County, where Judge Borelli is County Judge. All three of these were recent.

Dr. E. P. Henry, Superintendent of the Taft State Hospital, said that voluntary commitments were increasing at his institution, although, he noted, only twenty-five per cent were voluntary when he was interviewed. Most of these were, however, patients who came directly to the hospital, not through the court procedure.[20] In a later interview with Dr. Glass, it was noted that Taft is virtually no longer admitting patients, on any basis.[21] According to the Report of the Department of Mental Health, January 1, 1965-December 31, 1965, admissions to Taft State Hospital were suspended while renovations were carried out. Once these improvements are made, the hospital is to begin taking patients again to carry out the missions of serving as a geriatric mental health center for Eastern Oklahoma to provide treatment for persons in the area of the hospital, and to eventually serve as a regional

[19]Interview with Judge Francis Borelli, December 20, 1965.

[20]Interview with Dr. E. P. Henry, December 21, 1964.

[21]Interview with Dr. Albert Glass, November 18, 1965.

community mental health center.[22]

When he was interviewed, Dr. Bedford Peterson said that a majority of the patients in Eastern State Hospital came by involuntary commitment, although voluntary admissions were increasing. Many of these are handled through a court, which has advantages, Dr. Peterson believed, for the hospital. That is, the patient must stay in the hospital for a longer period of time, although he can always be released at any time if he is cured. When the hospital confronts people who have been in the hospital before and insisted on leaving before they were cured, they demand at least the court voluntary commitment so that longer treatment is possible. The hospital may occasionally initiate involuntary commitment proceedings for someone who wants to leave but should not because he may be dangerous to himself or others. This is not done when the patient is simply sick, but only when he would pose a danger to himself or someone else.[23]

This did not appear to be particularly significant when Dr. Peterson was interviewed. However, after making the study of fifty commitment cases in Tulsa County, the largest county which sends patients to Eastern State Hospital, it appeared rather important.

It appears that Judge Whit Y. Mauzy does not believe in voluntary commitments handled through the court and does not use them in Tulsa County. When he was interviewed, Judge Mauzy said that the voluntary commitment law had not changed things in Tulsa County. When someone

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[22]Report of the Department of Mental Health, January 1, 1963-December 31, 1965., p. 4.

[23]Interview with Dr. Bedford Peterson, December 21, 1964.

wishes to enter the hospital on a voluntary basis there, Judge Mauzy refers him to Eastern State Hospital for a conference with the superintendent. If the doctor thinks the person is mentally ill, and could benefit from hospitalization, he is hospitalized on the voluntary basis. Judge Mauzy says that the person, if he is mentally ill, is also incompetent. This being the case, there is no justification for entering into a legal agreement with the person. It wouldn't be valid. Therefore, the patient is simply sent to the institution. Judge Mauzy says that he would use the court voluntary procedure if a patient insisted upon it.[24] However, no voluntary cases were found in the Tulsa commitment sample.

On this basis, it would appear that some patients who appeared at Eastern State Hospital would not be allowed admission. Dr. Peterson said that his institution wanted "at least" a court voluntary for those who had come in on voluntary admissions before. This could become an involuntary commitment for Tulsa County patients, since Judge Mauzy does not use the court voluntary procedure. In addition to this limitation, Dr. Glass noted that a court voluntary assured the patient of admission to the hospital, while he could not be certain of this by simply going to the institution and asking for hospitalization. However, Dr. Glass doubted that this would be a significant problem because people who need hospitalization will usually get it.[25]

In Tulsa County, they are likely to get it through an involuntary

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[24]Interview with Judge Whit Y. Mauzy, November 16, 1965.

[25]Interview with Dr. Albert Glass, November 18, 1965.

commitment. Two cases were found in the sample taken in Tulsa which could, it appeared, have been voluntary. In fact, the patients did volunteer or ask for commitment to the institution. Both were alcoholics and both had been hospitalized several times in the past.[26]

The American Bar Foundation study found that all states but one (Alabama), have provisions for voluntary admission. However, Oklahoma is one of only four states which provide for the retention of civil rights and competency by the patient, specifically and by statute.[27]

With the exception of there being a specific time limit on the admission and no loss of competency, the voluntary patient is treated in the same way as the involuntary when he is actually in the institution. There are no differences in patient management, correspondence rights, and other matters which are discussed in the chapter on patient management. Despite this, the retention of competency while the patient is hospitalized is of value to him. He can be assured that his property and business affairs will remain in his control. His ability to vote, operate an automobile, and practice his profession, is again available to him once he is discharged. And upon discharge he need not face the potentially expensive and perhaps unsuccessful process of restoration to competency that is necessary for involuntarily committed persons.

Mentally Retarded Pupils

Mentally retarded persons may be admitted to the state hospitals

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[26]Commitment Study, cases T-21 and T-30.

[27]Lindman and McIntyre, Jr., op. cit., p.111, 43A O. S. (1961) Sec. 558. (The other states are Illinois, Ohio, and Texas)

for the mentally ill, if they are mentally ill, just as any other Oklahoman may. There are some mentally retarded people in these institutions.[28] However, admission to the state schools for the mentally retarded at Taft, Enid, Pauls Valley, and Sand Springs, is on a strictly voluntary basis since those schools were transferred from the Department of Mental Health to the Department of Public Welfare, in 1963.

The statutes on this provide:

> (a) Mentally retarded persons, who are legal residents of this State, with a mental age not above that of the average nine-year-old child, as determined by psychological examination, may be admitted to an institution named in this Act upon written application to the Director on forms provided for such purposes. Provided, that other mentally retarded persons, residents of the State, who are above such mental age may be admitted upon recommendation of the superintendent of the institution and approval of the Director.
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> The application shall be signed by:
> (1) The father or mother, if father or mother are living, or
> (2) the one having custody, if father and mother are not living together, or
> (3) a guardian, duly appointed, or
> (4) the person having management or the institution, if the person is kept in an institution.
>
> The psychological examination herein provided shall be on forms provided by the Department and must be completed before application can be approved by the Director and the applicant admitted to the institution.[29]

Joseph R. Deacon of the Pauls Valley State School for the Retarded explained the process in a bit more depth when he was interviewed. Persons who desire services for their retarded children make application for

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[28] Interview with Dr. Hayden Donahue, November 23, 1964.

[29] 56 O. S. Supplement, 1965, Sec. 310; Appendix D.

services to the Department of Public Welfare, which took over the state schools only recently but which has a long history of work with retarded persons through various other programs. There is an evaluation made of the child and studies made by a psychologist. The school also becomes acquainted with the family. If the recommendation is that the child be removed from the home and the community, the application for services becomes an application for admission. If the child's mental age is less than nine years, which has been determined to mean exactly nine years (9.0), he is admissible. The superintendent and the Director of Public Welfare, if they wish, may take a person whose mental age is greater than nine, if certain criteria are met. These criteria are that there is no other appropriate place for the person, that the individual should be in a residential institution, and that a positive program can be developed to aid the person.[30]

The statutes on mental retardation do not deal with chronological age. Admission is based upon mental age, determined by tests administered by psychologists. This means that persons of all ages populate the institutions for the retarded. Although grouping is carefully handled, one institution may have pupils as young as infants and as old as the upper limits of the human life span.

Miss Dorothy Channel, Social Work Consultant on Mental Retardation of the Unit on Social Services for the Mentally Retarded, Department of Public Welfare, indicated that there were no involuntary commitments to schools for the retarded. Occasionally a judge may sign a child into an institution, but this is only in cases when the judge is the legal

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[30]Interview with Joseph R. Deacon, December 22, 1964.

guardian of the child. When asked if the courts ever ordered parents to take their children to schools for the retarded, Miss Channel indicated that this was rare and that she had known of only two cases in which this had happened.[31]

Conclusions

There are some significant differences between voluntary and involuntary admissions to institutions. The differences in the handling of mentally ill persons and mentally retarded persons is particularly striking. Since mentally retarded persons are admitted to the institutions on a voluntary basis only, there are few civil rights problems in this area. Of course, voluntary pupils still face the limitations which may be placed upon them as a result of the school's in loco parentis role. It must also be noted that those admitted to institutions for the retarded are, according to Oklahoma law, legally children, despite their age. Thus the civil rights of the retarded probably belongs in a discussion of the rights of children, which is a large issue, itself.

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[31]Interview with Miss Dorothy Channel, December 9, 1965.

CHAPTER IV

CHARACTERISTICS OF COMMITMENT CASES

In the study of one-hundred-and-twenty-five commitment cases in three diverse counties in Oklahoma, a pattern began to emerge, depicting characteristics of those involved in commitment cases that are not quite like those of the total population. It is likely, and the research in commitment cases suggests evidence for this hypothesis, that involuntary commitment procedures and state hospitals for the mentally ill are used primarily by a group of people with special socio-economic characteristics. These characteristics are of concern in a study of the rights and freedoms of the mentally disabled because they indicate that those committed are at the bottom of the socio-economic scale. Persons in such a class position are typically least able to use society's institutions for their own protection and would tend to be less knowledgable in the uses of the law than other groups.

The hypothesis is not a new one. August B. Hollingshead and Fredrick C. Redlich published their book, Social Class and Mental Illness: A Community Study, in 1958. Since then, other books and studies have been published, dealing with many of the same problems. In any case, there seems to be general acceptance of the idea that the sort of mental illness one is diagnosed as having and the kind of treatment one receives for it is a function of the class scale. To generalize their conclusions,

one may say that they found very few people of the upper classes being treated for illnesses in state hospitals, while many from the lower classes received such treatment. Conversely, few lower socio-economic class people were treated by private practitioners, while many upper class mentally ill people were.[1]

In addition, they found that lower socio-economic class people were typically not provided with the various kinds of insight therapy, such as psychoanalysis, since this is expensive and only rarely paid for by a third party.[2] The researchers also discovered a significant difference between the value orientations of psychiatrists and lower class mentally ill people,[3] which were seen as erecting barriers which prevented a good treatment relationship.

While it would be inappropriate to use this study to prove or disprove the Hollingshead and Redlich methods when applied to Oklahoma, it is pertinent that some of their conclusions about the typical committed mental patient are borne out by some of the findings of this study in both the materials drawn from commitment records and interviews with officials.

Data on Persons Facing Commitment

In the sample of one-hundred-and-twenty-five commitment cases from three counties, those persons alleged to be mentally ill ranged in age from sixteen to eighty-four. The mean or average age was

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[1]August B. Hollingshead and Frederick C. Redlich, Social Class and Mental Illness: A Community Study, p. 283.

[2]Ibid., p. 300.

[3]Ibid., p. 301.

forty-six years, while the median age was forty-eight. The oldest sample was that taken in Kingfisher, where the mean age of those appearing for commitment hearings was fifty-one. In Cleveland County, the mean age was forty-three, and in Tulsa it was forty-seven. There is such a commonality in these figures that one may say, with some certainty, that the average age of persons appearing for commitment is in the forty to fifty range, although the total age range is wide.

There are slightly more females in the sample than males. Sixty-five of those who appeared for commitment were women and sixty were men. Racially, a large majority of the sample were white persons. The majority race represented one-hundred-and-seven of the total sample. There were only seven Negroes and one Indian in the sample, while the race of ten persons was not indicated.

It appears that a majority of those who appeared for hearings were not married. Only fifty in the total sample were married, six were widowed, twenty-three were divorced, twenty-eight were single, three were separated, and there was no indication of the marital status of fifteen. Since the charges which led to commitment proceedings for many of those who were married arose out of domestic altercations, one may assume that the proportion of the families in the sample having marital problems was even larger than the twenty-three divorced persons would indicate.

The educational level of those alleged to be mentally ill was similar in all three counties. In Kingfisher County, the mean number of years of education for those whose educational level was reported, was nine and one-tenth years (9.1). In Tulsa County, the mean educational

level attained was nine and seven-tenths years (9.7) and in Cleveland County, nine and nine-tenths years (9.9).

On the certificate completed by the Sanity Commission, there is space for an indication of the religion of the alleged mentally ill person. In twenty-seven cases, several of them voluntary and several involving persons who were not able to convey information about themselves, no indication of religion was made. The other cases break down as is indicated in Table 3. While one cannot accept these statistics as wholly reliable--one wonders what specific denominations the sixteen "Protestants" considered theirs--they do point to some trends, which may have significance in understanding persons who face commitment proceedings in Oklahoma.

TABLE 3

RELIGION OF ALLEGED MENTALLY ILL PERSONS

Assembly of God	3
Baptist	20
Catholic	9
Christian	5
Church of Christ	6
Christian Science	3
Episcopalian	4
Holiness	2
Lutheran	2
Methodist	12
Mormon	1
Nazarene	2
Presbyterian	2
Protestant	16
None	11

Another characteristic of persons who come before courts in commitment proceedings appears to be docility. At least, the persons who are alleged to be mentally ill in Oklahoma are typically neither suicidal nor violent. Many of those who are suicidal or violent--dangerous to themselves or others--were not committed. In the total sample, there were thirty-five cases of persons who were violent and twenty-four cases of persons who had some history of suicide. Some of these involved persons who were both violent and suicidal. The evidence for determining whether or not these persons were of danger to themselves or others ranged from specific suicide attempts and overt acts of violence to persons who simply became angry in arguments and lost their tempers. However, in the total sample there were seventy-seven cases of persons who were neither violent nor suicidal, presumably of no danger to themselves or anyone else. Many of these were older adults, although the typical case was neither violent nor suicidal.

Occupational data is important in assessing the characteristics of a group of people and the certificate completed by the Sanity Commission provides space for this information. In the total sample, however, twenty of the cases had no indication of the alleged mentally ill person's occupation, some because they were unable to give the information. The balance of the occupations were:as shown in Table 4.

These indications do not present the total picture. For example, several of those listed as having occupations were unemployed at the time of the hearing. Also, several of these were not committed. The psychiatrist, whose case was heard in Cleveland County, was not committed. Neither was the only registered nurse in the sample. In Tulsa County,

TABLE 4

OCCUPATIONS OF ALLEGED MENTALLY ILL PERSONS

Housewife	22	Dry cleaner and presser	1
Farmer	8	Farm laborer	1
Unemployed or no occupation	7	Farm labor mechanic	1
Student	6	Foreman	1
Self-employed	5	Furniture mover	1
Common laborer	4	Insurance claims adj.	1
Domestic servant	4	Janitor	1
Painter-carpenter	4	Machinist	1
Mechanic	3	Nurse	1
Sales clerk	2	Odd jobs	1
Typist-secretary	2	Optician	1
Retired	2	Paper hanger	1
Waitress	2	Plumber	1
Writer-journalist	2	Practical nurse	1
Attorney	1	Psychiatrist	1
Beautician-in-training	1	Service station attendant	1
Cab driver	1	Shoe repairman	1
Cement finisher	1	Teacher	1
Clerk	1	Truck driver	1
Common laborer	1	Welder	1
Clothes designer	1		
Dishwasher	1		

which was the only county with a number of persons not committed, a retired automobile dealer, two housewives, a beautician in training, two mechanics, a teacher, a dishwasher, a retired person whose former occupation was not indicated, a furniture mover, and one person with no occupation, were not committed, in addition to the nurse already mentioned.

Although there is no specific information on the Sanity Commission certificates relating to wealth or finances, there is a space for a listing of personal and real property held by the alleged mentally ill person. The typical practice is to leave these spaces blank. This is discussed in the chapter on guardianship, but it is important to recognize that one reason

for this lack of information is likely to be that the persons who appear for commitment proceedings generally have little or no property.

Analysis of Data

When subjected to even cursory analysis, these data indicate that mental health proceedings and commitment serve, primarily, the lower socio-economic classes of the state. The implication tends to be that commitment to a hospital for the mentally ill is not "something that may happen to anyone," but something that is more likely to happen to someone from a particular socio-economic class.

If the Hollingshead index of social position[4] is used in making determinations about social class, three characteristics are of primary importance. These are the location of the person's home, his educational attainment, and his occupation. Because of the limitations on the data available for this study, little may be done with street addresses. However, an impression of this researcher, who knows both Cleveland and Tulsa counties, was that few of the cases came from the "better" parts of town.

In turning to the other characteristics, some data is available. Hollingshead divides the educational level into seven positions, ranging from less than seven years of school through graduate professional training. The sample taken in the commitment study ranked in the sixth educational category on Hollingshead's scale, designating those who had completed junior high school or ninth grade.[5]

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[4] Ibid., pp. 387-397.

[5] Ibid., p. 391.

Hollingshead also ranked occupations according to a seven position scale:

1. executives and proprietors of large concerns, and major professionals
2. managers and proprietors of medium-sized businesses and lesser professionals.
3. administrative personnel of large concerns, owners of small independent business, and semiprofessionals
4. owners of little businesses, clerical and sales workers
5. skilled workers
6. semiskilled workers
7. unskilled workers [6]

When this scale is applied to the Oklahoma three-county sample, the results are pertinent. It must be noted that several cases, including students, housewives, and those for whom no occupation is indicated, are excluded. Ideally, housewives and students would rank at the level of the husband or father, but there is no data available on his occupation for these cases (see Table 5).

Forty-three of the cases fall in the lower three occupational categories. Both the median and mean category is five, although the modal category is number seven.

TABLE 5

OCCUPATIONAL POSITION OF ALLEGED MENTALLY ILL PERSONS

Position	Number
1	2
2	1
3	7
4	18
5	15
6	6
7	22

[6] Ibid., pp. 390-391.

One may conclude from the occupational and educational materials that those who appear for commitment generally fall into the lower socio-economic classes, when these elements are used as criteria.

Returning to the information on religion, Hollingshead and Redlich suggest that Baptist and Methodists comprise the largest portion of the lower-class Protestants. "The Baptist church has the largest single group . . . the Methodists are a poor second . . . . Significantly few Protestants claim to be Congregationalists or Episcopalians. These churches are oriented toward the higher social strata."[7] This sample indicated that twenty of the persons coming before sanity commissions were Baptists with the Methodists, represented by twelve, filling the second position. There were four Episcopalians in the sample and no Congregationalists.[8] It is likely that the large number of Protestants for whom no specific denomination was designated, would fall into one of the two major groupings.

This empirical data, alone, seems to suggest that involuntary commitment and the mental health institution, itself, is a predominantly lower socio-economic class agency, which is rarely used by persons of other classes.

Comments of Officials on Characteristics of Patients

When the analysis of the data began to point in the directions indicated, this researcher began asking mental health and legal officials about the socio-economic characteristics of the patients. Dr. Hayden

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[7] Ibid., p. 123.

[8] Table 3, p. 93.

Donahue, the first person interviewed in connection with this study, confirmed the suppositions. He suggested that there were significant social and cultural characteristics among mental hospital patients. There are very few cases of mental illness among the upper classes, particularly the severe forms of mental illness. And when mental illness does hit the upper classes, they can get private help and get it early, before the illness becomes severe. And they shy away from mental hospitals.[9]

Ethnically, he indicated that there are only a handful of Jewish patients in mental hospitals and that few Jews are psychotic. But there are many cases of alcoholism among the Italians and Irish.[10]

There are some changes in this, he suggested. The private sanitaria are beginning to admit more and more blue and white collar workers, primarily because so many members of the working classes now have health insurance that will cover their hospitalization in private institutions. In addition, many of the voluntary patients in state institutions are from the lower and middle middle classes.[11]

But by and large, the state hospitals for the mentally ill serve the lower classes. Commitment rarely occurs in the upper and middle classes. The persons who are in state hospitals almost constitute a special class. Dr. Donahue wondered if the movement toward community clinics would really change the behavior of those who use mental hospitals.

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[9]Interview with Dr. Hayden Donahue, November 23, 1964.

[10]Ibid.

[11]Ibid.

He speculated that the people who use these institutions are "not clinic types." He expects them to continue coming for hospitalization, even after the clinics have greater impact. As evidence of the special class characteristics of the patients, Dr. Donahue indicated that only twenty-two per cent of all the patients pay anything for hospitalization, and only two hundred or so pay the full amount. These typically obtain the money from some sort of pension or insurance.[12] Since Oklahoma statutes requires persons able to pay to do so, this is a good indication of the generally lower class position of the mental hospital patients.

Dr. E. P. Henry also indicated that a majority of the patients at the Taft State Hospital were from poorer families.[13]

The other two superintendents of state hospitals for the mentally ill did not agree completely or readily with the notion that most of the patients were from the lower socio-economic classes. Dr. Bedford Peterson of the Eastern State Hospital suggested that a large number of persons who have private insurance policies will use these for care in private institutions when they become mentally ill. Eastern State does get some patients who are fairly wealthy. In order to erase the differential, Dr. Peterson believes, a hospital must be sold as a hospital, something which he had done in Tennessee. People occasionally become better more rapidly in public hospitals than in private, simply because the public institution is interested only in the person, not his

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[12] Ibid.

[13] Interview with Dr. E. P. Henry, December 21, 1964.

money. The public hospital's criteria for success relates to discharging people. However, it is probably true that most patients currently committed are from the lower socio-economic classes. Voluntary patients are more likely to be from the upper and middle classes.[14]

Dr. Peterson was interested in the data obtained on educational levels attained by alleged mentally ill people. He said he had seen and done studies before which indicated that the average educational level of mentally ill persons was higher than the general public's. He speculated that the nine to ten years of education average indicated by this study would probably be higher than the educational level of the Oklahoma community, in general. Being mentally ill requires a degree of intelligence, he suggested.[15] In terms of the data for this study, Dr. Peterson suggested that some well-educated people may deteriorate, because of mental illness, to poverty. In other words, their poverty or lower socio-economic status may be a result of their mental illness, rather than vice-versa. The socio-economic level at the time of commitment, he indicated, doesn't tell everything about the person's characteristics.[16]

Dr. Harold B. Witten of Western State Hospital felt that there was no special socio-economic status that would typify his patients.

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[14] Interview with Dr. Bedford Peterson, December 21, 1964.

[15] The U. S. Deskbook of Facts and Statistics for 1964-65 indicates that the median education level of Oklahomans twenty-five years of age or older was, in 1960, 10.4 years, half a year more than the average educational level of those identified in the study of commitment cases.

[16] Interview with Dr. Bedford Peterson, December 21, 1964.

Representation from the various classes was average and the hospital has a good cross-section of the population, he said.[17]

As is mentioned in Chapter VIII, Dr. Albert Glass indicated that only half of all the patients in Oklahoma state hospitals pay anything, and only a few, perhaps five per cent, pay the maximum amount of one hundred and fifty dollars per month.[18] Because the statutes on payment for care are rather specific, one may assume that this is a rather valid indication of the socio-economic class of the patients. When ninety-five per cent are unable to pay one hundred and fifty dollars per month for their maintenance, this would appear to indicate that virtually every patient is a member of the lower socio-economic class.

The judges who were interviewed did not agree with these findings. Judge Whit Y. Mauzy of Tulsa County said that anyone can become mentally ill and that it could hit him or the interviewer. He estimated, however, that some twenty-five per cent of those committed were destitute while the remaining seventy-five per cent had fair incomes. Some intelligent and wealthy persons are committed and Judge Mauzy discussed several cases involving professional persons and college students.[19]

Judge J. David Rambo indicated that most of the people committed in Cleveland County were of moderate income, although most seemed to

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[17]Interview with Dr. Harold B. Witten, December 21, 1965.

[18]Interview with Dr. Albert Glass, November 18, 1965.

[19]Interview with Judge Whit Y. Mauzy, November 16, 1965.

have money problems. There are more persons committed from Cleveland County in the lower middle class, he suggested, than in the very low class. The lowest classes have a low incidence of commitment in Cleveland County.[20]

Allowing for some differences in definitions of classes, Judge Rambo may have an important point. While the evidence is conclusive that most of the persons committed are in the lower class, there do not appear to be a large number from the bottom of the social scale--those without education and without any history of steady work.

Judge Francis Borelli of Kingfisher County said that there were no special socio-economic characteristics among those committed to state institutions for the mentally ill.[21]

In the state schools for the retarded, the general belief seemed to be that most of the pupils were poor, primarily because those with better financial circumstances would be inclined to use private institutions. Dr. J. L. Dunigan of the Enid State School said he had no facts on this, but had a notion that this was the case.[22] Joseph Deacon at the Pauls Valley State School indicated that mental retardation is a problem that knows no socio-economic barriers but did confirm that the population of his school, as indicated in Chapter VIII, is typically unable to pay the cost of care.[23]

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[20]Interview with Judge J. David Rambo, December 20, 1965.

[21]Interview with Judge Francis Borelli, December 20, 1965.

[22]Interview with Dr. J. L. Dunigan, December 29, 1964.

[23]Interview with Joseph Deacon, December 22, 1964.

Dr. Peterson believed, when interviewed, that lower socio-economic characteristics might be more typical of the pupils of a school for the retarded than the patients in a mental hospital, because of the hereditary nature of retardation.[24]

Conclusions

It would appear rather clear from the research done in commitment cases in Oklahoma, that most of those who appear for commitment and who are committed are from the lower socio-economic classes. This appears to be in a proportion greater than what would be expected as a cross-section of the population. This means that in Oklahoma, mental illness and mental hospitalization are closely tied to the class and occupational structure. The mentally ill who are alleged to be mentally ill, taken before sanity commissions, and committed, are not like everyone else. The constitute an almost distinct class in the society.

They are usually in their late forties, although they may be as young as teenagers or as old as the late eighties. Many who are married have marital problems and the majority are not married. They are concentrated in jobs at the lower end of the occupational scale and few have any property that is sufficiently significant to mention on the certificate prepared by the Sanity Commission. Educationally, they are often high school graduates and some have college work, but the average educational level is only a bit higher than junior high school.

It would seem that those who are committed to state institutions

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[24]Interview with Dr. Bedford Peterson, December 21, 1964.

are among the weakest, in general terms, in the state. They are generally most vulnerable and less adept than the general population at using public institutions for their own benefit. This is due to their class position as much as their mental illness, it would seem. These facts make protections of those alleged to be mentally ill even more important, because they are among the least able to protect themselves.

The schedule used in gathering this data on the characteristics of commitment cases may be found in Appendix A.

CHAPTER V

COMPETENCE, GUARDIANSHIP, AND RESTORATION

An issue which arises out of commitment to a mental hospital is the competency of the hospitalized person. Legal guardianship of the person's property is at issue when competence is in question. Restoration to legal competence of a person declared incompetent once he is released from a hospital or recovered from his illness is a third issue of legal status arising from hospitalization.

The complexities of these issues and the practices and procedures which govern them in Oklahoma, along with recommendations by various experts and comparisons with practices in other jurisdictions comprise the subject matter of this chapter.

Competency and Incompetency

In an excellent discussion of the subject, the American Bar Foundation study notes that "Incompetency and hospitalization are two distinct legal concepts determining separate issues and leading to different results."[1] The report traces the concept of competency back to medieval English practices and says that it became a responsibility of the king to provide guardianship for the incompetent's property.[2]

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[1] Lindman and McIntyre, Jr., op. cit., p. 219.

[2] Ibid., p. 218.

With a rather clear table, the report distinguishes between the two:

TABLE 6

DIFFERENCES BETWEEN INCOMPETENCY AND HOSPITALIZATION

	INCOMPETENCY	HOSPITALIZATION
TEST	Unable to care properly for one's property or person due to one of the following conditions:	Dangerous to self or others, or in need of treatment due to one of the following conditions:
APPLICABLE TO CASES OF	Mental illness Mental deficiency Drug addiction Alcoholism Senility Physical disability Spendthrifts	Mental illness Mental deficiency Drug addiction Alcoholism Epilepsy
PURPOSES	Protect estate from dissipation and provide protection for persons who are unable to care for themselves	Removal from society for protection of the individual or of society and/or for treatment of the illness
PRIMARY RIGHT AFFECTED	Civil rights	Freedom to be at large
COMPARABLE TO	Legal status of a minor	Person removed from society for a contagious disease[3]

Although one may disagree with the specifics of the chart and wonder whether or not the role of a hospitalized mentally disabled person is more comparable to that of a prisoner than to a person removed from society for a contagious disease, the chart does clarify the significant differences between the two actions.

[3] Ibid., p. 219.

Oklahoma common law distinguishes between competency and mental health. The definitions of incompetency and insanity differ. It has been clearly stated that the procedures for determining the two also differ. In a case which was handled by the Oklahoma Supreme Court and twice denied certiorari by the United States Supreme Court, it was determined that the modes of procedure for the two are different and not to be confused. The same case found that the rules for determining insanity are stricter than those for determining incompetency.[4]

Incompetency has been rather clearly defined through court decisions. In the case of Charley v. Norvell, an incompetent person was defined as one who lacked sufficient mental capacity to understand in a reasonable manner the nature and effect of the act which he was doing.[5] The definition was clarified and sharpened in a later case, In re Winnett's Guardianship, which added that a competent person must be able to understand and act with discretion. Mental incompetence or incapacity was seen as existing when there was an essential privation of the reasoning faculties or an incapacity of the person in the ordinary affairs of life.[6]

Another case further developed the law and suggested that an important test for incompetency was the ability of the person in question

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[4] Ned v. Robinson, 181 Okl. 507, certiorari denied 58 S. Ct. 1054, 304 U. S. 550, L. Ed. 1522, rehearing denied, 59 S. Ct. 58. 305, U. S. 669, 83 L. Ed. 434.

