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Civil Rights and Mental Hospital Administration

*Ewing H. Crawfis**

LET US START OUR DISCUSSION by indicating a frame of reference for the comments we wish to give about civil rights. Our discussion will relate primarily to patients, who have been hospitalized for the observation and treatment of mental illness, rather than those patients seen either in the office or in the clinic. It is also based on the statutes in Ohio and on the practice in the courts and more especially in the receiving hospitals and state hospitals in Ohio. It should be noted that the state hospitals give long-term care for such patients and that the receiving hospitals give short term care for such patients. The receiving hospitals admit a high percentage of voluntary patients, whereas the state hospitals admit patients who have been committed. In the two receiving hospitals in Cleveland, the percentage of voluntary admissions exceeds fifty per cent, while the two state hospitals have less than ten per cent of voluntary admissions.

In Ohio, there is a clear distinction between voluntary admissions and medical certificate admissions, and all other types from the standpoint of the patient's civil rights. Section 5123.57 of the Ohio Revised Code provides that all patients except voluntary and medical certificate admissions are incompetent. There is one exception to this in that Section 5123.23 provides for a ninety day referral by the Probate Court in questionable cases where the Court cannot make a final determination as to whether or not the patient is mentally ill. It is assumed that under the provisions of this section of the statutes, the patient's competence is suspended during this period of time until the final disposition by the court. There has been no court decision on this, since it has been in effect only since November, 1959.

It is well for us to remember that even for the committed, incompetent patient, certain so-called "natural" rights are retained. I refer to such things as the right of privacy, the right to be protected from assault, libel and slander, the right to sue in tort for negligence (although the suit must be instituted in

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the patient's name, by someone else). The right to file an application for a hearing under a Writ of Habeas Corpus is also retained.

The primary civil right, which is lost by commitment, is that of freedom. As a psychiatrist, with long experience in the hospital field, there are several comments I should like to make regarding the commitment process and the loss of civil rights on a general basis.

Lawyers and