[5] Charley v. Norvell, 97 Okl. 114.

[6] In re Winnett's Guardianship, 112 Okl. 43.

to avoid being cheated by swindlers. The Oklahoma Supreme Court decided in Armstrong v. Martin that terms such as incompetent " . . . mean any person who is unable properly to manage or take care of his property unassisted and would likely be deceived or imposed on by artful and designing persons because of old age, diseases, mental weakness, or any other cause, though he is not insane."[7] This case also specifies that incompetency does not necessarily connote insanity. However, in Oklahoma involuntary commitment for insanity or mental disability does include incompetency.

The precise meaning of all the terms used in these definitions such as "unable properly to manage or take care of his property unassisted" or "knowing the nature and effect of the act" or "essential privation of the reasoning faculties" are determined by the court hearing the case. It was established in the case of In re Thomas that competency is an issue of fact which is to be determined by the court in the same way as other questions of fact.[8]

Persons who are alleged to be incompetent are protected by various procedures and rules. It appears that a person alleged to be incompetent must be given notice, personally served or served upon someone responsible for the alleged incompetent. Three cases, Tiger v. McCallom, In re Mize's Guardianship, and Shimonek v. Tillman make this clear.[9] However, one person's testimony to the person's incompetence

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[7]Armstrong v. Martin, 203 Okl. 565.

[8]In re Thomas 207 Okl. 321.

[9]Tiger v. McCallom, 89 Okl. 249; In re Mize's Guardianship, 193 Okl. 164; Shimonek v. Tillman, 150 Okl. 177.

is sufficient.[10] When there is a charge of incompetence brought to the judge of a County Court, he must call a guardianship hearing.[11] If it is found that the person is, in fact, incompetent, the judge must appoint a guardian of the person's person and estate.[12]

Most of the above would apply to an alleged incompetent who is not hospitalized. The rules on this and the guardianship which ensues are detailed and complex and discussed later in this chapter.

It is important to note that the statutes on mental illness do not positively say that mentally ill persons are automatically incompetent. These statutes do provide for restoration of competency and contain one section relating to the legal mental incompetency of patients. It says:

> No person admitted to any institution in the Department shall be considered legally mentally incompetent except those admitted in accordance with the provisions of Sections 55 and 58 of this Title and those admitted under Section 59 of this Title who have been declared legally mentally incompetent elsewhere.[13]

While the sections of the law mentioned in this section say nothing about incompetency, the implication is and the judicial opinion is that persons who are involuntarily committed are, at the same time, found incompetent. This adjudication of incompetency, implied in the commitment proceedings, along with various statutes which view involuntary commitment as prima facie evidence of mental incompetence, lay the

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[10] In re Prince's Guardianship, Okl. 379 P 2d 845.

[11] 58 O. S. (1961) Sec. 851.

[12] 58 O. S. (1961) Sec. 852.

[13] 43A O. S. (1961) Sec. 64.

basis for the loss of rights discussed in subsequent chapters.

According to one of the drafters of the mental health statutes, the intent was to make incompetence and illness separate issues. Dr. Hayden Donahue says that he and the others who worked on the Mental Health Law of 1953 intended to separate the two but that judicial officials from the beginning have held that it was the intent of the law to declare incompetent those who are found to be mentally ill.[14]

The issue of incompetence being determined along with mental illness was an important one at the United States Senate hearings on "Constitutional Rights of the Mentally Ill." Ultimately, the proponents of separation were successful and the new law governing mental health practices in the District of Columbia makes the difference clear. Because the hearings involved such a variety of experts on the subject, it would be pertinent to discuss some of their thinking.

Dr. Winfred Overholser, Superintendent of St. Elizabeth's Hospital in Washington, pleaded for the separation of the two issues. He told the subcommittee:

> Commitment should only authorize the patient's hospitalization. In a number of jurisdictions, including the District of Columbia, the commitment to a mental hospital by itself constitutes an adjudication of incompetency. Not all of those persons in need of hospital care are unable to carry on their business, and the existence of an adjudication of this sort operates against the interests of the individual, particularly when he is released from the hospital.[15]

Dr. Overholser's statement seemed to set the tone for the hearings. Most

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[14]Interview with Dr. Hayden Donahue, November 23, 1964.

[15]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary., op. cit., p. 21.

of those who appeared had either objections to or nothing to say about the adjudication of incompetence along with the decision to hospitalize a patient. No one seemed to defend the current practice. For example, Albert Deutsch said: " . . . commitment in most States automatically strips them (committed patients) en masse of specific civil rights--sometimes of all such rights, regardless of their individual capacity."[16]

Dr. Francis J. Braceland of the American Psychiatric Association and the National Association of Mental Health said, on behalf of his organizations:

> We would like to say also that the diagnosis of a mental illness does not ipso facto warrant a finding of incompetency . . . As a matter of fact, in some instances there is no connection. A person who is paranoid; that, is has ideas of persecution along a certain system, as long as he discusses or thinks about that delusional matter he is sick, but when it comes to his other affairs he is not incompetent and he is usually perfectly capable of carrying on his own affairs.
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> Therefore, each individual must be judged in an individual fashion.[17]

Dr. Braceland and Dr. Jack R. Ewalt, head of the Psychiatry Department at the Harvard University School of Medicine, expanded on this idea somewhat in a joint statement prepared for the committee. They said that there was no medical reason for incompetence and mental illness to be considered synonomous and carried this further by saying that psychiatrists believe patients should retain as many civil rights as they are able to exercise. They consider this retention and the exercise of these rights therapeutically significant.[18]

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[16] Ibid., p. 42.

[17] Ibid., p. 68.

[18] Ibid., p. 82.

William A. Creech, the Staff Director and Chief Counsel of the subcommittee raised a question on the protection which is afforded a patient when he is either declared incompetent or not incompetent. Mr. Creech suggested that an absence of incompetency rulings, which would theoretically leave a hospitalized patient free to exercise any civil right, could conflict with hospital procedures and regulations on patient behavior. In essence, the hospital would then be in a position of denying rights without due process--without the legal right to do so.[19] It exercises such limits under its legal responsibility of in loco parentis, which is based upon the patient's need for care and supervision.

Presenting the prevailing opinion from a state which separates incompetency and mental illness proceedings, Dr. Manfred Guttmacher, Chief Medical Officer of the Supreme Bench of Maryland, said:

> My experience has convinced me that commitability because of mental illness should not be equated with incompetency. These are separate issues and they should be kept so. The stigma of incompetency should be added to that of insanity only when practical necessity so dictates and never otherwise in my opinion.[20]

Dr. Guttmacher continued by explaining that a committed patient in Maryland loses no rights and therefore has no need to enter into a restoration proceeding when he is discharged. Nothing is forfeited in Maryland, thus there is nothing to restore.[21]

Without offering any value judgments on the practice, Dr. C. H.

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[19] Ibid., p. 106.

[20] Ibid., p. 150.

[21] Ibid., p. 151.

Farrell, a psychiatrist in Omaha, Nebraska, told the subcommittee that committed patients in Nebraska automatically lose their right to vote and are declared incompetent.[22] This would appear to be comparable to the Oklahoma practices.

Public Law 88-597 which ultimately resulted from these subcommittee hearings states:

> No patient hospitalized pursuant to this Act shall, by reason of such hospitalization, be denied the right to dispose of property, execute instruments, make purchases, enter into contractural relationships, vote and hold a driver's license, unless such patient has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.[23]

The law further outlines specific provisions for declaring a hospitalized patient incompetent. It also restores competency, automatically, to all persons hospitalized before the date of the law at the end of one year following the date of the enactment of the act.[24]

It is important to recognize that in Oklahoma and many other jurisdictions the determination of incompetency along with hospitalization applies to only one part of all the persons institutionalized. For the mentally ill, it applies only to those who enter hospitals on an involuntary court order. One of the values of the voluntary admission procedure, as mental health officials see it, is that it does not involve the loss of any civil rights. Some of the reforms in admission procedures proposed by mental health officials are designed to help patients

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[22] Ibid., p. 161.

[23] 78 U. S. Statutes at Large, p. 951.

[24] Ibid.

avoid the loss of legal competency and the need for restoration procedures. Mentally retarded people, as has been indicated, do not lose their competency upon admission to a school for the retarded, because of the admission procedures used in such institutions. So even if declaring all of those sufficiently disabled to enter an institution incompetent were to be considered desirable as a protection of the public or the committed person, the present laws and practices do not provide for this. They only provide for the incompetency of some of these individuals.

The precise meaning of competency, the limits placed upon incompetent people, and the protections they are afforded by the law, are all complex issues. It is obvious that the issue of competence is no small matter. In addition to certain kinds of specific rights which are lost due to the incompetency declared upon commitment to a mental hospital, there are a variety of property rights and protections which turn on this issue.

Despite the importance of the issues, there is only minimal clarity on the subject of competency, when one is able to take action on the basis of a number of correlative concepts such as "unsound mind," or "totally lacking in understanding." For example, Oklahoma law provides that "All persons are capable of contracting, except minors, persons of unsound mind and persons deprived of civil rights."[25] Since involuntarily committed mentally ill people fall under the last two categories, it would appear that they are unable to make contracts. The courts have clarified this in one decision which provides

[25] 15 O. S. (1961) Sec. 11

that a contract purportedly made by someone who totally lacks understanding is void.[26] But what this means and when this total lack of understanding was to have existed is not easy to determine.

Other statutes specify that persons of unsound mind only have capacity as it is defined by the state statutes.[27] The notion is further developed in a statute which says "Persons of unsound mind within the meaning of this chapter are idiots, lunatics, and imbeciles."[28]

A case which was ultimately appealed to a United States Circuit Court of Appeals and denied certiorari by the United States Supreme Court, determined that an adjudication of incompetency is not the same as an adjudication of unsound mind.[29] In other words, being declared incompetent does not always mean that one is of unsound mind.

Despite the seeming clarity of these matters, the case or common law rules on such issues are not nearly so clear. According to Judge J. David Rambo, a mentally ill person is able to write a legally valid will in Oklahoma.[30] Precisely how this may be possible will be evident in the discussion of common law rulings on the meaning of competency. For example, the case of Hill v. Davis resulted in a ruling that a person whose recovery from mental illness was never adjudicated

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[26] Dozier v. Schuermann, 175 Okl. 298.

[27] 15 O. S. (1961) Sec. 12.

[28] 15 O. S. (1961) Sec. 16.

[29] Thlocco v. Magnolia Petroleum Co., CAA Tex, 141 F 2d 934, certiorari denied 65 S. Ct. 276, 323 U. S. 785, 89 L. Ed. 627.

[30] Interview with Judge J. David Rambo, December 20, 1965.

could still write a will which was valid if, at the time he wrote it, he was actually recovered.[31]

The assumption appears to always be that one is sane until the opposite is proven. Sanity and competence are always presumed.[32] One case carries this somewhat further and says that a presumption of sanity prevails until the contrary is shown.[33]

So whether or not a person is competent or incompetent may depend upon the details of the circumstances, his condition at the time of the contested action, and his behavior. Oklahoma statutes attempt to spell this out. One provision deals with people who are entirely without understanding:

> A person entirely without understanding has no power to make a contract of any kind, but he is liable for the reasonable value of things furnished to him necessary to his support or the support of his family.[34]

Again, the case law on this issue turns on the definition of what may constitute the condition of being "entirely without understanding." The common law rule appears to be that one must prove a lack of understanding at the time the contract was executed. It must be shown that the person in question was not able to comprehend the nature and effect of the contract to an extent that was reasonable.[35] This would mean that the allegedly incompetent person need not completely understand the

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[31] Hill v. Davis, 64 Okl. 253.

[32] Metropolitan Life Ins. Co. v. Plunkett, 129 Okl. 292.

[33] Lantis v. Davidson, 60 Kan. 389.

[34] 15 O. S. (1961) Sec. 22.

[35] Charley v. Norvell, 97 Okl. 114.

contract but may generally comprehend its implications and be competent to contract.

Through a number of cases, this principle is defined and redefined. One case was concerned with a woman who had been in an asylum but was later released to the care of her husband. After this release she was locked in a room, guarded by a man, had fits, and frequently became violent. She often wanted to fight and acted irrationally. She could carry on no conversation. When this condition was shown to exist within a few days of the making of the contract, the Oklahoma Supreme Court ruled that she was without understanding in the meaning of the statutes.[36]

Another case led to a ruling that a man who was an idiot for his whole life and had never transacted any business or understood anything was without understanding within the meaning of the law.[37]

But it is doubtful that many cases are this clear. Thus there have been various cases dealing with the gray areas of incompetence. In regard to deeds, if a person who grants a deed is without understanding and cannot comprehend that the effect of his deed will be to divest himself of his property, the deed is void.[38] However, when an incompetent person makes a deed before his incompetency is judicially determined, the deed is considered voidable but not void. Thus someone who obtains a mortgage on the property without knowledge of the grantor's

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[36]Norris v. Dagley, 64 Okl. 171.

[37]Long v. Anderson, 77 Okl. 95.

[38]Harris v. International Land Co., 89 Okl. 163.

incompetence has a valid lien.[39] This tends to reflect the tendency for each case to be decided on its own merits. When engaging in business with a person who is or may be incompetent, the effect of the negotiation is not, it would seem, wholly predictable.

As is the case in other areas involving legal actions by people considered incompetent, the actions are typically voidable, but not always void. This is true of a judgment against an insane person, according to the decision in one case.[40] But the laws generally seem designed to protect persons who are incompetent, rather than those who enter into contracts with them. One specific ruling says that a person without understanding, as defined in the statutes, is responsible only for the reasonable value of those things furnished to him for the support of himself or his family.[41] This would tend to protect a mentally ill or retarded person against deception and inflated prices.

Provided for specifically by the law are contracts made by persons who are of unsound mind, but not wholly without understanding:

> A conveyance or other contract of a person of unsound mind, but not entirely without understanding, made before his incapacity has been judicially determined, is subject to rescission without prejudice to the rights of third persons, as provided in the article on extinction of contracts.[42]

It has been decided by the courts that this statute does apply

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[39] Maas v. Dunmeyer, 21 Okl. 434.

[40] Blair v. Blair, 124 Okl. 128.

[41] McKone v. McConkey, 77 Okl. 3.

[42] 15 O. S. (1961) Sec. 23.

to persons who have not yet been judicially determined incompetent.[43] However, this statute and all the statutes relating to contracts made by incompetents are for the purpose of protecting the incompetent. That is, avoiding a contract because one of the makers is mentally ill is only for the purpose of protecting the incompetent person, according to a decision in Davidson v. National Aid Association.[44] Another case relating to this statute defines "insane" or "of unsound mind" as referring to a mental condition produced by age, disease, grief, or affliction.[45]

Several cases seem to indicate that the courts are willing to allow unusual latitude in admitting evidence which will clarify the mental status of a contracting person when this is in question. A decision in one case said that when the mental condition of a person executing a contract was being determined, great latitude could be allowed in admitting evidence of acts and declarations inconsistent with that person's sanity.[46] Another case allows non-experts who have observed the behavior of the person in question to give an opinion on his sanity.[47] Specialists are also given extra latitude in such cases. When some specialists in mental illness were asked if they knew what constituted incompetency in Oklahoma and whether or not they knew that the person in question had been judged competent, this subject

[43] Jones v. Mead, 111 Okl. 16.

[44] Davidson v. National Aid Association, 174 Okl. 155.

[45] Oklahoma Natural Gas Corp. v. Lay, 175 Okl. 75.

[46] Edwards v. Miller, 102 Okl. 189.

[47] Conwill v. Edridge, 35 Okl. 537.

matter was held immaterial.[48]

The rules on the admission of evidence from proceedings to determine competency also appear to be restricted. The case of McIntosh v. Reason established that a County Court order which adjudges a person incompetent is not admissible as evidence of the person's incompetency at the time of a previous conveyance of real estate.[49] This would appear to be related to the ability of the person to reason and understand at the time of the conveyance of the property. The operative rule on this seems to be that the person's capacity to make a deed is determined by whether or not he has the ability to understand the nature and effect of the act in which he has engaged.[50]

This "ability to understand" test appears to have been tested in some rather clear cases. In one case it was determined that when one obtains property from a feeble-minded person and gives nothing in return for the property, there is a very strong presumption of fraud. If the presumption is not rebutted, a court of equity will set aside the transaction (in this case a deed).[51] Another case ruled that when a grantor cannot understand the value of his land which he has conveyed and cannot distinguish between ten and one hundred dollars and when payment for the property was grossly inadequate, a court of equity will set aside the transaction.[52]

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[48] McIntosh v. Reason, 69 Okl. 314.

[49] Ibid.

[50] Grayson v. Brown, 166 Okl. 43.

[51] Guinan v. Readdy, 79 Okl. 111.

[52] Poulter v. Manuel, 25 Okl. 59.

As mentioned earlier, however, an adjudication of incompetency does not last forever and a person so judged may be able to carry on certain kinds of activities:

> After his incapacity has been judicially determined, a person of unsound mind can make no conveyance or other contract, nor designate any power, nor waive any right, until his restoration to capacity is judicially determined. But if actually restored to capacity, he may make a will, though his restoration is not thus determined.[53]

This was tested in one case and found to mean that if a person was actually recovered from his incapacity he could make a valid will, even if this restoration had not been adjudicated by a court.[54]

It would appear to this non-lawyer that the status of mentally ill persons in terms of competency in Oklahoma is uncertain. There are conflicting rules based upon common law. Whether or not a mentally ill person is competent depends upon the circumstances of the case and the services of an attorney would probably be needed to determine this. Although a committed mentally ill person is supposed to be legally incompetent until he is legally restored, as will be discussed later, precisely who was and is competent, when and under what circumstances, appears to be a matter for the courts to determine. The issue of competence is probably of greatest concern when property is involved. Of course, competency has a number of implications and applications outside of the mental health field. The laws seem to be designed to protect incompetent individuals, who may

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[53] 15 O. S. (1961) Sec. 24.

[54] Hill v. Davis, 64 Okl. 253.

be victims of a variety of problems, including but not limited to mental disability.

Individuals who are considered incompetent are protected in one other way, through a variety of statutes which may generally be classified under the title of statutes of limitations. One section says:

> Any person entitled to bring an action for the recovery of real property, who may be under any legal disability when the cause of action accrues, may bring his action within two years after the disability is removed.[55]

The case of Lantis v. Davidson established that an insane person is disabled within the meaning of this statute, even if this has not been determined by a court.[56] Thus a mentally ill person, whether or not he is officially adjudicated as such, would have two years from the date of his recovery to recover real property.

Another section deals with other kinds of actions:

> If a person entitled to bring an action other than for the recovery of real property, except for a penalty of forfeiture, be, at the time the cause of action occurred, under any legal disability, every such person shall be entitled to bring such action within one year after such disability shall be removed.[57]

A number of cases have established that once the "statute has attached" the period runs without suspension even if the person has subsequent disabilities.[58] This does not apply, however, in Workman's Compensation

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[55] 12 O. S. (1961) Sec. 94.

[56] Lantis v. Davidson, 60 Kan. 389.

[57] 12 O. S. (1961) Sec. 96.

[58] Givens v. Jones, 158 Okl. 124; Shawnee National Bank v. Merler, 106 Okl. 71; Overstreet v. Wichita Falls and N.W.R. Co., 73 Okl. 191.

Act claims.[59]

The evidence presented here, which can only be summarized by a disclaimer--that one may only guarantee uncertainty in regard to the competence and legal powers of the mentally ill or retarded--tends to support some of the conclusions drawn in the American Bar Foundation study. That report says that the statutes which regulate the personal and property rights of the mentally disabled are unclear,[60] and that the relationship between hospitalization and incompetency is also unclear. That report suggests that competency and hospitalization are two separate issues and should be dissociated.[61] When interviewed, Judge J. David Rambo agreed with this position. He said that not all mentally ill people are incompetent.[62]

The ideal arrangement would probably be that suggested by the American Bar Foundation Study which suggests that the personal and property rights of a mentally disabled person be dependent upon his ability to exercise them.[63] That is, mentally disabled persons should be enabled to handle as much of their own business as they are able to handle, without any sweeping declarations of general incompetency handicapping them. The report observes that the lack of clarity in most state laws leads to overly cautious dealings with the mentally ill even

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[59] United Brick and Tile Co. v. Roy, Okl. 356 P 2d 107.

[60] Lindman and McIntyre, Jr., op. cit., p. 272.

[61] Ibid., p. 228.

[62] Interview with Judge J. David Rambo, December 20, 1965.

[63] Lindman and McIntyre, Jr., op. cit., p. 272.

though the law may permit greater activity.[64]

If the law is unclear on the legal competence of involuntarily committed patients, it would appear to be even less clear on the competence of voluntary patients. Although such individuals are specifically excluded from being declared incompetent by mental health laws,[65] the common law position on this does not seem to have been established.

The loss of competence is one of the most significant effects of hospitalization and it is one which is not generally known. Dr. Thomas S. Szasz blames this lack of information on what he calls the "mental health lobby" which he says propagandizes the public about the need for treatment but fails to tell the other side of the story--that one may be declared incompetent, lose the right to make contracts, or lose the right to drive a car. Dr. Szasz says that the "lobby" has an unlimited ability to disseminate propaganda for "health," which is not easy to oppose. Part of his role and his desire is to balance these matters by providing Jeffersonian checks and balances to that propaganda. People must know the dangers of mental hospitalization, too, he says.[66]

Guardianship

One of the results of involuntary hospitalization and the declaration of incompetence which goes along with it may be the appointment of a guardian for the property of the committed patient. The statutes provide that the person of the patient or pupil be guarded

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[64] Ibid.

[65] 43A O. S. Supplement, 1965, Sec. 558.

[66] Interview with Dr. Thomas S. Szasz, August 10, 1965.

by the superintendent of the institution:

> The superintendent of any institution within the department shall be the guardian of the person of the patients committed to such hospitals for the purpose of retaining them therein. The superintendent of the hospital shall have exclusive custody and control of the person of the patient during the period of time he is detained for observation or treatment or both, whether a guardian of the person of said patient has been appointed or is appointed by any court.[67]

The law applying to guardianship of mentally retarded pupils seems to be equally clear:

> The superintendent of any institution named in S 1 of this Act shall be guardian of the person of the pupils admitted to such institutions. The superintendent of the institution shall have exclusive custody and control of the person of the pupil during the time he remains in the institution, whether a guardian of the person of said pupil has been appointed, and no other guardian of the person shall be appointed while said child remains in said institution.[68]

Oklahoma statutes provides for the appointment of a guardian in cases where this seems justified, to handle the patient's property:

> . . . The court, upon making such order for admission into a hospital if, in his judgment, a guardian of such mentally ill person is needed before his admission to the hospital, home or institution, may by separate order and without further notice appoint summarily a guardian of the person only of such mentally ill person, which guardianship of the person shall continue only until the mentally ill person is admitted to the hospital, home, or institution. Such guardian of the person shall give bond in such sum as may be directed by the court or the judge thereof. A guardian of the estate of such mentally ill person shall be regularly appointed, and such guardian shall have the same rights and be subject to the same duties with respect to the estate of his ward as guardians of incompetent or mentally ill persons have by law . . .[69]

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[67] 43A O. S. (1961) Sec. 95.

[68] 56 O. S. Supplement, 1963, Sec. 311.

[69] 43A O. S. (1961) Sec. 55.

Although there seems to be no question about the guardianship of the person, there may be a lack of clarity in the guardianship of property. Out of fifty cases examined in Cleveland County, only five made any mention of property. In the rest of the Sanity Commission reports, there was no indication of property holdings. In the sample studied in Tulsa County, thirty-five cases had no indication of property held by the alleged mentally ill person, and most of the fifteen who had some indication said that they had none. Only in Kingfisher County did a majority--almost all--have some indication of property. This tends to support the notion that most people who are alleged to be mentally ill are also poor, as is discussed in Chapter IV.

Another explanation for this discrepancy was offered by Judge Whit Y. Mauzy of Tulsa County. He said that property is a matter which is involved in guardianship, a separate procedure which often follows the commitment proceedings. Because financial issues are dealt with in depth during the guardianship proceedings, they need not be raised or examined with the Sanity Commission.[70] Since part of the folklore of "railroading" relatives involves having people sent away so that the family can possess the patient's property, one would think that a large issue would be made of the alleged mentally ill person's wealth. Apparently, however, these matters are protected by other statutes and procedures.

Judge J. David Rambo explained that the judge rarely appoints a guardian on his own motion--at least in Cleveland County. Generally, he

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[70]Interview with Judge Whit Y. Mauzy, November 16, 1965.

explains the situation to the family and they initiate proceedings for guardianship. A guardian is not always needed, according to Judge Rambo. If the committed person has no assets or if his assets are protected, such as United States Savings Bonds, no guardian is necessary. If, however, the assets are wasteable, such as an operating business, or stocks, there is such a need.[71]

This appears to be the practice in most states which merge hospitalization and incompetency.[72] That is, a person declared incompetent but not hospitalized usually has a guardian appointed for his assets.[73] This is not always true for the person who is incompetent because of institutionalization.

Once a guardian is appointed he assumes a special legal status in relation to the ward and is enabled to act for the ward in all sorts of procedures. However, the guardian remains responsible to the court which appointed him and, because of statutes and court decisions, remains responsible to the ward.

Several statutes clearly define the relationship, which permits the guardian to act for the ward:

> Whenever an infant or an insane or incompetent person, has a guardian of his estate residing in this State, personal service upon the guardian of any process, notice, or order of the county court concerning the estate of the deceased person, in which the ward is interested, is equivalent to service upon the ward; and it is the duty of the guardian to attend to the interests of the ward in the matter. Such guardian may also appear for his ward, and

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[71] Interview with Judge J. David Rambo, December 20, 1965.

[72] Lindman and McIntyre, Jr., op. cit., p. 225.

[73] Ibid.

> waive any process, notice, or order to show cause which an adult or a person of sound mind might do.[74]

It is clear that the title to property, both legal and beneficial, of the incompetent ward resides in the ward rather than in the guardian. The guardian does not become an alter ego of the ward. He is not empowered to act for the ward in matters of personal discretion to change something that was done while the incompetent was normal or of sound mind.[75]

This principle is spelled out in a statute which makes the guardian both responsible to the ward and liable.[76] Thus the powers of the guardian are limited. Another statute spells out the procedure for ending guardianship at the time the ward is restored to competency. The judge must hold a hearing and must notify the guardian and near relatives.[77] This would seem to indicate that the procedure for ending guardianship is more complex than that required for restoration to competency alone, which is discussed later in this chapter.

While the guardianship continues, however, the guardian's powers over the material assets of the ward are rather extensive.

> Guardians of incompetents are authorized and empowered to sell and convey all or part of the homestead of the incompetent, and to lease all or part of the homestead of the incompetent for oil, gas, and other mineral exploration, development and production purposes and for agricultural purposes.[78]

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[74] 58 O. S. (1961) Sec. 810.

[75] Hendricks v. Grant County Bank, Okl., 379 P 2d 693.

[76] 58 O. S. (1961) Sec. 853.

[77] 58 O. S. (1961) Sec. 854.

[78] 58 O. S. (1961) Sec. 856.

But these powers are not nearly so sweeping as they may seem. Another statute requires the guardian to give the judge of the County Court an inventory of the ward's estate after three months of guardianship. After this time, the guardian must report annually on the estate, and there are complicated rules for appraising property and assets which bind the guardian.[79]

The guardianship may be terminated if the guardian becomes insane or unable to handle the responsibility. In addition, it may be ended if the guardian wastes or mismanages the estate or is thirty days or more late with an accounting of the ward's assets. If such circumstances prevail, the guardian may be removed after proper notice is given him.[80]

There are many more restrictions, which go into great detail on the assets of the ward. For example, the spouse of an imcompetent ward must be a party to the act of sale when real property transactions are involved.[81] There are also some highly specific rules on the kinds of investments which may be made with the ward's assets and the fees which may be collected by the guardian.

In general, the property rights of mentally ill or retarded persons are protected by complex, numerous, and specific rules, arising out of statutory and common law. It would appear that the law gives greater protection, or at least more specific attention, to the property of a mentally ill or mentally retarded person than it does to the person. The

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[79] 58 O. S. (1961) Sec. 871.

[80] 58 O. S. (1961) Sec. 875.

[81] 58 O. S. (1961) Sec. 857.

laws on property are far more detailed and the litigation on such issues is far more extensive than it is on involuntary commitment, sterilization, treatment procedures within the hospital, restoration to competency, or any of the other civil rights issues which would seem to be crucial to the patient or pupil. While this can only be categorized as conjecture, it would seem possible that the patient would be concerned with protection of his person while others around him would be more concerned than he with property issues. Since the patient is not able to take to court those issues of greatest concern to him while those around him are able to deal with the courts on issues that concern them, the differences in the legal position of the ward and guardian may account for the differences in the amount of protection.

While the laws on guardianship seem to be designed for the protection of the mentally ill or retarded person, it appears incongruous that some of the serious issues relating to the handling of people in institutions are not handled in as much depth as those issues relating to the property of the same persons. Perhaps this is a reflection of the law's greater concern for property than human rights or the tendency of people to involve themselves in court actions over property more readily than they might over human matters.

Restoration

As defined by the American Bar Foundation study of The Mentally Disabled and the Law, "Restoration is a legal determination that an individual previously adjudged incompetent has regained the ability to

manage his business and personal affairs adequately."[82] There appear to be provisions for this kind of legal restoration to competency in most states, including Oklahoma. However, the practices are varied and the status of a discharged mental hospital patient who has lost his competency is far from clear. Most of the confusion would seem to arise from varied interpretations of the statutes. The 1953 Oklahoma mental health statutes included a section which outlined in detail the proceedings necessary for a declaration of restoration to soundness of mind.

The procedures outlined provide an opportunity for the patient, a relative, or the superintendent of the hospital which had held the patient, to petition the County Judge in the patient's home county or in the county where the hospital is located for an order declaring that the patient has been restored to soundness of mind. If the superintendent enters the petition, he must also submit an affidavit stating that the patient is no longer in need of care and that no further confinement is needed for the patient's safety or the safety of others. If the person seeking restoration to competency requests the hearing, those who petitioned for the original order declaring incompetence must be notified of the hearing. The judge then takes evidence and may restore, through an order, the person to competence. However, he must hear evidence from two qualified examiners, who must establish that the person is sane. The same procedures are followed when restoring persons to competence who were declared incompetent, though not institutionalized.[83]

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[82]Lindman and McIntyre, Jr., op. cit., p. 226.

[83]43A O. S. Supplement, 1965, Sec. 75.

This is obviously much more than a routine procedure. It virtually requires a Sanity Commission in reverse, with testimony from physicians, appearance of the original petitioners, and others who may have an interest in the case. This is not a perfunctory procedure which merely recognizes that a mentally ill person, declared incompetent because of his hospitalization,is now cured. It is a complex procedure which may be contested.

To simplify the process and provide better opportunities for restoration to competency to persons adjudicated mentally ill or retarded and thus incompetent, four new sections were added to the laws on mental health in 1961. One of these requires the superintendent of the institution to examine the patient and determine whether or not the person has become restored to mental competency.[84] Another allows the superintendent to verify this:

> If the Superintendent is satisfied from the examination required by Section 1 of this Act (Section 391 of this title) that such person has become restored to mental competency, it shall be the duty of said Superintendent to execute a certificate in triplicate wherein that fact is recited and to forward the original certificate to the court which ordered said person's admission to the institution where it shall be filed with the official files of the court in the case wherein said person was ordered admitted to said institution. The copies shall be executed as duplicate originals and one copy shall be given to the person released and the other copy retained in the files of the institution.[85]

It appeared to be the legislative intent that this certificate would be sufficient for restoring the person to competency. While a medical

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[84]43A O. S. (1961) Sec. 391.

[85]43A O. S. (1961) Sec. 392.

person or institution would not normally be empowered to take such legal action, another section of this act seems to direct the courts to restore competency on the basis of the certificate:

> The certificate executed in accordance with Section 2 of this Act shall be prima facie evidence upon which the County Court may, without additional evidence, enter an order restoring such person to legal competency or capacity for all matters shall operate as a restoration of such person to legal mental competency for all matters, and no further action, in court or otherwise, shall be necessary for such restoration.[86]

The last section of these 1961 statutes on restoration makes them cumulative to existing laws.[87] A bill enacted by the 1965 legislature makes it possible for county judges to restore competence in the county where the discharged patient lives. The earlier laws had made it necessary for the person to return to his county of commitment for restoration. Now the judge where he is presently living may restore him, although an order of restoration must be sent to the court where the incompetency was declared.[88]

As simple as this may sound and no matter how clear the intent to make restoration to competency a manageable procedure based upon discharge from the institution, the law remains what the judges believe the law to be. Therefore, there are wide variations in the way the laws on restoration to competency are applied and interpreted in Oklahoma. The way in which this occurs can be of great significance to

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[86] 43A O. S. (1961) Sec. 393.

[87] 43A O. S. (1961) Sec. 394.

[88] 43A O. S. Supplement, 1965, Sec. 75.

the person involved. Under one procedure, which seems to be the one provided for in the law, the County Judge issues an order legally restoring the discharged patient to competence, upon receipt of the certificate issued by the institution superintendent. Under another procedure, apparently like that outlined in section seventy-five of the mental health laws, there must be notification, representation by counsel, and some sort of formal hearing. This procedure must be initiated separately from the certification by the superintendent. It may also be expensive. According to one mental health official, many people who are released do not have their competency restored. For one reason, it may cost as much as (perhaps more than) seventy-five dollars for the costs of the hearing and attorney fees. This leads some discharged mental patients to carry their superintendent's certificate with them as "proof" of their competency. However, it is worthless without a complementary court certification.[89]

Cleveland County Judge J. David Rambo uses the system outlined in the sections quoted above. That is, he restores discharged patients to competency on receipt of the superintendent's certificate, without the participation of the ill person. He attributes other procedures which are used to judges who believe they would be practicing law for the discharged patient, who, they believe, should come to the court with his own attorney for restoration procedures.[90]

Of the fifty commitment cases studied in Cleveland County, there

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[89]Conversation with John H. Holt, December 16, 1965.

[90]Interview with Judge J. David Rambo, December 20, 1965.

were ten cases of persons being legally restored to competence by court order. This was of a total seventeen cases which involved a discharge from the institution. The balance either remained in the hospital, died, were not committed in the first place, or left the hospital on some sort of conditional discharge, such as to the custody of a nursing home or relative or on convalescent leave. This would indicate that during the period of time when these cases occurred, some fifty-nine per cent were legally restored to competence in Cleveland County.

Before proceeding further with this discussion and comparisons, it important to note that the information upon which these conclusions are based does not lend itself to complete accuracy. That is, the cases in the sample cover different time spans and there is some indication that the courts and judges change their practices with time. In addition, more than one judge may have served during the time span covered and judges may differ in their applications of these laws. One sample covers some five years while another covers less than two. This is appropriate for the purposes of the study of commitments but this data does not lend itself, with precision, to the issue of restoration. In other words, the instrument used in the study was not designed to gather data on restoration practices. Rather, it was designed to learn more about commitments, as is discussed in an earlier chapter. Some tenative trends on restoration may be observed and mentioned. However, the information on restoration taken from the commitment study should not be considered definitive.

In Tulsa County, Judge Whit Y. Mauzy apparently operates in a

rather different manner than Judge Rambo. Based upon an interview with him, it appears that Judge Mauzy requires that a petition for restoration be filed. If the original petitioner agrees to the restoration, the court agrees. If the petitioner joins in the petition for restoration, notification to various persons is eliminated. The recovered patient is represented by his own attorney or Legal Aid.[91] This would mean, it would appear, that a person could be discharged from an institution with a certificate of competence from the superintendent and still not be restored to legal competency in Tulsa County. This would probably not be true in Cleveland County, solely, it would appear, on the basis of the attitudes of the judges in the two counties.

In Tulsa County, only seven persons in the cases studied were discharged from the hospital. This is not surprising since the Tulsa sample covered a much briefer time span. And, of the fifty cases studied, twelve alleged mentally ill persons were adjudged not mentally ill and released. Of the seven discharges, four were restored to competence. This would mean that fifty-seven per cent of those eligible for restoration were restored to competency.

Judge Francis Borelli of Kingfisher County was the judge for only a brief time covered in the sample of twenty-five cases studied there. When interviewed, he indicated that he had not yet had a restoration petition or situation arise during his tenure. If one arises, he said, he would think that a sort of mental health hearing in reverse would have to be conducted. That is, there would have to be a new

[91]Interview with Judge Whit Y. Mauzy, November 16, 1965.

petition to the court for restoration and a finding by experts that the person was now competent.[92] In the cases studied in Kingfisher County, of eight people discharged and eligible for restoration, only one person was formally and legally restored to competence.

Under the new regulation passed in 1965, it would appear possible for a discharged patient to establish residence in a county where the judge applies the law more liberally, even though he may be turned down for restoration in his home county. It would appear that restoration is virtually automatic in some counties and a major court action in others. This would seem to make Oklahoma restoration rather unpredictable and unequal. It may cost money in some counties yet be handled without any fee or costs in others. Of course, there does not appear to be any malice on the part of those who apply the law rigidly and require a formal hearing before the court. Their attitude is that the person cannot be certain his rights are restored without such formal action. This is in line with the conclusions drawn by the American Bar Foundation study:

> Because of the great confusion in this (restoration) area of the law, the discharged patient's safest course of action in any of these states would appear to be the instigation of regular restoration proceedings. Unfortunately, in the absence of legal counsel it is quite likely that the patient will not be aware that such action is advisable.[93]

Judge Mauzy, who tends to follow a more or less restrictive pattern in the restoration proceedings, as in other matters, believes that he does

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[92]Interview with Judge Francis Borelli, December 20, 1965.

[93]Lindman and McIntyre, Jr., op. cit., p. 228.

so for the protection of citizens. During his interview, he said several times that he does more than is necessary to guarantee the protection of constitutional rights. He was once a prosecutor and knows both sides of the story, he says.[94]

The real problem for discharged patients in Oklahoma may be confusion over what their rights are, whether or not they have been restored, and how they may achieve restoration. Such matters only become issues, it would seem, at times of special problems. However, one who thinks he has been restored and then discovers, at some crucial point, that he has not, faces some serious problems.

Some examples of the kinds of things which might happen were mentioned at the subcommittee hearing on the mentally ill. Hugh A. Ross, an attorney who practices in Ohio, is a member of the Western Reserve University Law School, and who teaches a seminar for law and social work students on "The Mentally Disabled and the Law," told the subcommittee about a military officer who had been in an institution under a doctor's care for some nine months when he was a teenager. He recovered, was released, and later graduated from college. He entered the military and served during the Korean war. Later, when he planned to marry, his parents wanted to give him some property. The title company discovered that his civil rights had never been restored.[95] It is conceivable--perhaps likely--that this could happen to discharged mental patients in Oklahoma.

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[94]Interview with Judge Whit Y. Mauzy, November 16, 1965.

[95]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 187.

Little mention has been made in this chapter of the mentally retarded. Because of the laws on admission to state schools for the retarded, the pupil does not automatically lose his competency, need not have a guardian appointed for his property, and, because no loss of rights is involved, does not need to have his competency restored. Of course, such an issue could come up around a specific issue, such as the inheritance of property or the need to sell assets. But this must be an entirely separate procedure. So the problems raised in this chapter deal almost exclusively with involuntary mental hospital patients.

Conclusions

It would seem that a number of changes are needed in this area. As has been suggested by many, the blanket judgment of incompetency for all purposes is probably an error. Dr. Thomas S. Szasz suggests that the hospitalized patient retain as many of his rights as is possible.[96] In other words, the person who is judged in need of institutionalization does not also need to be considered totally incompetent. It would seem that incompetency should revolve around specific kinds of activities, rather than around all activities. Ideally, hospitalization and incompetence should be separated. In reality, they do not mean the same things and should not be linked together. Were such steps taken in Oklahoma, the confusion over guardianship and restoration would seem to be resolved. If there is no loss of rights, there is no need for their restoration.

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[96]Thomas S. Szasz, Law, Liberty, and Psychiatry, p. 233.

CHAPTER VI

PATIENT MANAGEMENT

Oklahoma laws generally follow the patterns suggested in the National Institute of Mental Health's A Draft Act Governing Hospitalization of the Mentally Ill.[1] These provisions demand relative freedom for the patient to correspond with persons outside the hospital and receive correspondence from them without censorship, visitation from family, friends, and counsel, and freedom from mechanical restraint. If correspondence or visits are limited or if mechanical restraints are imposed, the reasons for these actions must be formally entered in official records.

The right to exercise controls and the responsibility for exercising them judiciously, derive from the institution's in loco parentis duties and the superintendent's role as guardian of the person of the patient or pupil.

While many of the issues discussed in this chapter are not technically defined as civil rights matters, they do represent important human freedoms.

Restraints

The term "restraints" relates to the whole range of objects used

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[1]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 522.

to hamper movement or restrict activity. However, classifying all of them together is not particularly illuminating since they are so varied. One of the earliest, Dr. Benjamin Rush's "tranquilizer chair,"[2] was almost total in its control of the patient. Other devices which have been used or which are used include strait jackets, muffs, belts and isolation rooms.

Mechanical restraints are usually held to be unnecessary and unjustified. The Council of State Governments has called restraints rarely justifiable[3], as have most professionals in the mental health field. In his appearance before the Subcommittee on the Constitutional Rights of the Mentally Ill, Dr. Winfred Overholser, superintendent of St. Elizabeth's Hospital in Washington, D. C., first told the investigators that no mechanical restraints were used at the institution. However, he retracted that statement and explained:

> We have a few patients, elderly patients who, if they didn't have some sort of protecting band around them, might slide out of their wheelchairs, and we do have a few patients, elderly again, who might fall out of bed by reason of their restlessness, and we do have some sideboards on the beds, on a few of them.[4]

He added that he had never seen a straitjacket used during his 24 years at the hospital and said that padded cells had gone out with the bustle. After Dr. Overholser indicated that single rooms were used for isolating patients who posed a danger to themselves or others, he was asked if

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[2]Albert Deutsch, The Mentally Ill in America, Second Edition, p. 79.

[3]E. Brevard Crihfield, The Mental Health Programs of the Forty-Eight States, p. 12.

[4]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 27.

there were times when an ordinary room would not restrain a patient. In such cases, he said, the hospital would " . . . resort to make some sort of what might be termed chemical restraints"[5] and added that the hospital rarely found such cases of violence.

This kind of development reflected significant changes in mental health practices according to another subcommittee witness, Albert Deutsch. The author of several books on mental illness and mental hospitals, he reported that in the institutions he visited some twelve years earlier:

> I saw hundreds of sick people shackled, strapped, straitjacketed, and bound to their beds . . . I saw them incarcerated in 'seclusion rooms' -- solitary isolation cells, really -- for weeks and months at a time.[6]

But Deutsch seemed to believe, as did other witnesses, that one of the primary reasons for the decrease in mechanical restraint was the advent of chemical restraints or tranquilizers.[7]

While mental health officials in Oklahoma tend to confirm the trend toward abolition of mechanical restraints, they are still used. Dr. Hayden Donahue said, when interviewed, that these are used at Central State Hospital but may be applied only under a written order from a physician. And once the restraint is applied, it must be checked each day. While Dr. Donahue also noted that restraints are used infrequently and he had personal objections to all forms of them, certain necessities caused their use. One group which needs them, he said, is

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[5] Ibid.

[6] Ibid., p. 42.

[7] Ibid.

oldsters with organic disabilities. These patients tend to roll out of bed or go over the side rails when ill. Keeping them in bed would require more nurses than are available, so restraint belts are used instead. Some older people itch "all the time" and they are fitted with soft muffs during certain hours of the day to restrain them from scratching. There are also some 400 retarded and disturbed patients at Central State Hospital with whom reasoning is difficult. Restraining cuffs are often necessary for them. Seclusion of patients whose behavior is uncontrollable is used and there are some seclusion rooms in the hospital. But this is on the decrease, too. Many rooms which were originally built for seclusion purposes are now used for storage, psychologists' offices, and other non-restraint purposes. The hospital sees this kind of action as isolation, rather than seclusion. In any case, Dr. Donahue receives a list daily of all patients in seclusion and the length of time they are isolated from the rest of the hospital. In the interview he displayed that day's list, noting that it was short and that several of those listed were criminal cases who had been sent to the hospital for observation.[8]

Superintendents of other mental hospitals reflected the same policies. Dr. Bedford Peterson said that no strait jackets or other mechanical restrains are used at Eastern State Hospital, although straps are used to keep older persons from rolling out of bed, which is a practice in most hospitals, including general hospitals. The use of these must be ordered by a physician. Isolation is used for

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[8]Interview with Dr. Hayden Donahue, November 23, 1964.

patients, but in regular rooms, rather than special seclusion quarters.[9]

Dr. E. P. Henry said that no physical restraints of any kind are used at Taft State Hospital. There are no isolation rooms used. Restraining belts, such as those described by Drs. Donahue and Peterson, are used but not considered mechanical restraints.[10]

At Western State Hospital, a minimum of restraints of all kinds are used, so that the treatment process may be as humane as possible, according to Dr. Harold B. Witten.[11]

Jack Barthold, administrator of Coyne-Campbell Sanitarium, said that wrist, ankle, and waist restraints are used at the institution, on the order of the attending physician. The same permission is required for the use of isolation or seclusion rooms, with the exception of emergencies, when the administrator may isolate a patient and report this to the physician. Emergencies involve danger to the patient or to others.[12]

Mechanical restraints are not used at the University of Oklahoma Medical School psychiatric unit. Dr. Mindlin indicated that he does not believe in these and never has. Their use is a result, he said, of the neglect of the psychiatric hospitals both in financing and in the adequacy of staff. Some seclusion may be needed to avoid harm to the patients but surviving without restraints is a matter of staff education. Staff

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[9]Interview with Dr. Bedford Peterson, December 21, 1964.

[10]Interview with Dr. E. P. Henry, December 21, 1964.

[11]Interview with Dr. Harold B. Witten, December 21, 1965.

[12]Interview with Jack Barthold, January 27, 1966.

members must be taught that patient violence is a result of the patients' fears. An intelligent hospital administrator with a moderately capable staff can run a hospital quite well without the use of restraints, Dr. Mindlin believes.[13]

In many ways, practices at the state schools for the mentally retarded are comparable. James Boren at the Hissom Memorial Center said no strait jackets are used at his institution and that no seclusion rooms were built there. On physicians' orders, some simple mechanical restraints are used for the residents. For example, a splint might be placed on the arm of a child who constantly picks at his eyes.[14]

Restraints may be used at the Enid State School on a physician's orders, according to Dr. J. L. Dunigan. "Quiet rooms," for isolation, are located only in cottages for the severely retarded. Although cloth restraints are sometimes used to keep people in their beds, leather straps are not used.[15]

Joseph Deacon at the Pauls Valley State School indicated that there are no isolation rooms at that institution. He added that he preferred not having them because they offer an easy solution to staff members. It is always simpler to isolate a child who is causing problems than to deal with the child. When there are cases of severe disturbance, the child who is acting up is sent to the medical service, often to be sedated. Some simple restraints are used on little children to prevent

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[13]Interview with Dr. Eugene Pumpian-Mindlin, January 31, 1966.

[14]Interview with James Boren, December 3, 1964.

[15]Interview with Dr. J. L. Dunigan, December 29, 1964.

their falling from chairs.[16]

While most of these superintendents expressed misgivings about any use of restraints, they are still used. Dr. Donahue explained this in terms of a lack of alternatives. Chemical restraints tend to increase the toxicity of older people, which their livers cannot handle. Using closer supervision by staff members would be preferable, but a shortage of staff is one of the problems faced by most mental hospitals. But even if there were sufficient staff members, some situations would require mechanical restraints, Dr. Donahue believed.[17]

Despite the concern of the superintendents, excessive or punitive use of restraints may still be possible in Oklahoma, As the American Bar Foundation report points out;

> . . .one physician may be responsible for hundreds of patients and therefore obliged to rely on the attendant's recommendation rather than on a personal investigation . . . Unless the use of physical restraint becomes so infrequent that the physician can check each case, it is difficult to see how a patient can be protected against possible abuses.[18]

Such potential abuses may be realized in Oklahoma and other states which have adopted the Draft Act, which authorizes the hospital head's designee to use a mechanical restraint. The uses of such restraints and the reasons for their use must be made part of the patient's clinical record.[19] However, according to the American Bar Foundation study, "The success of this procedure is dependent . . . on who may see the record and on his

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[16]Interview with Joseph Deacon, December 22, 1964.

[17]Interview with Dr. Hayden Donahue, November 23, 1964.

[18]Lindman and McIntyre, Jr., op. cit., p. 146.

[19]43A O. S. (1961) Sec. 92.

authority."[20]

As a matter of statutory provision, Oklahoma is one of only twelve states which attempt to protect patients from the improper use of mechanical restraints.[21] However, the Oklahoma law is not as explicit as that of some other states. The Massachusetts law provides:

> Restraint is to be applied only in the presence of the superintendent, the physician or an assistant physician on his written order. In the case of an emergency it may be applied in the physician's absence or without a written order but immediately after the imposition of the restraint its use is to be reported to the physician who is to investigate the case and approve or disapprove the restraint imposed. Restraints are to be applied only in cases of extreme violence, infliction of self-injury, active homicidal or suicidal condition or physical exhaustion.[22]

However, the unauthorized use of mechanical restraints by Oklahoma institutional staff members is specifically mentioned in the section of the law covering mistreatment of patients and constitutes a felony:

> Any officer or employee of any of said hospitals who shall maliciously assault, beat, batter, abuse, or use mechanical restraints without authority, or wilfully aid, abet, advise or permit any patient confined therein to be maliciously assaulted, beaten, battered, abused, or use mechanical restraints without authority shall be guilty of a felony, and on conviction thereof, shall be punished by imprisonment in the State Penitentiary for not more than five (5) years, or a fine not exceeding Five Hundred ($500.00) Dollars, or both said fine and imprisonment.[23]

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[20] Lindman and McIntyre, Jr., op. cit., p. 145.

[21] Ibid. (The other states are Georgia, Idaho, Kansas, Kentucky, Massachusetts, Missouri, New Mexico, North Dakota, Pennsylvania, Texas and Utah)

[22] Lindman and McIntyre, Jr., op. cit., p. 164.

[23] 43A O. S. (1961) Sec. 134.

While the strong wording of this section and the reassuring comments of the superintendents would tend to reflect rather adequate protection of patients from undue restraints, it is difficult to draw firm conclusions from the material available. One piece of information which may give cause for further questions is a report made by the Southern Regional Education Board on disciplinary practices in twenty-three institutions for the mentally retarded located in southern states. When the institutions were asked what forms of discipline were approved and available to them when residents demonstrated "inappropriate behavior," twenty-one said they could use isolation rooms, seventeen had drug restraints available, and fifteen identified physical restraints as disciplinary devices.[24] This would appear to indicate that isolation, physical restraints, and drugs may be commonly used by institutions for the retarded in the south as disciplinary measures. The use of such measures for treatment and their use for discipline would appear to be rather different.

In this area, one item of varying interpretation but general usage is the tranquilizing drug, which Dr. Overholser called a "chemical restraint." Each of the institution superintendents interviewed was asked if chemical restraints were used. Each said that tranquilizing drugs were utilized in the institutional treatment program, but not all agreed to the description of them as chemical restraints. Dr. Peterson, for example, said that drugs were used but that this usage did not constitute

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[24]Southern Regional Education Board, "Behavioral Management of the Institutionalized Mentally Retarded--A Survey", p. 4.

chemical restraint of patients. Drugs could be used as restraints, he said, but this would mean giving an overdose and knocking the patient out. Sodium amatol is a real chemical restraint, he added. It will render a patient unconscious while it is being administered.[25]

Dr. Harold B. Witten expressed violent objections to the designation of tranquilizers as chemical restraints. He called the use of the term ridiculous and said that tranquilizers were no more restraints than drugs for diarrhea.[26]

Dr. Donahue called this a semantic problem but agreed that drugs had a restraining function. However, they are more than restraints, he believed, in that they are used effctively in treating and controlling mental illness.[27] In view of the use of the term "chemical restraint" by Dr. Overholser and the identification of this form of "discipline" by most of the institutions for the mentally retarded in the South, one wonders if the term is not wholly justified.

Perhaps the best indication of the restraining function of tranquilizers are the advertisements for them placed by the drug companies in The American Journal of Psychiatry. A typical advertisement for Schering Corporation's Trilafon shows on one page a nurse or aide apparently holding a patient who is acting in an agitated manner. The copy says, "When the target sympton of schizophrenia is aggressiveness or agitation, cooperative ward behavior may be rapidly restored and

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[25]Interview with Dr. Bedford Peterson, December 21, 1964.

[26]Interview with Dr. Harold B. Witten, December 21, 1965.

[27]Interview with Dr. Hayden Donahue, November 23, 1964.

maintained with Trilafon (perphenazine)."[28] The following page, in full color, depicts a nurse or aide giving a cup of comething to a female patient. The copy says, "Beyond improved ward behavior, Trilafon (brand of perphenazine) helps to accelerate normal recovery, to facilitate psychotherapy, and to encourage social participation."[29] Although this indicates that such drugs are used for more than restraint, the implication of the advertising is that there is also a restraining function.

In a personal interview, Dr. Thomas S. Szasz considered the use of drugs a potential form of punishment. Perhaps the greatest difference between a drug and alcohol (a martini was his example) is that the effects of the drug are unpleasant, while those of alcohol are pleasant. The drugs lead to lethargia and the patient who takes a drug becomes more submissive.[30]

Drugs are not the only form of treatment that may be used for restraints. Dr. Donahue noted that shock treatment and cold packs were once used in institutions for restraint, but are no longer used for these purposes.[31]

Drugs pose a health problem, too, because of the danger that may be associated with prolonged usage. In addition to lengthy discussions of cautions in all of the advertisements from them carried

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[28]The American Journal of Psychiatry, Vol. 121, No. 7, Jan. 1965, p. ix.

[29]Ibid., p. x.

[30]Interview with Dr. Thomas S. Szasz, August 10, 1965.

[31]Interview with Dr. Hayden Donahue, November 23, 1964.

by The American Journal of Psychiatry, an article in a recent issue of that publication indicated that liver damage could result from prolonged use of certain drugs in certain patients and that great caution should be exercised in using these drugs. The research referred to tranquilizing drugs, as a group.[32]

Because of the problems of definition on where treatment may end and punishment begin and because of the relative flexibility with which restraints of various kinds may be used by institutions, the subject of restraints seems to constitute a potential rights concern in Oklahoma. Although the laws on the subject are explicit and the penalties for violations severe, the mentally ill patient's and the mentally retarded pupil's lack of power makes it unlikely that they would seek protection under the law. While major violations might be discovered and corrected, occasional violations and biased attendant recommendations would seem to be difficult to discover or control.

Correspondence and Visits

Communication with persons outside the hospital and visits from relatives and friends are limited by Oklahoma statute. Rather wide discretion is available to the individual hospital, but certain kinds of communication are guaranteed. Specifically, the statute says:

> Patients at institutions within the department shall have the privilege of freely writing to and corresponding with their relatives, friends, physicians and legal advisers, and they may also receive visits from them, except when it is deemed inadvisable by the superintendent or person in charge of such institution, and in such instances, the

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[32]Joseph B. Bloom, M. D., Norman Davis, M. D., and Cyril H. Wecht, M. D., "Effect on the Liver of Long-Term Tranquilizing Medication," The American Journal of Psychiatry, Vol. 121, No. 8, Feb., 1965, pp. 788-797.

> superintendent shall place on file in the institution, subject to departmental inspection, a written assignment of the reason for not permitting such correspondence, writing or visits. Notwithstanding any limitations authorized under this section on the right of communication, every patient shall be entitled to communicate by sealed mail with the director, the court, if any, which ordered his commitment and with other official agencies.[33]

While this does not follow the wording of the Draft Act, it follows the spirit of that recommended legislation.

An addition to the mental health statutes in 1965 provided for special communication privileges and rights for persons detained in public or private facilities awaiting sanity hearings, examination, or treatment. The statute requires that such persons have an opportunity to contact, immediately, a relative or friend, if they are so detained.[34]

At Western State Hospital, two five cent postage stamps are provided to each patient who would not otherwise be able to mail letters, twice each week. Dr. Witten added, when interviewed, that outgoing mail was examined because, he reasoned, the hospital is the guardian of the patient and as such cannot permit the violation of postal regulations. Incoming mail is not read. In regard to telephone calls, limited facilities at the hospital make it impossible for patients to receive calls. However, they may make calls when authorized to do so by a physician.[35]

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[33] 43A O. S. (1961) Sec. 93.

[34] 43A O. S. (1961) Sec. 451.

[35] Interview with Dr. Harold B. Witten, December 21, 1965.

When Dr. Albert Glass, Director of the Department of Mental Health, was interviewed and asked specifically about correspondence, he indicated that this is handled differently at each institution. His preference is for incoming mail to be searched only for contraband, either by an aide opening it or by the patient opening it in front of the aide. Outgoing mail would be examined only on closed wards. Although he suggested that this responsibility would best be handled by nurses, he acknowledged that it is likely that aides and attendants screen mail on some hospital wards. Discussion on this subject ended with Dr. Glass placing the issue of correspondence on the agenda for the next meeting he would hold with the superintendents of all the hospitals.[36]

At Coyne Campbell Sanitarium, the same general practices are followed. Patients may receive any mail, although packages are opened and inspected for dangerous objects and to avoid loss or theft of personal property. Outgoing mail is censored, according to Jack Barthold. Phone calls are made only with the permission of the patient's attending physician.[37]

According to the American Bar Foundation, only twenty states have statutes on the subject of correspondence and visitations.[38] But the writers of the Bar Foundation report expressed concern that wide latitude remains with the hospital, both in the Draft Act and in the

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[36]Interview with Dr. Albert Glass, January 25, 1966.

[37]Interview with Jack Barthold, January 27, 1966.

[38]Lindman and McIntyre, Jr., op. cit., p. 145.

several states which follow it. Some states allow unrestricted visits by clergy and others specify the right to see an attorney. However, no state has established sanctions which would apply against persons who deprive patients of such rights.[39]

The purposes of restrictions are varied, according to hospital superintendents. Central State Hospital, said Dr. Donahue, inspects outgoing mail to guard against materials which are pornographic or potentially disturbing to the recipient. If incoming mail, from a patient's family, seems disturbing it may be held up for a day or two while the patient is calmed down and the family contacted. Under the provisions of the law, correspondence with various officials and the hospital superintendent is by sealed envelope and may not be censored.[40]

At the University of Oklahoma Medical School psychiatric unit, there are limits on correspondence between the fifteen patients and the outside, according to Dr. Eugene Pumpian-Mindlin, acting director of the Department of Psychiatry. However, these limits are mutually determined in this closed, voluntary ward, by the physician and the patient.[41]

At Eastern State Hospital, the same basic practices prevail. Dr. Peterson spelled out some details in his interview, presumably on issues which are handled at the discretion of the hospital. For example,

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[39] Ibid., pp. 161-162.

[40] Interview with Dr. Hayden Donahue, November 23, 1964.

[41] Interview with Dr. Eugene Pumpian-Mindlin, January 31, 1966.

patients at Eastern State are not automatically permitted to use telephones. If they wish to do so, they must have permission and/or be supervised. Of course, this depends upon the facts of the individual case. One problem is that patients may telephone their families collect, becoming angry or abusive during the conversation. This often leads the family to become concerned and telephone the hospital staff for an explanation. There are also some specific limits on correspondence. That is, Eastern State Hospital will mail one letter each week for indigent patients at hospital expense. Any more letters would be too expensive. Incoming mail is opened, not so much for content but to control the cash which families often enclose with letters. The hospital is generally held responsible for such funds and cannot control it unless incoming correspondence is examined. Dr. Peterson planned, when he was interviewed, to work out a new plan which would ask families to send funds directly to the hospital for deposit to the patient's account. Then there would be no hospital responsibility for cash in patient mail and no need to examine letters routinely. Sealed communications with officials is permitted, as specified by the law.[42]

At Taft State Hospital, Dr. E. P. Henry said that all incoming and outgoing mail was censored by the institution's supervisors. This is done, according to the superintendent, to find out what is being told to and told by the patients. At the time, these same restrictions were applied to mail designated for state officials and judges, despite the provisions of the law. Dr. Henry said he was not familiar with the

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[42]Interview with Dr. Bedford Peterson, December 21, 1964.

statute on sealed communications which was passed in 1953.[43]

Because of the nature of the hospital population and the problems dealt with, correspondence is not the same sort of problem in the state schools for the mentally retarded. Mr. Boren said that parents and children were encouraged to correspond whenever possible. While the rule on sealed communications with officials is observed, very few examples of this are found in facilities for the retarded.[44]

Some twelve states require that patients be furnished with materials for correspondence. Oklahoma is not one of these.[45]

There seems to be widespread agreement among mental health professionals and attorneys that limitations on correspondence are appropriate. The American Bar Foundation study notes that unlimited correspondence could violate postal regulations, contain libelous statements, or disclose information about other patients which would violate their rights. The Foundation sees these restrictions as protective of the patient, who might write things he could later regret, about the hospital, the general public, and other patients.[46]

The problem of correspondence is more complex than it may appear. For example, Charles Halleck, a Washington,D. C., attorney who appeared before the subcommittee on Constitutional Rights of the Mentally Ill, was concerned that patients at St. Elizabeth's Hospital were not per-

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[43]Interview with Dr. E. P. Henry, December 21, 1964.

[44]Interview with James Boren, December 3, 1964.

[45]Lindman and McIntyre, Jr., op. cit., pp. 158-160.

[46]Ibid., p. 144.

mitted to communicate freely with their attorneys, families, and ministers. He said, " . . . I don't think, frankly, that it is proper for a psychiatrist to be reviewing any complaints that an inmate may make to his attorney . . . They ought to have the right to communicate with their family, their attorney, their minister, and persons of that nature, without the question of censorship coming up."[47] He added that such freedom to communicate ought to be guaranteed by statute and told the senators that his clients frequently complained that they were punished when they wrote uncomplimentary letters. The legislation ultimately passed by the Eighty-eighth Congress incorporated Halleck's suggestions, but its provisions on correspondence are similar to Oklahoma's. A patient is given the right to communicate by sealed mail with anyone, including official agencies. There is no provision for censorship of outgoing mail. He may receive uncensored mail from his attorney or personal physician. Other incoming communications may be read if this is deemed necessary by the chief of service. If mail is not delivered, however, it must be returned immediately to the sender. Within these rules, the superintendent is permitted to make reasonable rules in regard to visits and the use of telephone and telegraph.[48] Thus the federal statute demands freedom to send any mail, to receive uncensored mail from certain persons, and to have prohibited incoming mail returned to the sender promptly. This deals with one of the problems raised by the American Bar Foundation study--that distinctions

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[47] U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 113.

[48] 78 U. S. Statutes at Large, p. 951.

are typically not made between incoming and outgoing mail in laws on communications.[49]

Visits pose a rather different problem in the conduct of an institutional treatment program. The psychiatrists who direct the state mental hospitals in Oklahoma and those who supervise the schools for the retarded indicate that visits too early in the institutionalization of the patient or pupil may interfere with treatment objectives.

Visits are discouraged during the first ten days at Central State hospital, according to Dr. Donahue, although these are not stopped if relatives come to see the patient. This is to help the patient become accustomed to the institution and involved in the treatment program. After this, visiting is open. Any limits are set on a medical basis. Even though the letterhead of the hospital lists three afternoon visiting periods per week, visitors are allowed to come at all times, with very few restrictions. No effort is made to suppress visiting, although there are problems involved. For example, there are few appropriate visiting rooms and an insufficient number of staff members to prepare patients for visits and insure their return. Some families visit and take the patient home with them, without notifying the hospital of this action. But with the average forty-seven day hospitalization period, Dr. Donahue believes it is important for patients to retain contact with their families.[50]

Dr. Harold B. Witten indicated that at Western State Hospital

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[49]Lindman and McIntyre, Jr., op. cit., p. 144.

[50]Interview with Dr. Hayden Donahue, November 23, 1964.

visiting is organized.[51] At the Coyne Campbell Sanitarium, visiting is handled according to the directions of the attending physician.[52]

As indicated earlier, any limitations on visits are supposed to be set for specific reasons and entered in the appropriate records.

Visiting seems to be a far more sensitive issue at the schools for the retarded, where admission is generally on a voluntary basis and where feelings of guilt, abandonment, and loneliness, are often involved. These institutions have rather clear and specific rules on visiting.

At Pauls Valley, Mr. Deacon called the policy reasonably permissive. He said several times that there must always be a first visit, which is presumed to be difficult for both the pupil and the family. While he termed an effort to enforce a strict limit on the first visit as "ridiculous," he indicated that the school asked for a reasonable period of time to help the child adjust. This is normally a week or ten days. When children are brought in, the parents meet the staff members and are told that within a specified period they will receive a letter telling them of the child's progress and the tenative date for the first visit. If problems develop or if there are special concerns, they are told, immediate contact will be made. After this initial period, families may visit on any weekday during visiting hours, so long as they do not conflict with educational programs. They are asked to leave before meal times unless they want to stay and help serve meals. Of course, the meal time policy relates to administrative

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[51]Interview with Dr. Harold B. Witten, December 21, 1965.

[52]Interview with Jack Barthold, January 27, 1966.

problems at the institution. Serving food requires a total staff effort. Thus it would appear that visiting policies are the result of compromises between treatment goals and institutional needs.[53]

Both the Hissom Memorial Center and the Enid State School have written policies on visits, following the same principles outlined by Mr. Deacon, with some variations. At Enid, the first visit is scheduled flexibly, based upon the recommendation of the social worker, who communicates with the parents about visits.[54] At Hissom, visits are allowed after the pupil has been in the institution for three weeks.[55] Enid's visiting hours are 9:00 a. m. to 4:30 p. m. each day, with special times designated for visits to cottages and off-campus visits. Special times are also set for children who are in the infirmary and hospital. Parents may designate other individuals who they do not want visiting their children and may designate others, by letter to the superintendent, who may only visit at specified times. Home leaves or vacations are permitted from Enid on an individual basis, by request.[56]

At Hissom, visiting hours are 1:00 p. m. to 4:00 p. m. each day. After nine weeks in the institution, children may leave the grounds with their parents or other responsible persons. Overnight visits or home vacations are permitted after four months residence,

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[53]Interview with Joseph Deacon, December 22, 1964.

[54]Department of Public Welfare, Handbook for Parents, p. 5.

[55]Department of Public Welfare, "Visiting Regulations."

[56]Department of Public Welfare, Handbook for Parents, p. 7.

with permission. Children under fourteen years of age are not permitted to visit in the infirmary or cottage areas. Visits to critically ill patients in the infirmary are possible at any time. Hissom's list of visiting regulations has a form attached for parents or guardians to list persons who are not to visit the pupil.[57]

An article on the "Rights of Patients in Mental Hospitals" which is appended to the subcommittee hearings on this subject pinpoints the significance of visits and correspondence. The authors, who are political science faculty members at Duke University, call communication by mail with persons outside the hospital an issue which is at the threshold of " . . . the area of general civil rights in that they either link the patient with the outside world or protect him from it."[58] They identify the first effort to guarantee postal rights to mental patients as one that was first made one hundred years ago. They indicate that these rights are often restricted and that this " . . . is obviously a recognition of the custodial responsibility of hospitals in reference to their patients."[59]

Of equal importance, the authors note, is the right to visitation.

> The privilege to receive visitors should not be lightly restricted as it may have a definite impact on the patient's final release. Close relatives or friends, visiting the patient, may often be the first to detect signs of improvement or recovery and may inform the hospital of the change or request the discharge.[60]

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[57]Department of Public Welfare, "Visiting Regulations."

[58]Robert S. Rankin and Winfried B. Dallmayr, "Rights of Patients in Mental Hospitals", U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 342.

[59]Ibid., pp. 342-343.

[60]Ibid., p. 343.

One of the difficulties in examining questions of correspondence and visits from a legal, civil rights viewpoint is that this, like many other issues, is approached by mental health officials from a different perspective. Their concern is, typically, the treatment program for the patient and/or the effective functioning of the institution. Perhaps the best illustration of this approach, which tends to be that of Oklahoma's institution superintendents, is Dr. Morton Birnbaum's statement before the subcommittee on the rights of the mentally ill. Dr. Birnbaum is an attorney and a physician. He developed the "right to treatment" concept, which is discussed in Chapter VII. When asked what he thought about communication and visitation rights, Dr. Birnbaum answered:

> At first, I believed, that there should be unlimited communication by mail with members of the family, and with clergy, lawyers, doctors, social workers, and other similar categories, unless special circumstances caused needed restrictions. I also believed that limitations could routinely be placed upon communications to persons outside these categories to prevent the sending of obscene, threatening or annoying letters; however, after further reflection, I would allow unlimited communication as a matter of general principle but with the reservation that in certain cases, the attending physician could limit communications to certain persons.
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> I have changed my mind because, one, I believe that the sending and receiving of mail has a definite therapeutic value to anyone who is isolated from a normal environment, and two, because I believe that to expect the institution's personnel to censor and restrict the patient's correspondence places an unnecessary burden on their shoulders.[61]

When asked about visitation rights and restrictions on them, Dr. Birnbaum pointed to the administrative burden faced by the hospital. He noted that restrictions on visiting were usual in hospitals and said that

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[61]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 303.

a patient might well be restricted from seeing even close relatives if a psychiatrist thought this was important. " . . . I think that the psychiatrist, as a responsible person, can quite properly say that any person, even a man's wife cannot come in."[62] Members of the family or close friends who have a strong desire to visit the patient but are not permitted to do so would probably be able to secure permission by writing a large number of letters of complaint. Under such circumstances, "It would probably be less trouble to let him come in than to answer the letters that he is writing to various authorities."[63]

Obviously Dr. Birnbaum's concern is for the patient's treatment and the hospital's problems. Although the right to send and receive mail without censorship and the right to visit and be visited by family and friends are basic guarantees in a free society, this attorney does not view them from that perspective.

The regulations on visiting seem to be based partially on the treatment needs of the patient and partially on the staff burdens of the hospital. While, again, one cannot argue with the significance of such reasons, the issue of patient rights does not seem to be considered equally important.

Discipline and Punishment

Disciplining and punishing patients and pupils were not discussed extensively in the interviews with superintendents and are mentioned in only the most general way in the statutes. The intent of the legis-

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[62] Ibid.

[63] Ibid., p. 304.

lation seems to be that no patient should ever suffer because of his institutionalization. In addition to the section of the statutes already quoted which prohibits mistreatment, two other sections discuss the subject. Section 91 of the statutes on institutions for the mentally ill and retarded says that, "All patients at institutions within the department shall be given humane care and treatment. The food shall always be sufficient and wholesome. No severe punishment shall ever be inflicted, and the rules and discipline shall be designed to promote the well-being of the patients . . ."[64] One sentence in the section establishing schools for the retarded conveys the legislature's simultaneous attitudes of hopelessness and desire for kind treatment. "The physical, manual, and literary training shall be of a practical nature and the school work and recreation shall be adopted to promote the comfort and happiness of the inmates."[65]

It would be inappropriate to discuss or speculate upon the kinds of punishment and discipline used in Oklahoma institutions without field studies of these practices. It seems to be true that "total institutions," as they are described by Erving Goffman[66] and of which institutions for the mentally ill and retarded are examples, exhibit a wide range of practices in this field. The staff would tend to have an almost absolute control over the patient or pupil behavior. Discipline may be a product of the institution's "underlife" which is difficult to identify by

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[64] 43A O. S. (1961) Sec. 91.

[65] 43A O. S. (1961) Sec. 94.

[66] Erving Goffman, Asylums.

other than long-term, direct observation. Consequently state inspectors, researchers, and even superintendents, could find their knowledge of the specific practices quite limited.

There may also be difficulties in differentiating between treatment and punishment. Drugs, shock therapy, mechanical restraints, and isolation, are all used for treatment purposes. Each has the additional characteristic of unpleasantness. When such procedures are used for treatment and when they are used for punishment is a question on which equally qualified professionals may differ.

Perhaps the significant rights issue is that although the emphasis in the laws is on humane treatment and care, the same laws also provide for punishment. Thus a patient in a mental hospital or a pupil in a state school for the retarded may be punished under the protection of the law, in line with the institution's guardianship role.

Work Programs

Institutions for the mentally ill and retarded are frequently criticized for their work programs. Typically the criticism isn't of work, in itself, but of the possibility that as patients become adept at their jobs, they become too valuable to discharge. Thus the institutional work program raises a possible question of patient rights.

It appears that all of the institutions in Oklahoma use work as part of the program. While none deny that the work performed is essential to the school or hospital or that an end to patient work would require employment of significant numbers of additional employees, the superintendents consider work educational and therapeutic.

Dr. Donahue provided a rather clear analysis of the problem and its antecedents, along with some insight on how the patient is safeguarded against improper work procedures. Work, itself, he said was never the problem. In the old days (and he indicated several times that the "old days" for mental institutions were ten and fifteen years ago) patients did all the work and professional staff was limited. Thus aides and other non-professionals were depended upon for discharge advice. There was a tendency, at times, for such personnel to recommend continued hospitalization of persons who could be discharged, simply because their work was important to the staff. The superintendent was careful to avoid generalizing about non-professional employees. He did not think their actions were conscious. In the "old days," most aides were poorly educated. Some could not read or write. Their recommendations were probably sincere but inappropriate.

The Central State Hospital Superintendent's current operating principle is that if a patient is able to work productively at a full time job, he probably ought to be discharged. When a patient becomes invaluable to a particular operation, he recommends changing the patient to another assignment or discharging him.

Recently, the hospital instituted a vocational rehabilitation program in co-operation with the state education department. Through the services of this unit, an effort is made to provide work experiences which will be useful to the patient when he is discharged. In addition to maintenance jobs at the hospital, patients are placed on jobs in the city of Norman. Several hotels and motels use patients as maids.

If it were not for work, the superintendent wondered what the

patient would do with his time. With some luck, he might see his physician every two days. But little else would be available. There is a recreation program and this, too, is designed to help prepare the patient for a return to a normal life. The hospital employs a Chief of Industrial Therapy, who supervises the work program and guarantees its therapeutic value, on a full time basis.[67]

Mr. Deacon at the Pauls Valley school presented many of the same ideas, when he was interviewed. Work is fully utilized at his institution, he said. This means that in food service, clothing management, agriculture, and all other work areas, pupil labor is used. Furthermore, it is used at all levels. Such work is considered educational. Once a pupil reaches his maximum in formal education, he moves into full time involvement in the work program, if he is capable of doing so.

There are two sides to the program, the superintendent agreed. If patient work were discontinued, the institution would need a significant number of additional employees, but if there were no work program, there would be a significant problem of pupil occupation. For control purposes, the institution attempts to keep pupil working hours at the same level as regular employees. However, this is not always stringently followed because some pupils find satisfaction only in work. He told of one young female patient who helped in caring for younger children. As a worker she was treated as a staff member. She drank coffee with the employees; her advice and aid were solicited. In no other situation would she be accorded such high status and defer-

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[67]Interview with Dr. Hayden Donahue, November 23, 1964.

ence. Thus she was likely to spend more than a normal number of hours at her work. He used this example to point to the status and rights pupils could earn in the institutional community which they would have difficulty reaching in the general community.

A more significant problem, Mr. Deacon suggested, was in the area of recreation and leisure time. Many pupils are able to leave the institution and hold a job. The breakdowns occur around leisure time for which mentally retarded people are poorly equipped.[68]

Work programs are conducted through the vocational training program at the Hissom Memorial Center, according to Mr. Boren. These efforst are closely co-ordinated with the educational program. At the time of the interview, many pupils had work assignments and an increase in these was projected. Mr. Boren said there were many ideal situations for the training of retardates at Hissom, such as in the cafeteria and hospital which are comparable to outside institutions.[69]

Although the issue of work was not discussed as thoroughly in the interview with Dr. Peterson, the principles followed at Eastern State Hospital seem similar to those at other institutions. Dr. Peterson's attitude was that "We basically work that we might play." His institution also has the services of a vocational rehabilitation unit, operating within the hospital.[70]

Dr. Witten objected to the use of the term "work programs" in discussing practices at Western State Hospital. Instead, the proper

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[68]Interview with Joseph Deacon, December 22, 1964.

[69]Interview with James Boren, December 3, 1964.

[70]Interview with Dr. Bedford Peterson, December 21, 1964.

designation should be "industrial therapy." Work, Dr. Witten said, is for production. Industrial therapy is for the benefit of the patient. Therefore, the two are not synonomous.[71]

At Enid, similar attitudes and practices prevail. Dr. Dunigan said that the work program gave everyone something to do within his abilities. It is designed for training and occupational therapy and as a pastime, too. The program is called industrial therapy. The less severely retarded work a forty hour week, with variations for patients who are more retarded. There were no work programs in the Enid community when the interview was conducted but Dr. Dunigan saw these as possibilities.[72]

Oklahoma statutes, prior to 1965, provided that patients could work no more than forty hours per week. While this feature was maintained by the 1965 legislature, another provision was added, making it possible for patients to be paid up to twelve dollars per month for their services.[73] Currently, patients are only being paid four dollars per month when they are working and some of the administrative problems associated with payment are still being discussed, according to Dr. Glass. There was a need to decide whether payment would be made primarily to those who received no other funds or to those who worked effectively. The superintendents seem to agree that payment ought to be made for work performed rather than as a form of charity.[74]

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[71]Interview with Dr. Harold B. Witten, December 21, 1966.

[72]Interview with Dr. J. L. Dunigan, December 29, 1964.

[73]43A O. S. (1961) Sec. 191.

[74]Interview with Dr. Albert Glass, January 25, 1966.

The notion that patients are often kept in hospitals because they are valuable workers was forcefully stated by Albert Deutsch, before the Senate subcommittee. He suggested that every institutional psychiatrist in the country knew of such situations.[75]

A meaningful discussion of work programs may turn again to the underlife of total institutions. What such programs precisely mean to the patient is determined by elements removed from the institution's objectives and treatment goals. Goffman's statements on work are pertinent:

> Sometimes so little work is required that inmates, often untrained in leisurely pursuits, suffer extremes of boredom. Work that is required may be carried on at a very slow pace and may be geared into a system of minor, often ceremonial, payments, such as the weekly tobacco ration and the Christmas presents that lead some mental patients to stay on their jobs. In other cases, of course, more than a full day's hard labor is required, induced not by reward but by threat of physical punishment . . . In some institutions there is a kind of slavery, with the inmate's full time placed at the convenience of staff; here the inmate's sense of self and sense of possession can become alienated from his work capacity . . .
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> Whether there is too much work or too little, the individual who was work-oriented on the outside tends to become demoralized by the work system of the total institution. An example of such demoralization is the practice in state mental hospitals of 'bumming' or 'working someone for' a nickel or dime to spend in the canteen. Persons do this - often with some defiance - who on the outside would consider such actions beneath their self-respect. (Staff members, interpreting this begging pattern in terms of their own civilian orientation to earning, tend to see it as a symptom of mental illness and one further bit of evidence that inmates really are unwell.)

There is an incompatibility, then, between total

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[75]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., pp. 50-51.

institutions and the basic work-payment structure of our society.[76]

Goffman's research was not done in Oklahoma institutions. His study is based upon one year's intensive field work at St. Elizabeth's Hospital in Washington, D. C. It provides an excellent description of the social functioning of a large mental hospital. His theory is that all total institutions have certain characteristics. These are discussed below. Goffman's materials would appear to offer insight into the ways in which large institutions, particularly mental hospitals, actually operate.

Total Institutions

The significance of these patient management practices as rights issues can be understood better within the framework of the concept of "total institution." The concept was developed by Goffman, and Dr. Thomas S. Szasz has abstracted the characteristics of such institutions from Goffman's writings:

1. All aspects of life are conducted in the same place, under a single authority.
2. There is little or no room for private activity and effort. The inmate is always in the company of others: 'all are treated alike and required to do the same thing together'.
3. There is a strict schedule of daily activities which does not issue from the inmates' interests or wishes, but are imposed from above.
4. The contents of the various enforced activities are brought together as parts of a single overall rational plan purportedly designed to fulfill the official aims of the institution.[77]

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[76]Erving Goffman, op. cit., pp. 10-11.

[77]Thomas S. Szasz, Law, Liberty, and Psychiatry, p. 54.

Goffman defines the total institution as " . . . a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life."[78] Although mental hospitals are his prime example, the concept applies to other institutions such as prisons, prisoner of war camps, and leprosaria. There are various kinds of total institutions. The mental hospital is classed with those " . . . established to care for persons felt to be both incapable of looking after themselves and a threat to the community, albeit an unintended one."[79]

Goffman describes in his Asylums, the same practices which have been discussed as typical traits of total institutions. These are some selected examples:

> . . . in some total institutions the inmate is obliged to take oral or intravenous medications, whether desired or not . . .[80]

> Another kind of contaminative exposure brings an outsider into contact with the individual's close relationship to significant others. For example, an inmate may have his personal mail read and censored, and even made fun of to his face.[81]

> . . . any member of the staff class has certain rights to discipline any member of the inmate class . . . On the outside, the adult in our society is typically under the authority of a single immediate superior in connection with his work, or the authority of one spouse in connection with domestic duties.[82]

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[78]Erving Goffman, op. cit., p. xiii.

[79]Ibid., p. 4.

[80]Ibid., p. 28.

[81]Ibid., p. 51.

[82]Ibid., p. 42.

> One set of . . . punishments consists of the temporary or permanent withdrawal of privileges or the abrogation of the right to try to earn them. In general, the punishments meted out in total institutions are more severe than anything encountered by the inmate in his home world . . . Whatever their severity, punishments are largely known in the inmate's home world as something applied to animals and children; this conditioning, behavioristic model is not widely applied to adults, since failure to maintain required standards typically leads to indirect disadvantageous consequences and not to specific immediate punishment at all. And privileges in the total institution, it should be emphasized, are . . . merely the absence of deprivations one ordinarily expects not to have to sustain.[83]

Without drawing any conclusions about severity, application, and prevasiveness, it may be observed from the materials preceding this that the characteristics cited by Goffman are identifiable in Oklahoma institutions for the mentally ill and retarded. These institutions meet the definition of total institutions. Being a participant in a total institution has consequences itself.

Simply living in such an institution for a time causes problems over and above those which bring the patient to the hospital. As Dr. Donahue suggests, "Long term care in a mental hospital results in hospitalitis."[84] Though some call the process "institutionalization," the meaning is that too adequate adjustment to the institution causes later difficulty in, or renders impossible, readjustment to the outside world.

Total institutions, such as mental hospitals and schools for the retarded are unlike other institutions. They differ from voluntary institutions such as hospitals and colleges which are also designed to

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[83] Ibid., pp. 50-51.

[84] Interview with Dr. Hayden Donahue, November 23, 1964.

change and/or cure people, primarily in the area of controls to which the participant must submit. They also differ from other involuntary institutions. For example, military organizations such as armies typically place the participant under control, but only at special times is the control total.

The mental hospital or school for the retarded also differs from other total institutions such as prisons, which are designed to punish, no matter how wrong some citizens may consider such an objective, and which normally hold the participant for a pre-determined time period.

Dr. Szasz draws the analogy between the management of patients in mental hospitals and slaves. He suggests that the slave system is the best model for involuntary hospitalization. The involuntary mental patient, he says, is not like the welfare client nor the medical patient. Rather he is like a slave on a plantation. He cannot change his status. He can be good or bad, co-operative or unco-operative. But he cannot set himself free, nor relinquish his status. The issue, as Szasz sees it, is not whether the treatment is brutal or humane nor whether it is psychiatrically justified or torture. The issue is freedom.[85] And the freedom of hospitalized mental patients and pupils in schools for the retarded is severely restricted.

Within the laws of Oklahoma, persons in institutions may have their mail censored. Their visitors may be restricted, both in the time alloted for visiting and the persons who may visit. They can be restrained, either through physical devices or drugs. They may be required to work, not at jobs they select but at jobs deemed therapeutic

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[85]Interview with Dr. Thomas S. Szasz, August 10, 1965.

for them. They may be punished. As is discussed in Chapter VIII, their personal property may be denied to them.

It is not so much that these specific limits may be placed upon patients and pupils. Each may be explained rationally and there is no indication that the institutions are interested in being punitive or unkind to their charges. These and other elements of patient management are simply manifestations of the institutionalized person's virtually total loss of freedom once he enters the institution. Decisions normally reserved to and basic to the individual are made by the institution instead. Decisions on restrictions must be based upon medical indications or the needs of the institution in line with its in loco parentis responsibility. The loss is of the right to decide.

There is one provision of the law which seems to be specifically designed to protect the patient against generally poor care or mistreatment, by providing for investigations of such cases. It states:

> When the Mental Health Board has reason to believe that any person alleged or adjudged to be mentally ill is wrongfully deprived of his liberty, or is cruelly, negligently or improperly treated, or inadequate provision is made for his skillful medical care, proper supervision and safe keeping, the director may ascertain the facts or may order an investigation of the facts for the board.[86]

Such a provision may be criticized for its weakness. It provides that the director may investigate inadequacies in a situation for which he is responsible. The American Bar Foundation report suggests that the adequate handling of such problems would require review procedures by an independent authority.[87]

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[86] 43A O. S. (1961) Sec. 98.

[87] Lindman and McIntyre, Jr., op. cit., p. 155.

Racial Segregation

It should be noted that racial segregation has been eliminated from Oklahoma's state mental hospitals and schools for the retarded. All of the judges and superintendents interviewed said that patients and pupils were sent to institutions on the basis of geography, alone. Similarly, housing within the institution is handled without regard to race. As is indicated in Chapter III, the function of Taft State Hospital, which has been a hospital for Negro persons, is being changed.

Staff and Supervision

Crucial in all of these procedures and problems is the staff member who administers them. In some ways, the performance of that staff person is dependent upon the administrative structure of the institution. The administration of the hospitals and the supervision and qualifications of aides and attendants were discussed with Dr. Albert Glass, Director of the Department of Mental Health.

He indicated that all large organizations are subject to entropy, a tendency to become less able to function as they become larger and more complex. If left alone, such organizations decay. Consequently, reorganization and supervision are needed to insure compliance with new policies and to avoid routinization and sterility in treatment programs.[88]

Those who are closest, in the administrative hierarchy, to the patients are aides and attendants. Several changes are being made in the qualifications required for these positions. There are four aide/

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[88]Interview with Dr. Albert Glass, January 25, 1966.

attendant classifications. Attendant I, and Psychiatric Aide I,II, and III. Qualifications for the Attendant I position are ten years of education, plus appropriate completion of the civil service examination for the position. Two years of satisfactory experience in an attendant position may be substituted for two years of education. So the basic qualifications is eight years of education plus two years of experience. Those who are willing to do so will attend, partially on their own time and partly through released work time, a two hour per day six month training program. Completion of this will qualify an attendant for a prompt promotion to Psychiatric Aide I, at an increase in salary. Of course, persons with higher qualifications may be immediately hired as Psychiatric Aides. However, it was only in 1965 that the minimum wage for hospital employees was raised to two hundred dollars per month. Thus low salaries interfere with opportunities to secure competent attendant personnel.[89]

The nursing staff, to whom the aides and attendants are responsible, is responsible to both the chief of nursing services and to the physician responsible for the ward on which they are working. It is the physician who is to make all of the decisions on patient care. However, this decision may be delegated to the nurse and the nurse may delegate it to the aide. Dr. Glass considers this an abrogation of responsibility, although he believes it is based upon too much work, rather than irresponsibility. Dr. Glass prefers that physicians actually see patients before placing them in restraints or seclusion. Although this may only

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[89] Ibid.

be done under the orders of a physician, this may be a telephone order, rather than one based upon a personal examination.[90]

Aides and attendants, themselves, may sometimes be persons who hold themselves aloof from the patients and function as guards, rather than as therapists, Dr. Glass suggested. The training program mentioned above is considered a partial solution to this problem.[91]

It would appear that those least professionally qualified have the closest relationship with the patients and may often render decisions on mail, visits, restraints, and all of the other vital patient management issues. This does not necessarily mean that all aides and attendants are unkind to patients, or even that they hold great power over the patients. This would be dependent upon administrative practices within the institution, itself, and upon the individual aides. However, there is some evidence that the administrative structure of the institution and the qualifications of the aides and attendants have some significant effect on the enforcement of regulations regarding patient rights.

However, administrative practices, along with statutory provisions already mentioned, seem designed to protect against patient mistreatment. In the Department of Mental Health's Standard Schedule of Disciplinary Offenses and Penalties, physical and mental abuse of patients and non-reporting of such actions by others requires a minimum penalty of five days loss of work and a maximum of removal from the position for the

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[90] Ibid.

[91] Ibid.

first offense. Any repetition of this behavior requires removal from the job.[92] Thus there appears to be a conscious administrative effort to protect patients from abuse and punish severely those who mistreat patients.

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[92]Department of Mental Health, Policy Manual, p. 49.

CHAPTER VII

TREATMENT PROCEDURES

Detailed discussion of psychiatric treatment procedures is outside the scope of this research and is not included in this chapter. However, some forms of treatment, because of their danger, pose a potential rights problem. They are the subject of some concern and controversy. The notion that the kind of treatment usually provided to emotionally disturbed persons who are not hospitalized is different than that afforded mentally ill persons in institutions is discussed in Chapter IV.

Electric Shock Therapy

The American Bar Foundation study on The Mentally Disabled and the Law says that:

> A discussion of the rights of mental patients relating to the use of electroshock treatment may be classified under the following main topics: (1) consent to treatment, (2) the use of treatment for its tranquilizing or restrictive effects, and (3) the recovery of damages resulting from such treatment.[1]

Since the second issue is briefly discussed in Chapter VI, Patient Management, this discussion will concentrate on the two other issues.

Oklahoma's practices, in brief, are that three of the four

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[1]Lindman and McIntyre, Jr., op. cit., p. 149.

hospitals for the mentally ill and none of the schools for the retarded use electric shock treatment. There is no mention of this procedure in the law and no requirement that consent be obtained, either from the patient or a relative. Neither are there any provisions for the recovery of damages resulting from electric shock treatments.

There are significant differences of opinion on use of electric shock treatments in the Oklahoma institutions. Dr. Hayden Donahue said that electric shock had not been used at Central State Hospital in over ten years and that it had been used with only a few patients on a few occasions in the years immediately preceding the decision to abandon it completely. That decision, however, was not based upon patient rights but upon medical opinions. It was believed that the new drugs were better. Furthermore, Dr. Donahue added that the trend was away from the use of electric shock therapy.[2]

On the other hand, Dr. Bedford Peterson at Eastern State Hospital said that his hospital used electric shock treatment. It is, he suggested, the treatment of choice in some cases and he mentioned involutional depression as a specific problem which responded well to shock. When the interviewer mentioned the Central State Hospital policy of using no shock treatment, Dr. Peterson responded, "(There are) only one or two in the whole country which don't use shock at all and one of those is Central. It happens that they've developed an image and there's many times they wish they did use shock. They'll admit they get pretty stumped on some of them and they need shock."[3] In certain

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[2]Interview with Dr. Hayden Donahue, November 23, 1964.

[3]Interview with Dr. Bedford Peterson, December 21, 1964.

cases, such as those mentioned above, the patient may recover and be discharged in four to six weeks with the use of shock.

While Dr. Donahue does not disagree with the decision of others to use electric shock therapy and acknowledges that it is an acceptable treatment procedure, he does believe that Central State Hospital has been quite effective in treating mental illness without it. When interviewed, he indicated that the hand of man, a few drugs, psychotherapy, and group psychotherapy, could accomplish the same results. Further, he believed that the record of his institution in all cases, including cases of depression, which is becoming the most common type of mental illness, indicated the truth of this. He doubted that anyone could have been helped more effectively with electric shock. Had he believed so, it would have been used.[4]

While there is no release required before such therapy is used, Dr. Peterson indicated that when a patient's family objected strongly to it, shock was discontinued. The family is told, however, that the patient's continued illness is its responsibility. In essence, the family is told that the patient is no longer being treated.[5]

Dr. Harold B. Witten, superintendent of Western State Hospital, indicated that electric shock therapy is used at his institution. Voluntary patients, however, must give their permission for this treatment. Committed patients' relatives are asked for permission before it is used.[6]

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[4]Interview with Dr. Hayden Donahue, November 23, 1964.

[5]Interview with Dr. Bedford Peterson, December 21, 1964.

[6]Interview with Dr. Harold B. Witten, December 21, 1965.

At the Coyne-Campbell Sanitarium, the responsibility for each patient lies with the attending physician, as specified in the statutes on private hospitals. According to Jack Barthold, administrator of the sanitarium, permission of the nearest relative is sought for treatment of all kinds, including electric shock therapy. A form sent to the family grants such permission and provides for a disclaimer of responsibility on the part of the hospital and attending physician.[7]

Whatever the merits or demerits of electric shock, the concern in this research relates to its potential dangers and patient rights in its use. There are no legal protections against its use in Oklahoma. Patients are not always faced with it but when they are not it is because of the individual medical judgment of a hospital or the result of pressure brought upon the hospital by the patient's family.

This is not the case in all parts of the United States. Dr. Overholser of St. Elizabeth's told the subcommittee on rights of the mentally ill that electric shock was only used for an occasional depressed patient. And when it is used, "We always get authority from the family and we explain it, at least, to the patient and try to assure him that this is for his best interest."[8]

There is disagreement on the potential danger of shock therapy. The American Bar Foundation, in its study, quotes materials which indicate that most mental hospitals use the treatment. It also notes that there is wide variance in the practices associated with it. Kentucky,

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[7]Interview with Jack Barthold, January 27, 1966.

[8]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 37.

for example, says that permission is unnecessary because the treatment is an accepted, non-experimental therapy. But Michigan and New York require permission from someone who is legally responsible for the patient, " . . . and New York emphasizes that shock treatment is accompanied by risks of serious injury or death."[9] The report also quotes materials which suggest that shock therapy is used for disciplinary measures, ranging from threats used to maintain order on the ward to a device used to end one patient's telling of a boring story.[10]

In his appearance before the subcommittee, Dr. Manfred Guttmacher, Chief Medical Officer of the Supreme Bench of Maryland, said that electric shock was not administered with the consent of the patient. However, " . . . one gets some member of the patient's family to sign a permission. The blank specifies that the member of the family has been acquainted with the dangers and so forth."[11] Dr. Guttmacher also favored explaining the procedure to the patient in preparing him for it. But he did not consider the patient's permission necessary.[12]

Dr. C. H. Farrell, a psychiatrist who is associated with public mental health facilities in Omaha, Nebraska, described a procedure that is different than the others cited. Dr. Farrell said that when shock treatment was planned for a patient, "We have a form which we ask the nearest kin to sign and we also, at times, if there are no members of

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[9]Lindman and McIntyre, Jr., op. cit., p. 149.

[10]Ibid.

[11]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 154.

[12]Ibid., p. 155.

the family present, then we have the patient sign it. Either the patient signs it or the nearest of kin. At the time they sign this, the treatment is explained to the patient or the relative and the dangers of it are brought out before the individual who signs it."[13]

The Rankin and Dallmayr article which is appended to the hearings of the subcommittee provides a clear discussion of the common law considerations on electric shock and other potentially dangerous treatments. While it is clear that doctors may not conduct surgery or other dangerous procedures on patients without consent in general hospitals, the same is not true in the mental hospital. Such procedures may be conducted in emergencies but " . . . doctors proceeding in violation of this principle may be liable in damages for technical assault."[14] The mental hospital's practices are typically quite different:

> The broad language of many commitment statutes and judicial pronouncements has encouraged the view that mental hospitals--exercising the governmental function of parens patriae--may administer any form of medically justified treatment even in the absence of consent . . . (The hospitals) are entitled to advance the medical welfare of the patient by any type of recognized treatment, including such therapies as electroshock or prefrontal lobotomy, without the requirement of consent. In practice, some State hospitals still consider these therapies as sufficiently dangerous for requiring the same consent as surgical operations; other hospitals have abandoned this requirement.[15]

One opinion of one state attorney general on electric shock therapy seems to have significance. This is an advisory opinion of the Pennsylvania Department of Justice. It says that patients may be given such

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[13]Lindman and McIntyre, Jr., op. cit., p. 168.

[14]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 340.

[15]Ibid., pp. 340-341.

treatments without the consent of family or guardian. " . . . while such consent may be desirable in some cases, it is not essential under the laws of this Commonwealth."[16]

Even though the subject of consent for electric shock therapy was discussed extensively at the subcommittee's hearings, there is no requirement of this in the District of Columbia mental health act which the committee developed.

On the subject of consent for the administration of electric shock therapy, Dr. Albert Glass, Director of the State Department of Mental Health, said that in emergencies no permission is sought. It is not legally required but hospitals are encouraged to obtain permission when there is time or an opportunity.[17] However, this is not an official department policy. It is encouraged by Dr. Glass but superintendents are not bound to follow it by either law or administrative regulations.[18]

In regard to recovering damages for injuries resulting from electric shock, there are few legal precedents. One state has a statute which bars the recovery of damages. The statutes of the state of Kansas provide:

> No person who, while a patient at any state hospital, receives psychiatric 'shock' treatment, and as a result thereof suffers physical or mental injury or death, nor the personal representative or guardian of any such person, shall thereafter have a cause of action for damages against any physician or technician of such hospital unless injury

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[16] Lindman and McIntyre, Jr., op. cit., p. 149.

[17] Interview with Dr. Albert Glass, November 18, 1965.

[18] Interview with Dr. Albert Glass, January 25, 1966.

> or death shall have resulted from the gross negligence of such physician or technician giving or supervising the giving of such 'shock' treatment: Provided, that approved and accepted methods and techniques of administering such 'shock' treatment are used. It is hereby made the duty of the attorney general of this state to defend any such action brought against any such physician or technician.[19]

The American Bar Foundation report identified three cases in which patients had attempted to recover damages. In all three cases severe fractures were suffered by the patients. The plaintiffs attempted in each case to invoke the res ipsa loquitur doctrine. According to Black's Law Dictionary this doctrine is, "The thing speaks for itself. Rebuttable presumption that defendant was negligent, which arises upon proof that instrumentality causing injury was in defendant's exclusive control, and that the accident was one which ordinarily does not happen in absence of negligence."[20] In all three cases, the courts refused to apply the doctrine and " . . . also refused to submit the cases to the jury on the issue of negligence."[21]

Apparently the issue of recovery of damages has never been tested in Oklahoma. There is no statutory law on the subject and it would appear that such a claim would have difficulty in being adjudicated to the satisfaction of the plaintiff.

Insulin Shock Therapy

Insulin shock, which Dr. Donahue called dangerous and which he

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[19]Kansas G. S. 1961 Supplement, Sec. 76-1239.

[20]Henry Campbell Black, op. cit., p. 1470.

[21]Lindman and McIntyre, Jr., op. cit., p. 149.

said required the services of many people to administer,[22] is not used in the state mental hospitals of Oklahoma, at all, according to Dr. Glass.[23] When he was interviewed, Dr. E. P. Henry said that his institution used some metrazol shock treatment, which is another form of chemically-induced shock.[24] None of the state schools for the retarded use insulin or any other shock therapy.

Significantly, the decision to abandon the use of insulin shock was an administrative one, based, it would appear, upon the medical judgment of the physicians who direct the state hospitals for the mentally ill. As with electric shock, there are no statutes dealing with this issue and no specific safeguards or recourses guaranteed to the patient.

Narco-Analysis

There is apparently little usage of chemically-induced twilight interviewing, or narco-analysis, in the state mental hospitals of Oklahoma. According to Dr. Peterson, this procedure involves the use of sodium amatol or sodium penatol. These are anasthetics which will put the patient into a kind of half sleep, when the proper dosage is used. Some interviewing of this kind is used at Eastern State Hospital.[25] Dr. Henry indicated that it was also used at Taft.[26]

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[22]Interview with Dr. Hayden Donahue, November 23, 1964.

[23]Interview with Dr. Albert Glass, November 18, 1965.

[24]Interview with Dr. E. P. Henry, December 21, 1964.

[25]Interview with Dr. Bedford Peterson, December 21, 1964.

[26]Interview with Dr. E. P. Henry, December 21, 1964.

Dr. Donahue said that little was done with this procedure, of which he was a co-founder, at Central State Hospital. Technically it involves narco-analysis for the purpose of extracting material from the patient's unconscious and narco-synthesis, which is the process of re-incorporating the material into the ego structure. The dangers are no greater than those involved in the use of any other anasthetic. Essentially, the procedure is used little at Central State Hospital because it is time-consuming and somewhat complicated.[27]

As with the shock therapies, there are no legal limitations on the use of this procedure. No release is needed from the patient or the patient's family.

Surgery

One of the primary issues, nationally, in the area of surgical procedures performed on hospitalized mental patients is psychosurgery, or the various labotomy procedures. As Albert Deutsch put it in his appearance before the subcommittee:

> On the question of lobotomy, I feel very strongly. Thirty thousand patients in this country were lobotomized in this country before the authorities caught up with the fact that it helps but very, very few and has harmed a great many . . . the damaging effects are irreversible . . . the lobotomies, I think, offer a classic example of how much wrong can be done by the premature general usage of a new and relatively untried therapeutic drug or device.[28]

Lobotomies, themselves are not an issue in Oklahoma at this time.

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[27]Interview with Dr. Hayden Donahue, November 23, 1964.

[28]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 48.

They seem to have fallen into general disrepute although there are still some who advocate their usage. According to the American Bar Foundation study, some states have specific regulations of an administrative nature, which require consent for lobotomies.[29]

While Oklahoma apparently has no specific rules on such operations, it is one of the few states which requires notice to be given to a patient's family before any major operation may be performed.

> Before proceeding with any major operation which in the judgment of the superintendent of the institution is advisable or necessary, the superintendent shall notify or cause to be notified the spouse, parent or guardian or one of the next of kin residing in Oklahoma, if such information is shown by the records on file with the superintendent and a copy of said notice shall be filed in the patient's records; except that in cases of grave emergency where the medical staff feels that surgical or other intervention is necessary to prevent serious consequences or death, authority is hereby given to proceed with such measure.[30]

It should be recognized that the statute requires notification rather than consent. Presumably the notification would afford the patient's family an opportunity to take legal action or use persuasion with the hospital officials if there was objection to the surgery.

Conclusions

While Oklahoma is not in the front ranks of states in terms of providing protection to patients who might object to shock therapy and other potentially dangerous treatment procedures, it is one of the few requiring notification of the patient's family when major surgery is contemplated.

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[29]Lindman and McIntyre, Jr., op. cit., p. 148.

[30]43A O. S. (1961) Sec. 96.

It is the present state position in regard to the administration of electric shock therapy which might give cause for concern. Where electric shock therapy is used extensively, obtaining permission for its use would probably require a significant amount of time along with some disruption of the treatment plans made for patients. However, the issue of its validity as a treatment procedure and its danger appears to be far from settled. As has already been discussed, one state considers electric shock well past the experimental stage while another warns of its grave dangers. In Oklahoma one hospital has abandoned it completely, while others use if often. When there is such disagreement between the experts it would seem that some protection for the patient would not be unreasonable.

It is perhaps in the area of treatment that the issue of treatment versus rights is best crystallized. To oversimplify, the treatment expert prefers a situation in which he is able to apply his best professional judgment without restriction. The rights advocate would not necessarily disagree, but he would want appropriate statutory guarantees to protect the patient from potentially dangerous procedures or provide him or his family with a choice in the face of controversial treatments.

Although the same statutes apply to the state institutions for the mentally retarded, the nature of their services does not make treatment procedures a particularly significant issue for them.

The Right to Treatment

Perhaps the most interesting blending of the civil rights view-

point with the medical is the "right to treatment" concept developed and advocated by Dr. Morton Birnbaum, who is both a physician and an attorney. In an article in the American Bar Association Journal in 1960 and in his appearance before the subcommittee he called for " . . . the recognition and enforcement of the legal right of a mentally ill inmate of a public mental institution to adequate medical treatment for his mental illness."[31]

In his subcommittee appearance, Birnbaum described a case he was handling as a lawyer. After three months' effort, Birnbaum was able to see his hospitalized client's hospital record and found that during one year of commitment the only recorded treatment was an indication that the patient had had an injection of typhoid vaccine.[32]

In his advocacy of this right, Birnbaum has some rather clear ideas:

> If the right to treatment were to be recognized, our substantive constitutional law would then include the concepts that if a person is involuntarily institutionalized in a mental institution because he is sufficiently mentally ill to require institutionalization for care and treatment, he needs, and is entitled to, adequate medical treatment; that being mentally ill is not a crime; that an institution that involuntarily institutionalizes the mentally ill without giving them adequate treatment for their mental illness is a mental prison and not a mental hospital; and, that substantive due process of law does not allow a mentally ill person who has committed no crime to be deprived of his liberty by indefinitely institutionalizing him in a mental prison . . . he must be given proper medical treatment or else

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[31]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 283. (Morton Birnbaum, "The Right to Treatment," American Bar Association Journal, Vol. 46, May 1960, pp. 499-505.)

[32]Ibid., p. 299.

> the inmate can obtain his release at will in spite of the existence or severity of his mental illness . . . the State would no longer have the absolute discretion to decide the standard of medical care for the inmates of public mental institutions.[33]

An article on due process and the mentally ill by Richard Arens and Lawrence Speiser for the American Civil Liberties Union pinpoints the sort of problem Dr. Birnbaum hoped to resolve. "Overcrowding, understaffing, mediocrity in therapeutic skill and occasional brutality in custodial treatment continue to characterize numerous, if not most, public mental hospitals throughout the country."[34] The issue is a real one. The Joint Commission on Mental Health and Mental Illness reported that more than half of the mental patients in state institutions received no active treatment designed to improve their condition.[35]

The subcommittee's counsel challenged Birnbaum's research by noting that he identified no actual cases involving the right to treatment. Birnbaum replied by describing Section eighty-six of the New York mental hygiene law which provides for a patient who feels he is not receiving adequate treatment to petition the state director to correct this. The fallacy in this is that the same person who administers the law and supervises the hospital would hear the petition. Birnbaum also noted that the Circuit Court of Appeals in the District of Columbia, when such an issue was brought before it, did not present a written opinion on it. In other words, Birnbaum says the courts will not say whether or not

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[33] Ibid., pp. 276-277.

[34] Ibid., p. 214.

[35] Ibid., pp. 300-301.

there is a right to treatment.[36]

The Draft Act and the Oklahoma statutes call for treatment of patients. "The medical care and treatment shall be in accordance with the highest standards accepted in medical practice to the extent that facilities, equipment and personnel are available."[37] However, there is no recourse for the patient who thinks he is not receiving adequate treatment. There is also no indication that lack of treatment would be grounds for release from the hospital under a habeas corpus application. This would appear to be Dr. Birnbaum's concern.

While the "right to treatment" has the surface appearance of a significant addition to the rights of mental patients and is lauded by such in an editorial in The American Bar Association Journal,[38] there is no unanimity on the subject.

Dr. Szasz, in his appearance before the subcommittee, seemed to say that the basic issue in mental health is the right "not to be treated."

> Does a person have a right to be 'mentally ill'? And further: Does he have the right to be 'mentally ill' and deliberately not seek treatment for it? . . . It seems to me that here we must rely on our practices in related areas of social life. As far as ordinary bodily illness as are concerned--for example, pneumonia or lung cancer--it is obvious that we have the right to be ill and also the right not to seek treatment. In a democracy, to receive medical treatment is basically an option, not a requirement. Usually, the recipient has to pay for it. If he wants to suffer without medical aid, he is free to do so.[39]

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[36] Ibid., p. 300.

[37] 43A O. S. (1961) Sec. 91.

[38] Ibid., pp. 292-293.

[39] Ibid., p. 255.

While Dr. Szasz in the same statement acknowledged the right of the state to isolate those with communicable diseases he added that mental illness is not comparable. In his personal interview, Dr. Szasz called the right to treatment "mythology" and likened it to the Crusades.[40]

Of course, Dr. Szasz's position goes deeper than is indicated. He seems to think that a statutory "right to treatment" would confuse the real civil liberties issue, which he thinks is involuntary commitment. In addition, the right to be treated could seem paradoxical to most psychoanalysts, such as Szasz, since patient involvement and the desire to be treated are implicit in this approach. Thus statements and approaches which would compel treatment are not in the psychoanalytic tradition.

Perhaps an example of the required treatment approach is Senator Sam J. Ervin, Jr.'s statement at his subcommittee hearings:

> I have thought for a long time that when a man is a narcotic addict or a chronic alcoholic-that there ought to be some way for society to step in and say, 'you need treatment' and to say 'we are going to see that you get treatment even if it involves some deprivation of your personal liberty, and we are not going to wait until you become a criminal before undertaking to give you the treatment you need.'[41]

Such a statement probably represents the direct opposite of Dr. Szasz's viewpoint on treatment.

The law which was the product of the Senate subcommittee specifically says that "Any person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical

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[40]Interview with Dr. Thomas S. Szasz, August 10, 1965.

[41]Ibid., p. 249.

and psychiatric care and treatment."[42] This appears to be a legalization of the "right to treatment," although it does not make provisions for the release of patients who are able to prove that they are not receiving such care.

Adequate treatment would appear to be an in loco parentis responsibility of an institution and a primary justification for involuntary commitment.

Research and Experimentation

There is a formal experimental program of drug research in operation at Central State Hospital, among the state institutions. Although the other hospitals occasionally try new drugs with patients, the only full research program is at Central State Hospital. Even this program, however, is not one of research on the effects of new compounds or untested medicines. Basically, the program focuses on the testing of the effects of drugs which have already been approved and determined to be pure and therapeutic, according to Dr. Hayden Donahue. The total effect of a drug, including the length of time it lasts, its results, the varieties of dosages, and the kinds of problems it may alleviate, are all subjects of research. However, the families of patients are always notified of the use of new drugs and their permission is requested, preferably in a personal conversation, but, if this is not possible, by mail. No such new drugs are administered if the family objects, although few refuse permission.[43]

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[42] 78 U. S. Statutes at Large, p. 951.

[43] Interview with Dr. Hayden Donahue, January 31, 1966.

Other drugs and procedures are tested for effectiveness but these are typically not cleared with the family. For example, some diabetics have been given oral medicine to control the disease, rather than injections of insulin and all patients were given influenza vaccine, some with the newly-developed gun-method and some with hypodermics. Since both these procedures involved approved devices and medicines, no permission was requested.[44]

No experimental research is done with patients at the University of Oklahoma School of Medicine psychiatric unit, although clinical research, or reports on therapeutic activities, have been recorded and published, according to Dr. Eugene Pumpian-Mindlin, acting director of the Department of Psychiatry.[45]

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[44] Ibid.

[45] Interview with Dr. Eugene Pumpian-Mindlin, January 31, 1966.

CHAPTER VIII

PROTECTION OF CIVIL, PERSONAL, AND PROPERTY RIGHTS

There are a number of personal freedoms and privileges which a committed mentally retarded or mentally ill person may lose.

Voting

Article III, Section 1 of the Oklahoma Constitution prohibits "idiots and lunatics" from voting.[1] Although there is no specific exclusion of mentally ill or retarded people from holding office, the requirement that candidates be qualified electors would exclude them.[2]

The position of the committed mentally ill person is quite different than that of the admitted mentally retarded person in this regard. Because mentally retarded people are admitted to the state institutions voluntarily they do not lose their right to vote. As has been indicated, voluntarily institutionalized patients and pupils may lose their rights only in connection with separate competency proceedings. It is likely that a severely retarded adult could go through life without losing voting rights. This prompted Joseph Deacon, Superintendent of the Pauls Valley State School for the Mentally Retarded, to speculate: "I wonder how many of our adults go home around election time and vote." When

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[1] Oklahoma State Constitution, Article 3, Section 1.

[2] 26 O. S. (1961), Sec. 1962.

told of such plans by one pupil, Mr. Deacon probed further and the pupil indicated that he always had voted and wondered why he shouldn't.[3]

Of course, the specifics of this are not totally clear. A statute prohibits from voting " . . . any person while kept in a poor house or asylum at the public expense, except Federal and Confederate ex-soldiers; . . . nor any idiot or lunatic . . ."[4] The institutionalized retarded or ill may be excluded from voting if they are supported by public funds, whether declared incompetent or not. However, there is no indication of a court test of this issue or litigation on voting rights of the mentally ill or retarded.

Drivers' Licenses

As is true in most states,[5] Oklahoma denies vehicle operator's licenses "To any person, as an operator or chauffeur, who has previously been adjudged to be afflicted with or suffering from any mental disability or disease and who has not at the time of application been restored to competency by the methods provided by law."[6] The same statute places a general limit, denying the right to operate a motor vehicle, to people who have mental diseases that would impair their driving ability.

This seems to mean that the committed mentally ill are, by

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[3]Interview with Joseph Deacon, December 22, 1964.

[4]26 O. S. (1961), Sec. 61.

[5]Lindman and McIntyre, Jr., op. cit., p. 222.

[6]47 O. S. (1961), Sec. 6-103.

their commitment, prohibited from driving. The general statute would tend to include, perhaps, most mentally retarded individuals, voluntary patients in state institutions, and anyone else adjudged mentally ill.

This is in spite of the fact that there are no scientific indications that mental illness, generally, is specifically dangerous in driving. While some emotional problems might render driving impossible or dangerous they would not tend to be confined to the mentally disabled. In a state such as Oklahoma, with its rural character and lack of public transportation, along with many occupations requiring the operation of a motor vehicle, the loss of the right to drive is a severe one.

Payment for Hospitalization

One of the incongruous developments in the effort to make mental hospital care like any other hospitalization is that patients--even committed patients--are required to pay the costs of their hospitalization.

Oklahoma law requires such payments, although there is a provision which specifically permits institutionalization at public expense:

> A patient or pupil at an institution within the department is liable for his care and treatment. This claim of the State for such care and treatment shall constitute a valid indebtedness against any such patient or pupil and his estate and shall not be barred by any statute of limitations. At the death of the patient or pupil this claim shall be allowed and paid as other lawful claims against the estate . . . Provided, further that no admission or detention of a patient in a state hospital or a pupil in a school shall be limited or conditioned in

> any manner by the financial status or ability to pay of a patient or pupil, his estate, or any relative.[7]

This statute applies to all patients and pupils. While voluntary patients and all of the pupils,[8] who are admitted only on a voluntary basis, might be expected to pay, the notion of charging involuntary patients for their care seems incongruous.[9] Although the institutions are not the same, the principle of charging committed mental patients for their care is comparable to charging prisoners for their care in state penitentiaries.

Payment for care is based upon the ability to pay, in all of the institutions for the mentally ill and mentally retarded. According to the officials of the programs, approximately half of the patients and pupils pay nothing toward their care.

When interviewed, Dr. Albert Glass, Director of the Department of Mental Health, said that the hospitals vary in the proportion of the patients who pay for their care. More money is collected, for example, from patients at Central State Hospital than from any of the other institutions. The highest per capita amount is paid at Western State Hospital, probably, said Dr. Glass, because the northwestern area is more affluent than the rest of Oklahoma, particularly more than the southeast, from which Eastern State Hospital draws many of its patients. Approximately one-half of the patients pay nothing, with a large number paying a small amount, ranging from about twenty dollars per month.

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[7] 43A O. S. (1961) Sec. 111.

[8] 58 O. S. Supplement (1963), Sec. 312.

[9] 43a O. S. (1961) Sec. 117.

Only a few--perhaps five percent according to Dr. Glass--pay the maximum amount.[10]

The maximum is set by statute at no more than the average monthly per capita cost of a patient in the department. The statute recognizes that costs may vary and authorizes the director, with the approval of the Mental Health Board, to fix the rate within those limits.[11] Dr. Glass said that the charges had been one hundred dollars per month, much less than the per diem cost of six dollars, but were recently raised to one hundred and fifty dollars per month.[12]

In the state schools for the retarded, the same conditions seem to prevail. Mr. Joseph Deacon, Superintendent of the Pauls Valley State School said that about half the families of the retarded pupils pay part of the cost of care, ranging from five dollars to the maximum of seventy-five dollars per month.[13]

Unquestionably, the mental health statutes provide for enforcement of this collection of fees. The mental health officials may reduce or waive fees, as indicated, for patients who are poor or indigent. But there must be precise evidence of poverty for the fees to be reduced or waived:

> Before any charge for care and treatment is reduced or waived there must be a report by a member of the Social Service Department of the institution or department, or such other person as may be designated by the Director,

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[10]Interview with Dr. Albert Glass, November 18, 1965.

[11]43A O. S. (1961) Sec. 112.

[12]Interview with Dr. Albert Glass, November 18, 1965.

[13]Interview with Joseph Deacon, December 22, 1964.

> as to the ability of the patient to support himself and those members of his family who are lawfully dependent on him for support. The report shall be in writing and shall indicate the assets and liabilities and the number of dependents of the patient. It must be filed with the patient's records. Any reduction or waiver of a patient's indebtedness for care and treatment must be in writing, must state the reasons for the reduction or waiver and must be signed by the superintendent granting such reduction or waiver. It must also be filed with the patient's records at the institution. For the purpose of carrying out provisions of Sections 111, 112, 113, 114, 115, and 116 of this Act the Oklahoma Tax Commission is directed to furnish to the Director, or some person designated by him, upon request, such information as may be of record in the Commission relative to patients, and their estates.[14]

Other provisions of the mental health statutes provide for a statement to be issued to people who are responsible for the care of the patient. " . . . but failure to send or receive this statement shall not affect the liability of a person who is otherwise liable for the patient's care and treatment."[15]

Persons who have guardians appointed are also covered and the guardian must pay for the care from the patient or pupil's estate. The law provides for suit of the family by the county attorney in the county where they live, in the name of the state. Such suits may be brought by the superintendent of the institutions where the patient or pupil resides.[16] The Director of the Department of Mental Health is further empowered, with the compliance of the Board of Mental Health, to employ counsel to institute such proceedings and

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[14] 43A O. S. (1961) Sec. 113.

[15] 43A O. S. (1961) Sec. 114.

[16] 43A O. S. (1961) Sec. 115.

recover any funds due the institution for the care of the patient.[17]

These statutes apply to both schools for the retarded and hospitals for the mentally ill.

Despite the specificity of the legislation, there is question as to how far this liability extends through the family. Parents, children, and spouses are held liable in the law, although this is within the statute which discusses a guardian's responsibilities.[18] It is possible that relatives who are not legal guardians of the patient, such as the children of mentally ill parents, are not responsible in common law for the support of their parents. The duty of the natural relatives of a mentally ill patient is an imperfect obligation at best. "In the absence of a statute, there is no obligation on a relative to maintain such person. What relatives, if any, should be liable, in such case, is a matter solely of legislative cognizance."[19]

In any case, the issue of payment for care by involuntarily hospitalized patients raises basic questions about a citizen's right to avoid payment for his own involuntary incarceration.

Jury Service

Persons who are declared mentally ill or retarded in Oklahoma may not serve on juries unless they have had their competency restored, in that they must be qualified electors.[20]

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[17] 43A O. S. (1961) Sec. 116.

[18] 43A O. S. (1961) Sec. 115

[19] State v. Wilson, 94 Okl 166.

[20] 38 O. S. (1961) Sec. 28.

Engagement in Occupations

State law forbids persons who are mentally ill or retarded from practicing a number of professions and trades in Oklahoma. This rule does not apply to all occupations and the procedures for enforcing it vary, as do the procedures for reinstatement. Most of the laws specify commitment to a mental institution as prima facie evidence of insanity or mental weakness or whatever the specific statute uses as its term for mental illness or retardation.

Chiropodists with a "mental weakness" cannot practice in Oklahoma. And under the statutes on the qualifications for chiropodists, commitment to a mental hospital is considered prima facie proof of mental weakness.[21]

Insanity is a ground for suspension of the license of a chiropractor in Oklahoma.[22] The Board of Chiropractic Examiners, which administers such matters may reinstate a chiropractor whose license is suspended under this statute so long as he is not in the institution when the reinstatement takes place.[23]

Similar rules apply to dentists who are proven mentally unsound. The Board of Governors of the Registered Dentists of Oklahoma may suspend the license when there is proof of the mental illness of the dentist. The same board also has the ultimate power to hear appeals and make decisions on requests for reinstatement.[24]

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[21]59 O. S. (1961) Sec. 148.

[22]59 O. S. (1961) Sec. 167.

[23]59 O. S. (1961) Sec. 168.

[24]59 O. S. (1961) Sec. 327.30.

Mentally incompetent pharmacists lose their licenses, too. They may appeal to the District Court for reinstatement or they may carry the case to the Oklahoma Supreme Court. The board concerned with setting the qualifications of and licensing pharmacists may also reinstate someone who has lost his license under the provisions of this statute.[25]

Physicians and surgeons are covered by similar rules. Their licenses or certificates may be suspended because of insanity and commitment is considered prima facie evidence of insanity.[26] The same procedures followed for other suspensions must be followed when insanity is the basis. Reinstatement by the State Board of Medical Examiners is possible.[27]

Nurses and Licensed Practical Nurses who are judicially determined to be mentally incompetent may lose their licenses.[28] Hearings on this issue are held before the board which governs the licensing of nurses. There is provision for a District Court review of actions suspending the licenses of nurses.[29]

Osteopaths who are adjudicated insane and committed to an institution for the insane may lose their licenses,[30] as may physical

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[25]59 O. S. (1961) Sec. 353.26.

[26]59 O. S. (1961) Sec. 516.

[27]59 O. S. (1961) Sec. 517.

[28]59 O. S. (1961) Sec. 567.7.

[29]59 O. S. (1961) Sec. 567.10.

[30]59 O. S. (1961) Sec. 637.

therapists who are declared mentally incompetent.[31]

There is some divergence in the statutes related to practice of occupations. Some have rather specific provisions for reinstatement and appeal and others only infer procedures. Most rely for their definition of insanity or mental illness or incompetency on a legal adjudication of such an issue. That is, the various governing boards do not take it upon themselves to decide whether or not a member of their profession is incapable of practice because of insanity. They rely strictly on a judicial judgment of incompetence or a commitment to a mental institution.

Whether or not these rights are lost by a voluntary patient or pupil is not clear. Although the mental health statutes specifically exclude voluntary patients from a declaration of incompetency,[32] the laws on practice of occupations may, in some cases, apply to voluntarily admitted persons. To date it does not appear that this issue has been tested.

Confidentiality of Records

Because there is a stigma attached to mental disability, disclosure of information about the patient and his problems may be damaging to him. In addition, since the proceedings are viewed as medical proceedings, the problem of protecting medical records also arises in connection with institutionalization of the mentally disabled.

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[31] 59 O. S. (1961) Sec. 880.

[32] 43A O. S. (1961) Sec. 64.

One of the most striking facts about involuntary commitments is that the reports on them are a matter of public record. They are filed in the various county court houses and any citizen may have access to them. The ease with which this research into commitment practices was done may constitute one of the gaps in protection of the rights of the mentally ill. Actually, public filing of court records may be seen as a protection itself. It obviates against secret hearings and mysterious disappearances. However, even if one is not committed to an institution, there remains, in perpetuity, a record of the hearing on the subject in the court house files. These hearings may call a person mentally ill, psychotic, constitutionally inadequate, schizophrenic, or a multitude of other names which could hamper people in seeking employment or engaging in certain other kinds of activities. As will be discussed later, there is specific protection of hospital records on a patient. However, it is possible for the commitment records to be protected, too. The Draft Act on hospitalization of the mentally ill suggests this section:

> Disclosure of information- (a) All certificates, applications, records, and reports made for the purpose of this Act and directly or indirectly identifying a patient or former patient or an individual whose hospitalization has been sought under this Act shall be kept confidential and shall not be disclosed by any person except insofar
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> (1) as the individual identified or his legal guardian, if any (or, if he is a minor, his parent or legal guardian), shall consent, or
> (2) as disclosure may be necessary to carry out any of the provisions of this Act, or
> (3) as a court may direct upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make such disclosure would be contrary to the public interest.

(b) Nothing in this section shall preclude disclosure, upon proper inquiry, of information as to his current medical condition, to any members of the family of a patient or to his relatives or friends.
(c) Any person violating any provision of this section shall be guilty of a misdemeanor and subject to a fine of not more than $500 and imprisonment for not more than 1 year.[33]

Oklahoma has not adopted this section of the Draft Act, but it does have some protective legislation, covering hospital records. In the section of the mental health statutes outlining the duties of the superintendent, the superintendent is charged with keeping records on all patients. "Such record shall be accessible only to the superintendent and such officers and subordinates of the institution as he may designate, to the Director and his representatives, except on the consent of the director or an order of a judge or a court of record."[34]

The 1965 legislature liberalized these rules to allow release of information to community agencies and therapists:

> Superintendents of State Mental Hospitals may make available pertinent extracts of a case record of former patients to community health services, community social agencies and private physicians, provided such services, agencies or physicians are engaged in a therapeutic endeavor with such former patients. Further, such information can only be furnished by the Superintendent with the consent of the patient concerned or his guardian.[35]

There appear to be no statutory penalties for improper disclosure. However, the most significant rights issue would appear to be the lack of confidentiality of records of commitment proceedings.

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[33]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., pp. 522-523.

[34]43A O. S. (1961), Sec. 18(10).

[35]43A O. S. Supplement, 1965, Sec. 18.

The Director of Mental Health also has some responsibilities for confidentiality. He is required to maintain a central registration of the nearest relatives of inmates of mental institutions. This is to be shown to and the information in it disclosed to only " . . . the State Commissioner of Health and Commissioner of Charities and Corrections, and the State Welfare Department and, on request, the same shall be available to authorized representatives of the United States of America."[36]

Patient Property

Personal property of hospitalized mental patients and pupils in schools for the retarded is important to the patients, the source of some difficulty for the administrators of institutions, but is typically not discussed in detail in state statutes. According to the American Bar Foundation study, most states do not make clear precisely how an admitted patient's property is to be handled when he is hospitalized or disposed of when he leaves.[37] The Oklahoma statutes do not discuss the total process or all of the questions which are involved. However, there are some provisions for the return of patient property to a discharged person or his guardian or next of kin, if he has died. Generally, a superintendent is required to return any patient property in his hands to the patient upon discharge. If the patient dies in the institution, the institution must, within a prescribed time limit, notify the patient's guardian or next of kin, or

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[36] 43A O. S. (1961) Sec. 14(13).

[37] Lindman and McIntyre, Jr., op. cit., p. 152.

legal representative of any property being held. If the property is not claimed within the time limit, it reverts to the state and becomes part of the revolving fund of the institution.[38]

One would assume from the interviews with superintendents that while these provisions guarantee certain protections to the patient or his estate, they do not deal with the most pertinent patient property problems.

Clothing

A typical criticism of "total institutions" is that they destroy the individuality of the inmate through the requirement that he wear only institutional clothing, without a choice of what to wear or when to wear it. Erving Goffman's comments are pertinent:

> The personal possessions of an individual are an important part of the materials out of which he builds a self, but as an inmate the ease with which he can be managed by staff is likely to increase with the degree to which he is dispossessed . . . Further, the efficiency with which the clothes of these patients can be kept clean and fresh is related to the fact that everyone's soiled clothing can be indiscriminately placed in one bundle, and laundered clothing can be redistributed not according to ownership but according to approximate size.[39]

Goffman goes on to describe a system which requires patients going outside on a cold day to file past a stack of overcoats. Each patient must take the next overcoat, regardless of size. He also discusses advertisements for clothing which is easily placed upon the patient but which is not attractive nor comparable to that worn in the rest

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[38] 43A O. S. (1961) Sec. 5, 171, 172, 173, 174, 175.

[39] Erving Goffman, op. cit., pp. 78-79.

of the society. Goffman's research points to the importance of clothing in patient morale, and ultimately, responsiveness to treatment.

According to the superintendents interviewed, such a situation does not prevail in Oklahoma. Patients are encouraged and permitted to keep their own clothing. According to Dr. Bedford Peterson, patients at Eastern State Hospital wear their own clothing if they have it. Clothing is furnished to those patients who do not.[40]

Dr. Hayden Donahue at Central State Hospital indicated that in former times, patients were forced to wear institutional clothing and their personal garments were taken from them. However, patients now are permitted and encouraged to use their own clothing. And Dr. Donahue noted a difference in the attitudes and feelings of those who have their own and those who must be provided with state-issued clothing. Those who have their own tend to look better and seem happier, he said.[41]

The same practices seem to prevail at the state schools for the mentally retarded. Families are encouraged to provide clothing for the pupils, according to James Boren at the Hissom Memorial Center. The institution makes an effort to keep up with patient property through marking and inventories.[42]

Dr. J. L. Dunigan at the Enid State School offered a rather

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[40]Interview with Dr. Bedford Peterson, December 21, 1964.

[41]Interview with Dr. Hayden Donahue, November 23, 1964.

[42]Interview with James Boren, December 3, 1964.

specific description of the clothing practices there. Pupils who are able to do so furnish their own clothes. Twice each year, clothing is requisitioned from the parents. Cards are kept on the clothing of all the patients. Even when clothing is purchased by the state, an effort is made to individualize it. A kind of uniform is worn by the pupils who are in the infirmary.[43]

Clothing practices at the Pauls Valley State Schools, as they were described by Joseph Deacon, appear to be similar to those of the other institutions.[44]

There is one statutory requirement on clothing:

> No patient shall be discharged or granted convalescent leave status from a state hospital without suitable clothing adapted to the season in which he is discharged or granted convalescent leave status; and if it cannot be otherwise obtained, the business manager of the institution shall, upon the order of the superintendent, furnish the same, and money not to exceed Twenty-five ($25.00) Dollars, to defray his expenses until he can reach his relatives or friends, or find employment to earn a subsistence.[45]

The intent of the statute seems to be to protect the patient from the elements and from destitution upon discharge. No specific provision is made for patients or pupils while they are institutionalized.

Other Property

All but one of the superintendents interviewed indicated that personal property brought to the institution by the patient or pupil

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[43]Interview with Dr. J. L. Dunigan, December 29, 1964.

[44]Interview with Joseph Deacon, December 22, 1964.

[45]43A O. S. (1961) Sec. 82.

caused some of the most difficult problems faced by the school or hospital. The exception, Dr. Dunigan, said that personal property was seldom a problem at the Enid State School. Parents are urged not to give expensive gifts to their children there.[46]

All of the others were more specific on the procedures involved and the problems they faced. Dr. Donahue called property the source of the greatest number of legal problems handled by the hospital. Patients at Central State Hospital are not allowed to keep all that they bring with them. This is because of the hospital's legal responsibilities. When there is a choice, Dr. Donahue suggests that the hospital attempt to be liberal. He would like to see the patients keep more and more of their personal belongings. However, there are many problems in the area of property.[47]

According to Dr. Witten, at Western State Hospital incoming patients are not searched. Instead, patients are required to change their clothing while those clothes worn to the hospital are marked. Then their clothing is searched for dangerous objects, which patients are not permitted to keep.[48]

Dr. Glass indicated that patients are not allowed to keep valuable property, although an effort is made to help them keep personal keepsakes such as wedding rings. The loss or theft of such items causes great difficulty on the wards but there have been no actual suits

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[46]Interview with Dr. J. L. Dunigan, December 29, 1964.

[47]Interview with Dr. Hayden Donahue, November 23, 1964.

[48]Interview with Dr. Harold B. Witten, December 21, 1965.

over this issue that have been brought to Dr. Glass's attention.[49]

One problem that Dr. Donahue mentioned is the patient who comes with very valuable property. Some patients enter the hospital with rings and watches worth several thousand dollars. One man arrived at Central State Hospital with bonds valued at fifteen thousand dollars enclosed in his shirt. The patients at Central, as well as those at the other institutions, live in large open wards. There is no privacy, there are usually no closets, and no lockers. As Dr. Donahue put it, "This place was built for storage,not for treatment." Consequently, the problem of theft is always present, as is the problem of destruction. Occasionally one patient will tear up all of another patient's pictures. And because of the nature of the patients, many are not able to protect their property. The decision on what may be kept and what must be held by the institution is thus made on a medical basis. The patient is allowed to keep those things his physician thinks he can hold and protect from theft. Cash is typically deposited to the patient's account at the hospital and expensive articles are held for him.[50]

The concerns over property expressed by James Boren were of a different emphasis. He acknowledged that pupils are searched when they arrive, primarily for dangerous articles. Pupils occasionally bring knives with them and this is a cause for some concern. Such dangerous articles are taken away.

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[49]Interview with Dr. Albert Glass, January 25, 1966.

[50]Interview with Dr. Hayden Donahue, November 23, 1964.

[51]Interview with James Boren, December 3, 1964.

At Eastern State Hospital, patients are also searched and all of their property is inventoried, according to Dr. Peterson.[52]

Mr. Deacon at Pauls Valley indicated that custody is taken of all property brought by the pupil and it is inventoried. Young children do not carry money. They are provided with one dollar accounts with the school's canteen, which are renewed once the dollar is depleted. In addition, funds are made available for canteen accounts by various individuals and groups for indigent children.[53]

In summary, it would appear that property is a major concern at most of the institutions. With regard to small items and small amounts of money, there is great latitude given to each institution for its handling, with specific statutory provisions to protect the patient upon discharge.

Sterilization

Under some circumstances institutionalized mentally ill patients and mentally retarded pupils in Oklahoma may be sterilized. Section 341 of the mental health statutes specifically provides for it and outlines the procedures under which it may be authorized. The booklets containing the laws pertaining to patients and pupils published by the State Department of Mental Health and the Department of Public Welfare do not include this section.[54] However, the section has not been

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[52]Interview with Dr. Bedford Peterson, December 21, 1964.

[53]Interview with Joseph Deacon, December 22, 1964.

[54]Department of Mental Health, Mental Health Law of 1953 (With Amendments Through 1963 Legislature) and Department of Public Welfare, Laws Relating to Institutions for Mentally Retarded.

repealed although the indication is that it is rarely applied.

Specifically, the law requires superintendents of state hospitals and wardens of penal institutions to perform sterilization on any male under 65 years of age or any female under 47:

> . . . which patients are about to be discharged from said institution, if such patients are likely to be a public or partial public charge or be supported by any manner or form of charity, or which patients are afflicted with hereditary forms of insanity that are recurrent, idiocy, imbecility, feeble-mindedness, or epilepsy, or any person incarcerated in any penal institution in this State who is an habitual criminal, that is any person convicted of a felony three times, he or she shall come under the provisions of this Act on his or her release. No such superintendent, warden, physician or surgeon authorized under the provisions of this Act to perform such an operation shall be liable for damages in any amount; provided that they have first complied with all the requirements of this Act.[55]

This portion of the laws on mental health is unique in that it defines a specific kind of treatment and specifically frees those who are involved in carrying it out from liability.

Purposes of Sterilization

The Oklahoma statutes seem to spell out with clarity the rationale for the sterilization of certain individuals. The apparent objective is to prevent various classes of people from producing offspring who would follow their parents onto the public charity rolls, although there is serious question on whether or not the problems of mental illness, mental retardation, epilepsy, and criminality, can be inherited. The American Bar Foundation's report notes that while some experts in eugenics have demonstrated that mentally retarded

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[55] 43A O. S. (1961) Sec. 341.

people produce more mentally retarded than the rest of the population, there are also many cases of retardation developing from other causes such as birth injuries and thyroid deficiency.[56] The report also quotes a study which says that " . . . about 89 per cent of inheritable mental deficiency is passed on by individuals not themselves deficient . . . . Thus, if it were possible to sterilize collectively all the feeble-minded, their number in the following generation would be cut down only about 11 per cent."[57]

In regard to the mentally ill, it would appear that the intent of the legislation is to keep them from becoming, through reproduction, even greater burdens on the welfare rolls although the statutes call for the sterilization of patients who have hereditary forms of insanity. There is simply no firm indication that any of the mental illnesses have an organic base that is hereditary.[58] Epilepsy, which is also specifically mentioned in the law, is no longer considered hereditary and is now controllable.[59] Although habitual criminals are in a class outside the scope of this research their position in relation to the sterilization laws is important in terms of understanding the position of the mentally ill or retarded in the face of similar laws. In any case, there is no evidence that criminality is hereditary and one must assume that the law is designed to keep this group from having children.

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[56]Lindman and McIntyre, Jr., op. cit., p. 186.

[57]Ibid., p. 187.

[58]Ibid., p. 186.

[59]Ibid., p. 187.

In other words, the statute must be viewed as having the effect of both limiting the birth of additional persons in the classes specified and denying children to persons in these classes.

Oklahoma is not the only state which has such laws. Twenty-seven others do, although two of these, Minnesota and Vermont, perform the operation on a voluntary basis only. Six of the states allow involuntary sterilizations to be performed on people who are not institutionalized.[60]

Legal Procedures

There are significant variations within the state laws covering sterilization on the procedure for making such surgery legal. Oklahoma's are neither the most liberal nor the most restrictive. They do provide rather detailed procedures which must be followed.

Section 342 of the mental health statutes says that the superintendent of an institution must present a petition stating the facts of the case to the Department of Mental Health, asking for an order to perform such surgery. The law specifically requires service of the patient with a written notice ten days in advance of the hearing before the department. The patient or pupil's guardian must be notified. If he has none, there must be a guardian ad litem appointed who is authorized a maximum fee of $25 for representing the patient. If the person to be sterilized is an infant, the parents must be notified.

The right to protest the action and the right to be represented by counsel is guaranteed but the sterilization may still be carried out

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[60] Ibid., p. 185.

involuntarily if the patient or pupil meets the criteria established in section 341 or is " . . . by the laws of heredity the probably potential parent of socially inadequate off-spring likewise afflicted."[61]

Certain rights of appeal are guaranteed by statute to the patient. Within ten days of the sterilization order being issued, the person in question may appeal to the District Court serving the area where the institution is located.[62] Within thirty days of the District Court appeal, any party to that appeal may appeal to the Oklahoma Supreme Court.[63] There have been appeals on this issue and they are discussed later.

An additional statutory safeguard for the patient is provided in the law. The kind of sterilization is precisely spelled out. Males who are to be sterilized are to have a vasectomy operation and females are to have a salpingectomy.[64] Each operation renders the subject incapable of reproducing and although the salpingectomy is a more serious operation than the vasectomy, "Neither interferes with the desire for sexual intercourse or with its gratification."[65] Oklahoma legislation carries the subject even further by guaranteeing that neither a castration nor hysterectomy may be performed in the process of sterilization. " . . . nothing in this Act shall be construed to authorize

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[61] 43A O. S. (1961) Sec. 342.

[62] 43A O. S. (1961) Sec. 343.

[63] 43A O. S. (1961) Sec. 344.

[64] 43A O. S. (1961) Sec. 342.

[65] Lindman and McIntyre, Jr., op. cit., p. 183.

the operation of castration nor the removal of sound organs from the body."[66]

Superintendents and medical specialists who participate in the sterilization are protected by statute from criminal or civil liability. "Neither any of said superintendents, nor any other person or persons legally participating in the execution of the provisions of this Act, shall be liable civilly or criminally on account of said participation."[67]

Sterilization or castration or hysterectomy which result from other kinds of treatment do not constitute a violation of the law. The act seems to be specific on this subject. "Nothing in this Act shall be so construed as to prevent the medical or surgical treatment for sound therapeutic reasons of any person in this state, by a physician or surgeon licensed by this state, which treatment may, incidentally, involve the nullification or destruction of the reproductive organs."[68]

These procedures appear to guarantee due process to the patient or pupil who is sterilized, according to Oklahoma Supreme Court decisions.[69]

Constitutionality of Sterilization

Sterilization for the purposes outlined in this statute appears to be constitutional, based upon decisions of the Oklahoma and United States supreme courts. Such laws have been attacked on the grounds that parenthood is a guaranteed human right, that sterilization con-

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[66] 43A O. S. (1961) Sec. 342.

[67] 43A O. S. (1961) Sec. 345.

[68] 43A O. S. (1961) Sec. 346.

[69] In re Main 162 Okl 65.

stitutes cruel and unusual punishment, and that the laws are discriminatory, denying equal protection under the Fourteenth Amendment to the United States Constitution.

An Oklahoma case, In re Main 162 Okl 65, found that the sterilization laws did not inflict cruel or unusual punishment. Neither, was the opinion of the court, does the law deprive the sterilized person of life or a part thereof without due process, nor does the statutory position on sterilization violate the right of the person to life, liberty or the pursuit of happiness.[70]

There have been some United States Supreme Court cases which tend to support the position that sterilization is constitutional under some circumstances. The most famous of these is Buck v. Bell, 274 U. S. 200, which dealt with a mentally retarded person in Virginia who was described as feeble-minded. Her mother had also been feeble-minded and the subject had given birth to a feeble-minded child. Although Glendon O. Schubert in his book, Constitutional Politics[71] questions the ability of the experts of 1927 to diagnose mental retardation or testify to its hereditary characteristics, the diagnosis of the patient was made on this basis and, as will be noted, the Court upheld the action with the belief that retardation was hereditary.

There was no question of procedural due process violations in the case. The patient had been accorded all of the procedural guarantees and the appeal was on the issue of sterilization itself. Justice

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[70] Ibid.

[71] Glendon O. Schubert, Constitutional Politics, pp. 657-659.

Holmes delivered the opinion of the Court. His last several comments were:

> We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Jacobson v. Massachusetts, 197 U. S. 11. Three generations of imbeciles are enough.[72]

The notions evident in the opinion are interesting. First is the presumption that mental retardation is hereditary. Second is the assumption that the mentally retarded are more likely to become criminals, even dangerous criminals. Third is the analogy of sterilization and vaccination. An unpublished thesis quoted in the American Bar Foundation study notes the difference between assessing a fine, as the vaccination statute did, and compelling submission, as the sterilization statute did. The same thesis contends that parenthood is a fundamental right.[73] There have been contentions that other classes of people could be defined as undesirable and eliminated, particularly racial groups. But perhaps the strongest evidence against the validity of the Buck v. Bell decision is the lack of knowledge about heredity and mental retardation.

One other United States Supreme Court case on compulsory

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[72]Buck v. Bell, 274 U. S. 200.

[73]Lindman and McIntyre, op. cit., p. 188, Walter Berns, Buck v. Bell The Sterilization Decision and Its Effect on Public Policy. Unpublished thesis, University of Chicago Library, June, 1951.

sterilization was concerned with a criminal case and related to an Oklahoma statute. In Skinner v. Oklahoma, 316 U. S. 535, the statute which required compulsory sterilization for habitual criminals convicted of crimes involving moral turpitude, and which specified those convicted of three such crimes as requiring sterilization, was declared unconstitutional. Skinner had first been convicted of stealing chickens. His later two offenses were on charges of armed robbery. The statute was declared unconstitutional on the grounds that it denied equal protection.[74]

There have been no specific cases before the United States Supreme Court or that of Oklahoma dealing with the mentally Ill. However, it would appear that current law makes it possible for them to be sterilized under the provisions of the mental health statutes. The constitutionality of sterilization so long as appropriate notice, right of appeal, and safeguards, are provided, appears to be a matter of settled law.

Current Oklahoma Practices

Despite the statutes and their constitutionality, mentally retarded and mentally ill people in Oklahoma have little reason to fear that they might be sterilized under current practices in state institutions. State officials of both the Department of Mental Health and the Department of Public Welfare indicated that such procedures are not used and had not been used during their tenure.

Dr. Albert Glass, Director of the Department of Mental Health,

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[74] Skinner v. Oklahoma, 316 U. S. 535.

said that no such operations had been performed during his more than two years' tenure and he knew of none being performed during the recent past. Requests for the performance of such operations would have to come through the Department and Dr. Glass indicated that any such requests probably would be rejected. "We have had no applications for them and we would look very askance at them if we did."[75] He suggested that the sterilization laws were probably passed several years ago when eugenics was riding high.

Miss Dorothy Channel, Social Work Consultant on Mental Retardation, Unit on Social Services for the Mentally Retarded, Department of Public Welfare, indicated the same sort of attitude in regard to the schools for the retarded. She said that a few sterilization operations had been performed many years ago at the Enid State School but that they are no longer requested by the institutions and are only performed at the request of parents, who must go through the required legal procedures to secure them. This is more likely to be requested by parents who have mentally retarded children living with them at home. In any case, the schools for the retarded do not initiate requests for sterilization of pupils.[76]

It would seem to this writer that if Oklahoma does not want its mentally retarded or mentally ill sterilized the statute authorizing this should be repealed. At this time the procedure is legal and constitutional, and could be accomplished over the protests of the patient or pupil and his family.

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[75]Interview with Dr. Albert Glass, November 18, 1965.

[76]Interview with Miss Dorothy Channel, December 9, 1965.

CHAPTER IX

DOMESTIC RELATIONS

Mentally ill and mentally retarded people in Oklahoma have some special protections in the area of domestic relations along with the loss of some rights when they are declared incompetent. One would assume that part of the reason for special protections in the domestic area is the belief that husbands or wives would attempt to obtain commitment for their spouses, who would be declared mentally ill, and subsequently divorced, if there were no statutes to guard against this.

Many Oklahoma judges have apparently had experiences with husbands and wives who attempt such actions against their spouses. When the Oklahoma Mental Health Planning Committee surveyed the county judges, asking about their experiences with attempts toward improper commitment, some recalled a number of examples. "The major cause was felt to be due to marital difficulties coupled with a falsified medical history. This reason was prevalent in all three (rural, urban and metropolitan) types of counties."[1]

Another indication of the judges' concern with this is Tulsa County Judge Whit Y. Mauzy's routine instructions to the attorneys who serve on Tulsa County sanity commissions. Judge Mauzy tells them

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[1]Oklahoma Mental Health Planning Committee, Report Number Three, p. 13.

to determine whether or not marital difficulties are the basis of the complaint when a husband or wife is the petitioner.[2]

Whether these kinds of concerns are universally valid or not is a question which would require more specialized research. However, the concerns expressed by judges do indicate the significant loss of legal rights and status which go along with involuntary commitment to a mental hospital. The balance of this chapter will be devoted to a specific discussion of these in the domestic relations area, specifically marriage, divorce, and parenthood.

Marriage

The marriage of a mentally ill person is subject to annulment under the same statute which makes annulment possible for marriages involving other people who are legally defined as incompetent.

> When either of the parties to a marriage shall be incapable, from want of age or understanding, of contracting such marriage, the same may be declared void by the district court, in an action brought by the incapable party or by the parent or guardian of such party; but the children of such marriage begotten before the same is annulled, shall be legitimate. Cohabitation before such incapacity ceases, shall be a sufficient defense to any such action.[3]

Both the statutes and the common law on the marriage of incompetents are specific but an examination of them tends to reveal what appear to be general principles. That is, the trend seems to be that courts will give a liberal interpretation of the rights of incompetents to marry with more strict rules on ending marriage.

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[2]Interview with Judge Whit Y. Mauzy, November 16, 1965.

[3]12 O. S. (1961) Sec. 1283.

For example, a Kansas case which has worked its way into the common law of Oklahoma clearly establishes that incompetence alone is not enough to render a marriage void. Not only must an insane person be proven to be incompetent under this rule, but he must also be proven unable to understand the nature of the contract itself. A weak mind, as the case expresses it, is not enough.[4]

Another indication of the efforts to expand the right to marry through legal interpretation is found in the rule established by Ross v Ross, 175 Okl 633. Among the precedents established by the case is that a marriage involving an adjudicated incompetent under guardianship is "voidable and not void."[5] This removes any indication that such marriages are void without action by an injured party. The principle seems to be that voiding such marriages is for the benefit of an injured marital partner, not for the benefit of the state.

In comparison with other states, Oklahoma's laws on the subject of marriages involving mentally ill or retarded people are generally less stringent than the most severe and less designed to achieve some pre-defined eugenic objective. There are only two basic reasons for the regulation of the marriage of mentally disabled people. The first is to protect the marital partners and their families--from entering contracts which are not understood or from unknowingly marrying a mentally disabled person. The second is to prevent the propogation of people with certain kinds of problems. One may deduce the state's pur-

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[4]Baughman v. Baughman, 32 Kan 538.

[5]Ross v. Ross, 175 Okl 633.

poses in its statutes. Oklahoma's appear to be concerned with only the first objective.

According to the American Bar Foundation study, even those states which wish to limit the marriage of such individuals seldom have laws to enforce their policies. The report says only twenty states have any machinery to enforce the prohibitions. Nineteen of these provide for criminal punishments and one requires a certificate from a physician attesting to the absence of any condition which would prohibit marriage. Generally, the laws attempting to prohibit such marriages are ineffective.[6]

Some states go to much greater lengths to prohibit such marriages. The marriage is automatically void in some states if it involves mentally ill or retarded people. In others, the marriage is valid but the partners are subject to prosecution. Others, including Oklahoma as is mentioned above, call the marriage voidable.[7]

In comparison to the practices of other states, Oklahoma's laws are not particularly stringent. It would appear, under the laws of the state, that marriages of legally incompetent people are legal. The only restriction is on those who do not understand the marriage contract. Thus one who may be defined as mentally ill or retarded by some may be able to marry without any special limitations under Oklahoma law.

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[6] Lindman and McIntyre, Jr., op. cit., p. 199.

[7] Ibid., pp. 199-200.

Divorce

Oklahoma's laws and practices on divorces involving mentally retarded and mentally ill people appear to be significantly more complex than those on marriage and more likely to be based upon the need to protect the retarded or ill person.

Under the Oklahoma statutes on divorce, insanity is included among the grounds for such an action. However, the plaintiff must prove that the insane person has been in such a condition for a period of no less than five years. In addition, those five years must have been spent in a state or private asylum for the mentally ill and the insanity must be of a kind which presents a poor prognosis for recovery. This prognosis may not simply be presumed. It must be verified through a special psychiatric examination conducted by three physicians, one of whom must be the superintendent. The divorce proceedings may not be instituted if the mentally ill spouse is in another state unless the plaintiff has been a resident of Oklahoma for five years or more.[8]

Obviously, this is one of the more difficult grounds upon which a divorce may be secured in Oklahoma. Because of the complexity of these provisions it may appear that a spouse who wishes to avoid a divorce could do so by becoming mentally ill. However, Oklahoma Supreme Court decisions seem to prevent this sort of escape. If the acts upon which the suit for divorce is based were committed prior to the onset of the insanity, the divorce action may be maintained, according to one decision.[9]

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[8] 12 O. S. (1961) Sec. 1271.

[9] Lewis v. Lewis, 60 Okl 60.

In another case, the Oklahoma Supreme Court decided that a divorce entered into by a person who was incompetent when it was completed could be upheld. The case, Scoufos v. Fuller, seems to distinguish between incompetency and long-term mental illness with a poor prognosis as is specified in the statute.

> We do not think that the record in the original divorce action justifies the assumption that J. D. Fuller was insane at the time the divorce decree was entered even though he had been adjudged incompetent. Many persons who are not insane have guardians appointed for them as incompetents because some of them are unable to manage their property in a discreet manner through lack of education, experience, and other unusual characteristics. Certainly one may be incompetent to manage his own affairs for his best interest and yet not be insane.[10]

The issue of mental illness as grounds for divorce is controversial in that some individuals and states believe that all divorces ought to be for cause, or fault of one party to the marriage. Mental illness is seen by some as a mere misfortune for which concepts such as fault, guilt, and such, are inappropriate. The trend toward divorce statutes which permit such action without fault is seen by many as including the permissibility of insanity as a ground for divorce.[11]

Among other states, some twenty-eight permit divorce on the basis of insanity. All these states, but one, require that the mental illness persist for a specified period and appear to be incurable. Like Oklahoma, "Almost all of these states require the condition to be incurable and more than one-half require that it be established by medical testimony. Thirteen states require that such testimony

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[10]Scoufos v. Fuller, Okl 280 P 2d 720.

[11]Lindman and McIntyre, Jr., op. cit., p. 201.

be established by more than one medical expert."[12] When such action is instituted against a mentally ill person, the law provides certain protections to him. Oklahoma provides a guardian ad litem to the patient, who functions as his legal representative in the action.[13] This is practiced in only about one-third of the states.[14] In addition, the divorce action does not, according to the statutes, relieve the spouse from financial liability for the mentally ill former husband or wife.[15]

This continuing financial responsibility, coupled with the inability of mentally ill people to sue for divorce, as is discussed later, causes some difficulties. A rule which appears to be followed in Oklahoma provides that a destitute, insane wife who is abandoned by her husband may be able to obtain equitable relief, although she cannot force the support of her husband in a divorce action.[16]

One additional issue relates to the service of papers on the defendant, a customary procedure in divorce actions. Since the person of the mentally ill patient is technically under the guardianship of the superintendent of the institution, that superintendent may receive the service of process for the patient.[17] That is, a spouse may be divorced without his personal knowledge in Oklahoma, if he is in an institution.

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[12] Ibid.

[13] 12 O. S. (1961) Sec. 1271.

[14] Lindman and McIntyre, Jr., op. cit., p. 202.

[15] 12 O. S. (1961) Sec. 1271.

[16] Birdzell v. Birdzell, 33 Kan 433 6 P 561.

[17] 58 O. S. (1961) Sec. 810.

There is another corrolary to the issue of divorce on grounds of insanity. This related to voluntary patients who may, based upon one Oklahoma Supreme Court case, be divorced on the grounds of abandonment for more than one year. According to a judgment rendered in the case of In re Crouch's Estate, such an action is possible. In the case, a husband became a voluntary patient at Eastern State Hospital. He was later declared mentally ill and spent the rest of his life in the institution. However, his wife divorced him after only a year in the hospital. She married another man who died. She was challenged as an heir to her second husband's estate on the grounds that she was never legally divorced from her first husband because insanity for a year is not a ground for divorce. The Court upheld her divorce, based upon abandonment for more than one year.[18] This case would seem to have significance for the marital status of voluntary patients in mental hospitals.

On the other side of the issue, there is little precedent for mentally ill spouses to sue for divorce. According to the American Bar Foundation study only two states, Massachusetts and Alabama, permit such action on the part of persons who are mentally ill.[19] Some states permit the mentally ill person's guardian to sue for divorce. Oklahoma apparently permits no divorces to be instituted by mentally ill people or their guardians. The Scoufos v. Fuller[20] decision established that an insane person could not institute or maintain a divorce action either on his own or through a guardian.

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[18] In re Crouch's Estate, 191 Okl 74.

[19] Lindman and McIntyre, Jr., op. cit., p. 203.

[20] Scoufos v. Fuller, Okl 280 P 2d 720.

It would appear that the spouses of mentally ill persons have recourse to divorce for insanity or on other grounds. However, mentally ill persons do not have the same recourse. There appear to be significant protections against improper commitment for the purpose of securing a divorce, in that the mental illness must persist for five years and be proven to have a poor prognosis.

An additional issue in the area of divorce is that mental illness may serve as a defense against such action. That is, a person who is sued for divorce on specific grounds, such as adultery, cruelty, or desertion, may defend against the divorce on the grounds that he was mentally ill at the time of the precipitating behavior. The test seems to be whether or not the defendant could distinguish right from wrong, in the fashion of criminal offenses, at the time of the incident or incidents.[21]

Adoption of Children

According to the American Bar Foundation report, thirty-eight states permit the adoption of children of the mentally ill without parental consent. That is, such children may be taken from their parents against their will and legally made a part of other families. The report says that this is relatively common, particularly with the consent of guardians or court representatives.[22] The report also notes that "Eight states allow the annulment of adoptions if the child develops

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[21]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 362.

[22]Lindman and McIntyre, Jr., op. cit., p. 204.

feeble-mindedness, epilepsy, or insanity as a result of conditions existing prior to the adoption and of which the adopting parents had no notice."[23]

Oklahoma has no statutes of this sort although it does permit the adoption of children whose parents are deprived of their civil rights.[24] There does not seem to be any appealed litigation on this issue in Oklahoma and the American Bar Foundation study says that "Adoptions involving mentally ill parents have rarely been litigated on the appellate level."[25]

It would appear that children of the mentally ill in Oklahoma may be adopted without parental consent. There are no safeguards for the parents or the child in this area comparable to those in divorce actions. This would appear to be a significant loss of an important right that is not sufficiently covered in the statutes on either adoption or mental disability.

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[23] Ibid., p. 205.

[24] 10 O. S. (1961) Sec. 60.6.

[25] Lindman and McIntyre, Jr., op. cit., p. 204.

CHAPTER X

DISCHARGE

Although admission to state hospitals and schools for the mentally retarded is handled through a relatively few procedures, the procedures for discharge are somewhat varied.

Habeas Corpus

Oklahoma law guarantees the right to a writ of habeas corpus:

> Anyone in custody as a mentally ill person or mentally retarded person, pursuant to this law, is entitled to a writ of habeas corpus, upon proper application made by him or some relative, or friend in his behalf. Upon the return of such writ, the fact of his mental illness or mental retardation shall be inquired into and determined. Notice of hearing on said writ must be given to the guardian of such patient if one has been appointed, to the person who applied for the original commitment and to such other persons as the Court may direct. The medical or other history of the patient, as it appears in the institution record, shall be given in evidence, and the superintendent of the institution wherein such person is held in custody, and any proper person, shall be sworn touching the condition of such person.
>
> The superintendent shall make available for examination by physicians selected by the person seeking the writ, the patient whose freedom is sought by writ of habeas corpus. Any evidence, including evidence adduced in any previous habeas corpus proceedings, touching upon the mental condition of the patient shall be admitted in evidence.[1]

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[1] 43A O. S. (1961) Sec. 99.

Despite this section, Oklahoma law does not provide for release on a valid writ of habeas corpus. According to common law:

> (A) Person confined in state hospital for insane under void order of commitment would not be set at liberty under writ of habeas corpus, where superintendent of hospital alleged that such person was insane and such person's present sanity was not relied on in petition, but such person would be remanded to proper authorities of county of commitment for proper proceedings.[2]

This would seem to mean that such a person would simply be returned to his county, where a valid order of commitment could be provided.

It has also been established through case law that a person released from a hospital under a writ of habeas corpus is not entitled to have his present sanity tried by a jury.[3] Apparently, a judge could permit this to be determined by a jury but is not required to do so, if it is requested by the patient.

However, writs of habeas corpus are not common in Oklahoma mental health practices, according to the various officials interviewed. Dr. Hayden Donahue said that Oklahoma has few of these and far fewer than most other states. He suggests that it is because of the Oklahoma mental health laws, which were well-designed and which drew upon the experiences of several other states.[4]

Dr. Bedford Peterson said that Oklahoma had few habeas corpus petitions filed. In Tennessee there had been many. When he was interviewed he had been at Eastern State Hospital for six months and had

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[2]Ex parte Schaeffer, 177 Okl. 464; Ex parte Smith, 150 Okl. 98.

[3]Ex parte Gonshor, 114 Okl. 143.

[4]Interview with Dr. Hayden Donahue, November 23, 1964.

not had one petition filed.[5] Dr. Harold B. Witten of Western State Hospital said that no habeas corpus petitions had been filed in the five or six years that he had been superintendent of Western State Hospital.[6]

Judge J. David Rambo, the only judge interviewed who served a county which incorporated a state institution, said that he handled some habeas corpus cases from Central State Hospital. However, these averaged no more than one a month, which is few. Ordinarily, when such petitions are heard, the court usually finds that the petitioner had due process.[7]

The reasons for this lack of petitions may be speculated upon and compared with the experiences in other states. For example, Dr. Winfred Overholser, of St. Elizabeth's Hospital in Washington, D. C., indicated that writs of habeas corpus were fairly readily issued by the courts of his community. When asked if much time was needed for dealing with such petitions in the courts, Dr. Overholser said:

> Well some of our doctors spend so much time there (in court) that they don't have much time to see the patients. . . .
>
> Well, it has been growing regularly. I think the last fiscal year it was 250 . . .
>
> I am glad to say that lately they have taken to hearing all habeases on 1 day of the week, which really simplifies the thing just a little.

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[5]Interview with Dr. Bedford Peterson, December 21, 1964.

[6]Interview with Dr. Harold B. Witten, December 21, 1965.

[7]Interview with Judge J. David Rambo, December 21, 1965.

> It cuts down the travel between the hospital and the courthouse to some extent.[8]

Obviously, habeas corpus writs are more than an occasional concern and minor matter in Washington, D. C., mental health practices.

There is some question about the usefulness of the writ of habeas corpus in obtaining a release from a mental hospital, however, Dr. Morton Birnbaum, the attorney and physician who advocates the "right to treatment" suggested to the Senate subcommittee that it was virtually nullified:

> . . . Theoretically, the writ has always been available to assure that only those who are sufficiently mentally ill to require care and treatment in a mental hospital will be committed; however, very few patients in a public mental hospital have the funds to retain competent counsel to adequately prepare and try a lawsuit to test an unjust and illegal decision by a medical board.
>
> . . . one realizes that the availability of the writ of habeas corpus has in no way served to cause the creation of a body of law that can aid a patient, or his counsel, to determine the standards by which it was decided to commit the patient.
>
> . . . for most patients in our public mental hospitals, the protection afforded by the availability of the writ of habeas corpus is often, in fact, a legal fiction, a virtual nullity. We fully appreciate that this nullification of the writ of habeas corpus probably has come about because many humane, enlightened, and intelligent judges are convinced, both from their own experience and from the writings of leading psychiatrists, that litigation in the field of commitment is, in its effects, generally harmful to the care and prognosis of a committed mentally ill person. We believe, however, that the nullification by our courts of the writ of habeas corpus has served to allow coercive regimes that would not be sanctioned in the name of punishment to be sanctioned in the name of therapy without having the knowledge, the personnel, and the physical facilities necessary to achieve the desired results.[9]

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[8] U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., pp. 32-33.

[9] U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., pp. 279-280.

Dr. Thomas S. Szasz suggests that habeas corpus is one of only two ways the patient may be discharged from the hospital. The other is to co-operate with the doctors and make them think that he is sane so he will be so judged and discharged.[10] And, Szasz suggests, habeas corpus is a wholly inadequate means of achieving release. This is important, he suggests, because so many psychiatrists are advocating medical, rather than judicial commitment, because the patient always has recourse to habeas corpus.[11] This was mentioned by Dr. Albert Glass when he offered non-judicial hospitalization for emergency and non-protesting cases as an alternative to the involuntary procedures presently used. He said that the patient would always have the right to habeas corpus.[12]

For a variety of reasons, Szasz says, " . . . most mental patients cannot avail themselves of this protection against false commitment. And even when they can, it is not an effective remedy."[13] He charges that most patients know nothing about habeas corpus and are not encouraged or taught to use it.

> Furthermore, it is unrealistic to expect too much from the writ of habeas corpus in a modern psychiatric setting. As originally conceived, the purpose of this legal measure was to protect victims of political harassment. It was never intended to protect people from deprivations of liberty at the hands of physicians and psychiatrists. Hence, it need not surprise us to find that habeas corpus is a grossly inadequate measure to protect the victims of psychiatric imprisonment.[14]

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[10]Dr. Thomas S. Szasz, Law, Liberty, and Psychiatry, p. 66.

[11]Ibid., p. 67.

[12]Interview with Dr. Albert Glass, November 18, 1965.

[13]Szasz, op. cit., p. 67.

[14]Ibid.

Szasz also contends that a patient cannot possibly defend adequately against the expert testimony of psychiatrists without having psychiatrists of equal skill helping him. Thus the habeas corpus proceedings are essentially useless to the patient who wants to use them for his discharge from the hospital. It is possible that they are not used in Oklahoma, to any great extent, because they are futile.

Discharge of the Mentally Ill

The statutes provide rather specific directions for superintendents of state hospitals for the mentally ill to follow in discharging mentally ill patients and those who have recovered. A superintendent may discharge a patient who, in the superintendent's judgment, is recovered or one who has not recovered but who would probably not benefit from further treatment and would not pose a danger if released.[15]

In cases when a patient's recovery may be determined only by a trial return to his home and community, a superintendent may grant the patient a convalescent leave, which may last for no more than twelve months. If the patient has not returned during the one year period, the superintendent may discharge him. If he must be returned, however, doing so is the responsibility of the person who removed him from the hospital or of the county where the patient happens to be when such a return is needed. The County Judge may authorize such a return and law enforcement officers are permitted to detain and

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[15] 43A O. S. Supplement 1965, Sec. 73.

transport the patient, in pursuit of the County Judge's order.[16]

Two other kinds of discharge are possible. The first is a transfer to out-patient status when the superintendent determines that such a status will not be injurious to the patient or the public welfare. The other is a visiting status which may be provided for a patient who is suitable for such privileges. The party who removes the patient from the hospital on a visiting status is responsible for his return.[17]

These are the basic policies on discharge, although they are not the only ones applicable to the mentally ill. These rules appear to be liberally applied in Oklahoma. In actual practice, the procedures for discharge are rather flexible, according to the mental health officials interviewed in connection with this research. In addition, the average stay of a newly admitted mental patient is rather brief, in comparison with stereotypes of practices. Dr. E. P. Henry of the Taft State Hospital, said that the average stay for seventy-five per cent of the patients has been between one and three months for the last several years.[18] Dr. Bedford Peterson indicated that the situation was relatively "free." When a person is ready to leave, the family is contacted and arrangements are made for a return. He felt that the institution benefitted only from discharges and said, several times, that no hospital wants to keep someone hospitalized

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[16] Ibid.

[17] Ibid.

[18] Interview with Dr. E. P. Henry, December 21, 1964.

who does not need care.[19]

Although the average stay of newly admitted patients to Central State Hospital is relatively brief (approximately one and one-half months), Dr. Donahue said that releasing patients from mental hospitals quickly is almost a fetish currently, and one to which he does not subscribe. The criteria is the need of the patient for treatment.[20]

Some Oklahoma officials are convinced that patients are released too quickly. Some commented to the Oklahoma Mental Health Planning Committee:

> When patients are committed to a mental institution, I think they should be retained in custody until they have completely recovered. Because of crowded conditions, it appears that the persons in charge are anxious to place patients on convalescent leave and forget about them.
>
> The courts should have some jurisdiction over patient's release from mental hospitals.
>
> To lessen readmission expenses to the courts the discharge period should be extended to two years and/or a strengthening of the within-a-year psychiatric discharge re-examination.
>
> The patient is back home frequently before the sheriff files his transportation claim.[21]

These were comments offered by county judges, when they were given an opportunity to freely give opinions on Oklahoma mental health laws and practices.

The American Bar Foundation study indicates that Oklahoma's

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[19]Interview with Dr. Bedford Peterson, December 21, 1964.

[20]Interview with Dr. Hayden Donahue, November 23, 1964.

[21]Oklahoma Mental Health Planning Committee, Report Number Three, pp. 19-21.

practices are neither the most restrictive nor the most liberal in the nation. Some states permit discharge of patients who have not improved, if this is necessary to make room for new patients. Others are so restrictive as to require a bond guaranteeing good behavior by the family before the patient is released.[22]

Several other facts of discharge practices are important to this discussion. One is that many older persons are ultimately destined for placement in nursing homes, where they will receive custodial care for the balance of their lives. Seven of the cases in the commitment study were promptly sent to such institutions. When such persons are removed from the hospital, they become, if they are indigent, public assistance cases. The hospital has room, because of their discharge, for more mental patients. Another important fact is the significance of the requirement that families or friends be ready and able to take the patient back and care for him. There are patients in hospitals who have recovered, perhaps, but who have no home to return to. Obviously, this poses a dilemma for the hospital, which may want to discharge a cured patient but which does not feel comfortable in doing so when adequate arrangements are not available for that person's care. This is a result of mental hospitals functioning, at times, as what Dr. Szasz calls "what else" institutions:

> When people do not know 'what else' to do with, say a lethargic, withdrawn adolescent, a petty criminal, an exhibitionist, or a difficult grandparent-our society tells them, in effect, to put the 'offender' in a mental hospital . . .
>
> To overcome this, we shall have to create an in-

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[22]Lindman and McIntyre, Jr., op. cit., p. 126.

> creasing number of humane and rational alternatives to involuntary mental hospitalization. Old-age homes, workshops, temporary homes for indigent persons whose family ties have disintegrated, progressive prison communities-these and many other facilities will be needed to assume the tasks now entrusted to mental hospitals. Some of the money and effort spent on mental hospitals should be devoted to such enterprises. As matters now stand, mental hospitals only waste our valuable human resources and funds. They also endanger our trusted political institutions and our personal liberties.[23]

Judge J. David Rambo told this researcher that he has put people in mental hospitals because there was no other place for them. Once, he said, he put a man into Central State Hospital to die. There were no funds for any other kind of assistance. No hospital would take him and his family was unconcerned.[24]

Discharge from private hospitals is achieved in somewhat the same way as from state hospitals:

> The attending physician may discharge a patient or grant leave to a patient only as provided in this Act. The attending physician may discharge a patient at any time as follows:
>
> (1) A patient, who, in the judgment of the attending physician, is recovered.
>
> (2) A patient who is not recovered but, in the judgment of the attending physician, will not benefit by further treatment in a private hospital or institution.
>
> A visiting or convalescent leave status may be granted a patient for a period not exceeding six (6) months to any patient upon authorization of the attending physician. Neither the attending physician nor the private hospital or institution shall be responsible for the patient or any act of the patient, while on a visiting or convalescent leave status. It at the end of said six (6) months period the patient has not returned as an in-patient to the private hospital or institution for further treatment he shall be automatically discharged from the books of said private hospital or institution. The committing court shall be

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[23]Thomas S. Szasz, Law, Liberty and Psychiatry, pp. 232-233.

[24]Interview with Judge J. David Rambo, December 20, 1965.

notified by a written sealed communication of said discharge.[25]

The basic difference between the statutes on patients in state institutions and those in private is that the person must function on convalescent leave for twelve months, when he leaves the former, and only six months when he is given such leave from the latter.

Because so many wards are open wards and with the trend away from using hospitals to lock patients up and isolate them from society, some patients simply leave the hospitals on their own, without any notification, without convalescent leave, and without the knowledge of the hospital officials. The statutes make a distinction between persons who do this, who are involuntary patients, and those who are voluntary. Voluntary patients who leave the institution without permission, but who do " . . . not cause trouble in the community to which (they go) . . . may be discharged or given convalescent leave at the discretion of, and by, the superintendent of the hospital."[26]

Those who are involuntarily committed are to be returned to the institution by their friends or relatives. If they fail to do this, it becomes the responsibility of law enforcement officers of the county where the patient is living to apprehend him and return him to the hospital.[27] In fact, it is a criminal offense to encourage such a patient to leave the hospital without permission:

Any person who takes a patient who has been lawfully

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[25] 43A O. S. (1961) Sec. 186.

[26] 43A O. S. (1961) Sec. 78.

[27] Ibid.

> admitted thereto from any institution within this department without the consent of the superintendent, or who entices, assists or encourages any such patient to escape therefrom shall be guilty of a misdemeanor and, upon conviction shall be fined not to exceed One Thousand ($1,000.00) Dollars or confined in jail not to exceed one (1) year, or both.[28]

In the case of patients in private hospitals who leave without permission, if they are committed patients, the committing court must be notified, along with the petitioners, who must return the patient to the hospital. If they do not, the county is obligated to return the patient to the institution.[29]

In practice, it does not seem that the handling of these matters is quite so severe. Patients walking away from hospitals are not terribly unusual. According to Dr. Donahue, several may walk away on any given day and this is not considered escaping. He also indicated that some families unthinkingly take their relatives home, without permission or notification, when they visit. This is not seen as a serious problem.[30]

In the commitment study done in connection with this research, five committed patients from Cleveland County were absent without leave from the hospital. The court was notified of this by hospital authorities. However, only one of these was returned to the institution. The other four were ultimately discharged. The practice seems to be one of allowing persons to stay away if they are able to do so without

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[28] 43A O. S. (1961) Sec. 133.

[29] 43A O. S. (1961) Sec. 187.

[30] Interview with Dr. Hayden Donahue, November 23, 1964.

difficulty. Mental patients are simply not considered dangerous, as a group, any longer. Those who are are typically kept in security wards. As Dr. Manfred Guttmacher of Maryland put it: "I think as a whole that the people who have been discharged from hospitals are less likely to be involved in serious criminal offenses than the general population."[31]

The notion that mentally ill persons are not dangerous is being called into question by some psychiatrists. Jonas R. Rappeport, M. D., and George Lorsen, Ph.D., suggest in their article,"Dangerousness-Arrest Rate Comparisons of Discharged Patients and the General Population,"[32] that in a study of Maryland mental patients, mentally ill people were as involved as the total community in some crimes and that in others, such as robbery and rape, they were more involved.

Discharge of the Mentally Retarded

There are some statutory limitations on the release of pupils from the state schools for the retarded. The approval of the Director of the Department of Public Welfare is required for this and is " . . . subject to such circumstances and conditions as may be prescribed by the Commission relating to release."[33] In practice, because admission is voluntary, separations from the schools for the retarded may be

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[31]U. S., Senate, Subcommittee on Constitutional Rights of the Committee on the Judiciary, op. cit., p. 158.

[32]Jonas R. Rappeport, M. D., and George Lorsen, Ph.D., "Dangerousness-Arrest Rate Comparisons of Discharged Patients and the General Population," The American Journal of Psychiatry, Vol. 121, No. 8, February, 1964, p. 779.

[33]56 O. S. Supplement, 1963, Sec. 310.

handled at virtually any time. According to James Boren, of the Hissom Memorial Center, most discharges are based upon the recommendations of the staff which are sent to the Director of Public Welfare. He goes along with these virtually every time. Even if he does not, however, parents can remove their children, although this is done against medical advice.[34]

Joseph Deacon of the Pauls Valley State School indicated that discharges were ordinarily effected when the program was no longer productive for the pupil.[35] Dr. J. L. Dunigan of the Enid State School said that the Department of Public Welfare was preparing a policy manual covering discharges from state schools. Release, he said, is possible upon written request from the parent or guardian, although the request must be approved by the Director. The limits of the law are designed to give the superintendent time to work with the family. There are differences in the manner in which different institutions deal with this. Some may try to convince the family to leave the child in the institution.[36]

Periodic Review

There is one significant difference in the discharge procedures practiced by the institutions for the mentally ill and those for the retarded. Pupils in institutions for the mentally retarded must have their records evaluated annually and "Failure on the part of the

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[34]Interview with James Boren, December 3, 1964.

[35]Interview with Joseph Deacon, December 22, 1964.

[36]Interview with Dr. J. L. Dunigan, December 29, 1964.

superintendent of the institution to institute a policy of annual evaluations, if sufficient personnel are available, shall constitute dereliction of duty."[37] The law further requires the institution to return to their families those children who are sufficiently changed to be sent home, if they have an adequate home to return to.[38]

Without a lengthy discussion, it should be pointed out that determining the improvement of mentally retarded people is a difficult task. Recently, there were newspaper stories of a deaf child who had spent several years in a school for the retarded and was discovered to be a genius. The newspapers reported that he was transferred to the state school for the deaf " . . . where he will soon discover a new world of learning."[39] After a short time at the school for the deaf, he was returned to a school for the retarded. He may have been a genius but his functioning was retarded.

The laws governing the care of the mentally ill do not require periodic evaluations. The only requirement is that the superintendent prepare a record on each new patient who enters, within three days of his admission " . . . and he shall make, or cause to be made, entries from time to time, of the mental state, bodily condition and medical treatment of such patient during the time such patient remains under his care. . ."[40]

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[37] 43A O. S. (1961) Sec. 411.

[38] Ibid.

[39] The Oklahoma Journal, December 20, 1965, p. 1.

[40] 43A O. S. (1961) Sec. 18 (10).

Dr. Hayden Donahue indicated, when he was interviewed, that the patients are regularly examined by and seen by a number of specialists, visitors, and students, every day.[41] However, there is no legal requirement for a formal periodic evaluation, except the examination of the patient and the entry of information about him from time to time.

Conclusions

There are several rights issues involved in discharge.

First among these is the sort of general objection voiced by Dr. Szasz, who thinks that discharge practices point up the poor position of patients in mental hospitals. That is, the committed patient cannot change his status, even though he may want to. Someone else decides whether or not he should be released--he does not. He can be released by acting in the way the psychiatrist wants him to act since this, Szasz says, constitutes the typical definition of a cure. He acknowledges that mental patients may walk away and earn a release but notes that they may not have this if someone objects. Thus, the fact that a patient cannot be discharged until he is permitted to do so, points up the severe loss of liberty of the hospitalized mental patient. Someone else is always in control of the patient's destiny.[42]

Another concern relates to the lack of formal periodic reviews for patients in state hospitals. Although the physicians may have and exhibit a deep interest in discharging patients, statutory review of every case on some periodic basis would serve as a more adequate

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[41]Interview with Dr. Hayden Donahue, November 23, 1964.

[42]Interview with Dr. Thomas S. Szasz, August 10, 1965.

guarantee that patients would be released if they were cured.

Under current practices, the greatest inequity of all, for the patient, is that he may have to stay in a mental hospital for years, even though his behavior may meet the definitions of "cured," because he has no suitable home to return to. Under these circumstances, the law and the practice serves the needs of the society and the family, rather than the patient. There should be institutions such as foster homes, halfway houses, and group living arrangements such as dormitories, to permit cured mental patients to return to freedom if they so desire, even though their families may not want them. The practice of retaining patients who could otherwise be discharged, because of the desires or inadequacies of their families, is an example of the ways in which mental health practices may operate in the interest of every agency, group, and institution but the patient.

CHAPTER XI

CONCLUSIONS

This dissertation surveys the statutes and case law dealing with the civil rights of mentally ill and mentally retarded people in Oklahoma, the attitudes of mental health officials and other people with expert knowledge on those rights, and the practices associated with commitment and institutional treatment of the mentally disabled in the state.

Field research on one-hundred-and-twenty-five cases in three counties reveals and interviews with judicial and mental health officials in Oklahoma tend to confirm that there are a number of problems associated with involuntary commitment practices in the state.

There appear to be significant discrepancies between practices in the various counties. Only in the metropolitan counties is an alleged mentally ill person likely to be examined, in connection with his commitment, by a psychiatrist. The limited psychiatric training of other physicians, who might serve on sanity commissions, may threaten the freedom of an alleged mentally ill person without sufficient cause. In addition, a physician who may have previously examined and diagnosed a person as mentally ill is not prohibited from serving on a Sanity Commission, appointed to examine that same person. This could work to the detriment of a person who did not want to be

hospitalized, despite his or his family's physician's advice.

Commitment proceedings, themselves, seem to be brief, superficial examinations at which the potential patient is rarely represented by his own attorney. While involuntary commitment to a mental hospital is not a criminal proceeding, it may lead to lengthy, perhaps permanent, denial of liberty. Although alleged mentally ill persons have a right to counsel, they are not guaranteed counsel.

A mandatory waiting period of at least one day before the sanity hearing is held makes it necessary for many alleged mentally ill persons to be held in a jail. Any suitable place is satisfactory but various considerations, typically economic in character, make the jail the only suitable place available for the temporary detention of the mentally ill.

More than half of all mentally ill people who enter hospitals and all mentally retarded persons who enter state schools for the retarded do so through voluntary admission procedures. This kind of admission tends to be better for the mental patient, primarily because there is no automatic loss of competence associated with it. However, there are significant variations in the administration of voluntary admission procedures. Some judges use it regularly, while others use it rarely, if at all. The regulations under which a person enters a mental hospital may depend upon the County Court which handles his case, more than on his condition or his own choices.

Those who do enter hospitals for the mentally ill through involuntary court commitments lose their legal competence. Legal status to make contracts, vote, and drive an automobile, is denied to all involuntary

patients, regardless of the degree of their illness. Involuntarily committed persons may lose the right to practice their professions, retain legal custody of their children, maintain their marriages, write letters without censorship, make telephone calls, manage their property, and reproduce, without specific regard to the severity or nature of their illness. The law on issues of competence is rather complex. It is difficult to determine the nature and extent of an involuntarily committed mentally ill person's rights without specific litigation.

Those who are alleged to be mentally ill seem to represent a special group. They are slightly less well-educated than the average citizen, hold lower status occupations, and typically do not have extensive property holdings. A generalization that would seem to be supported by the data gathered in the study of commitment cases is that most persons who are alleged to be mentally ill are from the lower socio-economic classes. This would not appear to reveal the characteristics of mental illness. Rather it would tend to reveal the characteristics of those whose illness comes to the attention of courts. These characteristics are of significance because they indicate that those who are committed to hospitals for the mentally ill are least able to use lawyers and legal institutions for their own protection. A more protective and cautious posture on the part of the state thus becomes desirable.

Practices within mental hospitals vary, both in treatment procedures and patient management practices. State hospitals play a custodial role with their patients as a part of the in loco parentis responsibility they fulfill. Generally, no permission is required by state policy or statute for potentially dangerous treatment

procedures, although some institutions make a practice of obtaining such permission. General custodial practices dealing with property, visits, and correspondence, seem to be the same for all patients, although there is a wide range of behavior and diagnosis represented among the patient group. Few details on management practices are determined on a state policy level and many decisions in these areas are left to those least well trained to determine the best course of action for the patient.

Discharge from mental hospitals takes several forms, including a trial discharge, called convalescent leave, successful functioning in the community after a departure without permission, and complete discharge. Voluntary patients are released, after a specified waiting period, when they officially request discharge. The waiting period may be used to initiate and complete an involuntary commitment, although recourse to this is infrequent.

Restoration of the civil rights and competence of a discharged patient may be a simple formality, handled by the County Judge, or a relatively complicated procedure, similar to commitment proceedings. The variation seems to occur because of the different interpretations of the law made by the county judges. A relatively recent statute, 43A O. S. (1961) Sec. 393, makes it possible for a County Judge to accept as prima facie evidence the certificate of restoration to competence executed by hospital superintendents in association with discharge. The judge may, with no further evidence or hearings, restore the person to competence. However, an earlier statute, 43A O. S. Supplement, 1965, Sec. 75, requires a rather complex restoration process,

similar to the procedures for commitment. Both kinds of restoration are currently used by Oklahoma judges and the ease with which a discharged patient may be restored to competence depends not on his condition, in all cases, but upon the judge who handles his case.

Proposals for Change

This researcher would see as a long range objective and goal the elimination of involuntary hospitalization of the mentally ill. Such a change could not occur in isolation. The conditions which would make the elimination of involuntary commitment possible are complex. One would envision, as the sole cause for involuntary loss of liberty, offenses against the law. People who may be proven to be dangerous to themselves or others are typically in violation of the law, through threatened or actual dangerous acts. Such individuals, who might now be committed as mentally ill, could be tried and sentenced to penal institutions for a period of time related to the dangerous behavior. Such a change would require, however, significant improvements and changes in the penal system. Movement to a system which would protect society yet function as a non-punitive, rehabilitative, perhaps therapeutic, institution would be necessary before such a change could be implemented. Those who are not dangerous but simply unconscious or disoriented could be treated as sick people, in general hospitals, just as accident victims and others who are obviously ill but unable to communicate are currently treated.

An end to involuntary commitment would appear to be the only way to eliminate the discrepancies in the applications of the laws, the unnecessary loss of rights, and all the other problems mentioned in

this dissertation.

This suggestion that involuntary commitment be eliminated is not a suggestion that public mental hospitals be closed or abandoned. Tax supported hospitals for those with emotional problems are as legitimate as tax-supported schools for the retarded, public general hospitals, and public colleges and universities. The only objection raised is to the involuntary commitment associated with them.

The involuntary commitment of patients to private mental hospitals presents the same difficulties as commitment to public institutions. The long range suggestion is that involuntary commitment to any institution for mental health reasons alone be eliminated.

Recognizing that the long-range proposal would not be readily accepted and that the conditions which would make it possible would require many years to evolve, certain short-term proposals, based upon limitations in current practices as they are identified in this dissertation, are in order.

The alleged mentally ill person who wishes to contest his commitment ought to have his own attorney. If he is unable to pay for one, the court ought to appoint counsel for the person, in much the same way that attorneys are appointed for those who are accused of crimes.

Requirements for those who serve on sanity commissions ought to be tightened to the extent that only psychiatrists or physicians with documented post-medical school training in psychiatry could determine the fate of one alleged to be mentally ill. This could be accomplished through intensive training programs, at the state level, for those who might wish to serve on commissions.

Another reform could involve the Department of Mental Health more directly in the commitment proceedings. To replace local county sanity commissions, the state agency could provide better equipped examining bodies, perhaps on a regional basis, to investigate allegations of mental illness. This could, perhaps, be accomplished through hiring and specifically orienting physicians and attorneys to mental health problems and diagnosis. All commitment cases could be referred to the examining group serving the region in which the case arose. Such a plan could be operated on a full or part-time basis depending upon the need throughout the state or in the particular region of the state. This may be the most feasible way to achieve standardization of commitment proceedings throughout the state, within the limits of the available resources. Under such a plan, commitment would continue to be a judicial function. Only the recommending body would change.

County judges should be required to explain the voluntary commitment procedure to those who appear before them, along with its advantages. Since voluntary admission causes no loss of legal competence and provides for discharge upon the request of the patient, it would seem to have advantages. The alternative ought to be offered to all prospective patients.

Any loss of rights or competence ought to be based upon the specific case and the limitations of the patient. Currently, anyone committed involuntarily loses all his rights, without specific regard to his illness or prognosis. Denial of rights ought to be based upon need, not admission to a hospital. It is possible that many patients need lose no rights at all. Many more may need to relinquish only a few.

Jailing of mental patients ought to cease, either through the construction of other facilities in communities, an extended use of general hospitals for temporary detention, or the addition of special wings to facilities such as mental health clinics.

Within the hospitals, correspondence ought to be examined only on the basis of need. The person who has given no indication of misusing the mails and telephones ought to be free to use them without extensive supervision, examination, and censorship. While administrative requirements leading to limits on correspondence may be understood, limits on hospitalized persons solely because they are hospitalized would seem unnecessary.

Permission of the patient and/or his family ought to be secured before electric shock therapy and other potentially dangerous procedures are used. Permission is currently sought before new drugs are used and before surgical procedures are carried out. The same kind of measures should be taken in relation to therapies which pose dangers.

Although the statutes on involuntary sterilization are not utilized currently, they ought to be repealed. They could be used and this represents a rather severe deprivation of freedom.

Each patient's case ought to be reviewed annually, with a view toward discharge. This should be a formal, legally required procedure.

Standardization of restoration to competency proceedings ought to be sought. In the case of mental hospital patients who have been discharged, judges should be required to legally restore them to competency on the basis of a superintendent's certificate of restoration. The more complex procedure used in only some counties seems unnecessary

and inequitable for those who must seek restoration under it.

Records of commitment proceedings should be confidential. It would appear that these could be protected in the same manner as records on adoptions and other sensitive issues. While access to these by an attorney on behalf of a patient is necessary, their current status as public information may work against the best interests of a person who is committed on either a voluntary or involuntary basis through a court.

It would appear obvious that the most significant issue is involuntary commitment. The other deprivations noted in these conclusions are all products of that one action. Its ultimate elimination would resolve most of the civil rights concerns of the mentally ill.

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APPENDIX A

SCHEDULE

Case No. _____ Mental Health Docket No. _____

Age _____ Sex _____ Race _____ Occupation _____

Education _____ Number of Children _____

Residence _____ Marital Status _____

Religion _____

Personal Property _____ Real Property _____

Person Initiating Commitment _____

_____

Disposition upon order being issued _____

_____

_____

_____

Represented by attorney _____

Diagnosis _____ Evidence supporting diagnosis _____

_____

_____

Previous commitment _____ Number _____ Suicidal _____

Violent _____ Failed to pay debts _____

Desertion _____ Escapee _____

Other _____

_____

_____

Precipitating causes _____

_____

Restored to legal competence _____

_____

_____

APPENDIX B

Items to be Discussed with Key Mental Health Officials

Doctoral Dissertation: Civil Rights of the Mentally Ill and Mentally Retarded in Oklahoma.

Leon H. Ginsberg

1. Admission
   - A. How do most patients come to the institution? If by court commitment, at whose initiative (relatives, officers of the law, institutional personnel, etc.?) Are those committed often sent to a prison before coming to the institution?
   - B. If by voluntary commitment is this usually through the patient's free choice or is it prompted by threats of legal commitment from families, officers of the law, etc?
   - C. What is the ratio of voluntary to involuntary commitments?

2. What is the procedure for discharge from the institutions? Are most a result of active efforts to discharge by the institution? Through appeals of habeas corpus? By the patient indicating a desire to leave?

3. Are there differences in discharge procedure for voluntary and committed patients? Are voluntary commitments turned into legal commitments at times? What are the criteria in such situations?

4. Are physical restraints used in the institution? If so, what kinds and under what circumstances?

5. Are chemical restraints such as tranquilizers used?

6. Are shock therapies such as electric and insulin shock used? If so, must the patient give his permission or is a release needed?

7. Is hypnotic or chemical hypnotic (narco-analysis) interviewing used? Must the patient give his permission or his any release needed?

8. Are work programs used in the institution? How are these viewed by the staff?

9. Is racial segregation practiced in the institution?

10. Are correspondence, visits, and other kinds of communications limited?

11. Are patients searched upon admission? Is there any special handling of patient property?

12. Do there seem to be special socio-economic or racial groups over-represented in the institution?

13. Is incompetency adjudicated separately from determination of mental illness or retardation?

APPENDIX C

DMH Form C-7 (1953) Part 1

CERTIFICATE OF SANITY COMMISSION AND REPORT

EXAMINER'S CERTIFICATE

We, the undersigned, together and in the presence of each other have made a personal examination of _____, an alleged mentally ill person, and do hereby certify that we did on the _____ day of _____, 19____, make a careful personal examination of the actual condition of the said person and have interrogated _____, the person seeking the commitment of _____ and on such examination we find, respectively, that he/she is mentally ill and that his/her condition is such as to require care, custody, and treatment in a hospital for the mentally ill. The facts and circumstances on which we base our opinions are stated in the following report of symptoms and history of case, which is hereby made a part hereof.

We are physicians licensed to practice in the State of Oklahoma, are not related to _____ by blood or marriage, and have no interest in his/her estate.

Witness our hands this _____ day of _____, 19____.

_____, M.D.

_____, M.D.

Subscribed and sworn to before me this _____ day of _____, 19____.

(Seal) My Commission Expires: _____ Notary Public

_____

REPORT OF SYMPTOMS AND HISTORY OF CASE BY EXAMINERS.

I. GENERAL

Complete Name _____

Place of Residence _____

Sex _____ Color _____ Age _____ Date of Birth _____ Place of Birth _____

_____ Length of Last Continuous Residence in Oklahoma _____

Single, married, widowed, separated, divorced _____

Number of children living _____ Number Dead _____

Occupation _____ Date of last employment _____

Education _____ Religion _____

Name, relationship, address, and telephone number of correspondents _____

_____

_____

_____

II. HISTORY OF FAMILY

Name of Father _____ Birthplace _____

Maiden Name of Mother _____ Birthplace _____

Name of Husband (or maiden name of wife) and Birthplace _____

_____

General characteristics of family _____

_____

_____

What relatives have had mental or nervous trouble? _____

III. HISTORY OF PATIENT PREVIOUS ILLNESS:

Describe the general health, development, sickness, and accidents prior to the present disorder _____

_____

Personality, school record, and social habits: _____

_____

Previous attacks and hospitalizations for mental health; Place and date _____

_____

DMH Form C-7 (1953) Part 2

IV. HISTORY OF PRESENT ILLNESS:

Supposed cause _____

Date of onset and course _____

Abnormal conduct _____

Abnormal talk _____

Suicidal Tendencies _____

History of Violence _____

Special and unusual symptoms _____

_____

Use of Alcohol _____

Use of Narcotics _____

Diagnosis, if determined _____

Treatment _____

Detention _____

Name and relationship of informants _____

_____

Value of personal property _____ Value of Real Property _____

Other Assets _____ Other Data _____

Statement as to whether said person should be detained pending hearing of petition for admission to a hospital and whether the condition of said person is such that removal of said person from the place where detained for the purpose of appearing at a hearing or the appearance of said person at a hearing would be improper and unsafe:

_____

_____

_____

_____

Dated at _____, Oklahoma, this _____ day of _____ 19____

_____ M. D. _____ M. D.

_____ _____

Address Address

_____ Legal Member

_____

Address

CERTIFICATE OF LEGAL MEMBER

This is to certify that I have personally been present during the examination _____ _____ and during the Court proceedings to determine his/her mental illness and that to the best of my knowledge all applicable provisions of the Constitution of the United States and the State of Oklahoma have been complied with.

I am not related to _____ by blood or marriage and have no interest in his/her estate nor will I act as his/her guardian or attorney for his/her guardian in the event such guardian is appointed as a result of these proceedings.

Based upon the apparent extent and value of real and personal property owned by _____ _____ and upon the probable length of his confinement in a mental institution, I do/do not recommend the appointment of a Guardian for the said _____

_____

Legal Member

CERTIFICATE AS TO COPY

STATE OF OKLAHOMA }
COUNTY OF _____ }

I, _____, the Court Clerk in and for the above named County and State, do hereby certify that the within and foregoing is a full, true, correct, and complete copy fo the original certificate of Sanity Commission and report of symptoms and History of Case by Examiners as the same appears on file in my office in the matter of the mental illness of _____

_____ Cause No. _____

_____ Court Clerk

(Seal) _____ Deputy

APPENDIX D

STATE OF OKLAHOMA
DEPARTMENT OF PUBLIC WELFARE

APPLICATION FOR SERVICES FOR MENTALLY RETARDED

Date _____ County _____

Asparents (or guardian) of the hereinafter named applicant, we hereby submit application to the Director of Public Welfare for whatever services are offered by the Oklahoma Department of Public Welfare for the mentally retarded. We will make said applicant available for evaluation at whatever facilities are designated by the Department of Public Welfare. We further agree to comply with all applicable laws, rules, and regulations of the Oklahoma Public Welfare Commission.

Following said evaluation of applicant, if admission to a state school or hospital for the mentally retarded or other residential facility outside the applicant's home is recommended by and available through the Department's services and accepted by us as parents or guardian of the applicant, we give our consent to said admission and for such care, treatment and services for said applicant as is deemed necessary by the proper officials of the Department of Public Welfare until applicant is discharged, or case is closed, as authorized by the Department of Public Welfare in accordance with the rules and regulations of the Oklahoma Public Welfare Commission.

The following information is correct to the best of my knowledge:

Witnesses:

_____ _____ (Signature)
Father (or Guardian)

_____ _____ (Signature)
Mother (or Guardian)

Address of Parents or Guardian: _____ Tel. No. _____

Finding Address: _____

SECTION I. IDENTIFYING INFORMATION

_____ MR- _____
Last Name of Child First Middle Case Number (To be completed by DPW)

_____ _____ _____ _____ _____
Birthdate Birthplace Sex Race Length of Okla. Residence

Present Legal Custody: Parents _____ Father _____ Mother _____ Guardian _____ Court _____

Other (specify) _____

SECTION II. COMMENT ON FAMILY SITUATION AND PROBLEM OF RETARDATION

SECTION III. FAMILY COMPOSITION (Including Child)

	Name	Relation	Birthdate	Occupation	Grade	Health
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

SECTION IV. INFORMATION REGARDING BIRTH OF CHILD

Was infant full term: Yes _____ No _____ If "No," in what month did birth occur: _____
If overdue, number of weeks overdue: _____ Birth Weight _____

How long did labor last (Approximately) _____ Kind of delivery: Normal _____
forceps _____ breech _____ operative _____

Condition at birth: Color_____ breathing _____ cry _____. Administration of oxygen necessary _____. How long _____

Was there anything unusual in child's appearance or action. Explain: _____

_____

Age of mother at birth of child: _____ Illnesses during pregnancy: Bleeding _____
Bed rest required _____ Convulsions _____ Diabetes _____ Exposure to X-ray radiation _____ Measles _____ (If "Yes," what month _____) Other Illnesses:
_____

SECTION V. DEVELOPMENTAL HISTORY OF CHILD

Was child breast fed _____ Bottle fed _____ Was there difficulty in feeding _____ How old when weaned _____ Was there difficulty in weaning _____ If "Yes," explain: _____
_____ Does child feed self now _____

Does child sit alone _____ If "Yes," at what age _____ Does child walk _____ If "Yes," at what age _____. Does child talk _____ If "Yes," at what age: _____ How well does child talk _____

Is child toilet trained _____ If "Yes," at what age _____. Are there "toilet accidents" _____ If "Yes," how frequent _____. Can child feed self _____ If "Yes," does he use hands _____ Spoon _____ Fork _____. Does child drink from glass _____

Is child able to dress and undress self Yes _____ No _____ Partially _____. Can child attend to own personal care Bathing _____ Care of hair _____ Teeth _____

SECTION VI. GENERAL INFORMATION

Does child sleep well and quietly _____. If "No," explain _____

Does the child have temper tantrums _____. Is child destructive _____. Does child understand when spoken to _____. Explain _____

Is child presenting any problems in the sexual area _____. If "Yes," explain _____

SECTION VII. PSYCHOLOGICAL EVALUATION

Has applicant had a psychological examination. Yes _____ No _____ When _____
Where _____ By whom _____

Mental age _____

SECTION VIII. EDUCATION

Has child ever attended school _____ If "Yes," give name and address of last school attended _____

Was child in a special class or regular class _____. If regular class, what was last grade completed _____ Age ____. Can the child read _____ If "Yes," how well _____. Can the child write _____ If "Yes," how well _____. Can the child count _____ If "Yes," how far _____. Can child make change with money _____ If "Yes," how well _____. Can child tell time _____ If "Yes," how well _____

SECTION IX. FAMILY DATA

Father

Name _____ Birthdate _____ Education (last grade completed) _____ Occupation _____ Social Security Number _____ Veteran's C-Number _____ Status of Health (give details if "poor") _____

Address (if different from that of applicant) _____
If deceased, give date and cause _____

Mother

Maiden Name _____ Birthdate _____ Education (last grade completed) _____ Occupation _____ Social Security Number _____ Veteran's C-Number _____ Status of Health (give details if "poor") _____

Address (if different from that of applicant) _____
If deceased, give date and cause _____

Both Parents

Are parents related _____ Degree of relationship _____
Date of marriage _____ Is family intact _____ If "No," Separated _____
Date _____, Divorced _____ Date _____, Death _____

Is the child covered by insurance _____ If "Yes," complete the following:
Hospital Insurance _____ Health Insurance _____ Type of Coverage _____

Name and address of company _____
Policy Numbers _____

SECTION X. RESPONSIBILITY OF PARENT OR GUARDIAN

Title 56, Section 312, Oklahoma Statutes, provides: "A pupil at an institution named in Section I of this Act (Enid State School, Pauls Valley State School, and The Hissom Memorial Center) is liable for his care and treatment. This claim of the State for such care and treatment shall constitute a valid indebtedness against such pupil and his estate and shall not be barred by any statute of limitations. At the death of the pupil this claim shall be allowed and paid as other lawful claims against the estate. Persons making application for admission of a pupil are also liable for the pupil's care and treatment, provided that such persons are legally obligated to support such pupil. Provided, further, that no admission or detention of a pupil in a school shall be limited or conditioned in any manner by the financial status or ability to pay of a pupil, his estate, or any relative."

The amount to be paid for the care and treatment of the person for whom this application is made must be fixed and agreed upon before admission, and will be based upon ability to pay. The amount payable will not be more than the average monthly per capita cost of maintenance as determined by the Director of Public Welfare, with the approval of the Oklahoma Public Welfare Commission. The current maximum rate for maintenance is $75.00 per month.

SECTION XI. PREVIOUS EXAMINATIONS AND TREATMENT

List places and persons, where and by whom, your child has been examined or treated, such as hospitals, clinics, special classes, physicians, psychologists, and other specialists. Include name, address, and approximate dates of examination, treatment, or hospitalization.

SECTION XII. AUTHORIZATION FOR RELEASE OF INFORMATION

An application having been made to the Director of Public Welfare for the furnishing of services for the mentally retarded to _____ (Name of Child), We, the undersigned parents or guardian of such person, do hereby authorize the Director of Public Welfare, or his authorized representative, by the use of this executed document or a photostatic copy thereof, to inspect or examine all or any hospital, medical, psychological, financial or other records pertinent to a determination of eligibility for the furnishing of such services; and we do hereby authorize the release of any information from such records by the custodian thereof. We understand that any such information obtained by the Director of Public Welfare, or his authorized representative, will remain confidential, and will be used only for the purpose of determining eligibility or furnishing such services.

Dated this _____ day of _____, 196 __

WITNESSES:

_____ _____ (Signature)
Father (or Guardian)

_____ _____ (Signature)
Mother (or Guardian)

The completed application will be mailed to: L. E. Rader, Director of Public Welfare, P. O. Box 53161, State Capitol Station, Oklahoma City, Oklahoma 73105.

SECTION XIII. MEDICAL EXAMINATION

THE PHYSICIAN MAY PREFER TO SUBMIT THE INFORMATION REQUESTED BELOW ON HIS OWN FORM OR LETTERHEAD AND EITHER ATTACH SAME TO THIS APPLICATION OR MAIL SEPARATELY TO THE ADDRESS GIVEN BELOW. THIS FORM IS DESIGNED SIMPLY TO RELATE THE TYPE OF INFORMATION THAT THE DEPARTMENT CONSIDERS MOST NEEDED.

Name of child _____ Date of Examination _____
Sex _____ Birthdate _____

Weight _____ Height _____ Temperature _____ Pulse _____ Blood Pressure _____

(Check normal findings - record abnormalities)
Head, face, neck, and scalp _____
Sinuses _____ Nose and throat _____
Ears (general) _____ Hearing _____
Eyes (general) _____ Visual Acuity _____
Lungs and chest _____ Heart _____
Vascular system _____ Teeth _____
Abdomen and viscera (include hernia) _____
External genitalia _____ Pelvic Organs (female) _____
Anus and rectum _____
Extremities (upper) _____ Extremities (lower) _____
Feet _____ Muscles, bones, and joints _____
Skin and lymphatics _____
Endocrine system _____
Deep reflexes _____
Urinalysis: Date _____ S. G. _____ Protein _____
Sugar _____ Microscopic _____
Chest X-ray: Date _____ Report _____

Smallpox Vaccination (during last 5 years) Date _____
Immunizations: Diphtheria (date) _____
Tetanus (date) _____
Pertussis (date) _____
Typhoid-Paratyphoid (date) _____
Polio Vaccine (date completed) _____
Others (dates) _____

Other pertinent findings: _____

Diagnosis: _____

Present medications: _____

Behavior and specific management problems: _____

Remarks: _____

Date _____ Signature _____ D. O. M. D.
Address _____

The Physician's report may be mailed directly to: L. E. Rader, Director of Public Welfare, P. O. Box 53161, State Capitol Station, Oklahoma City, Oklahoma 73105.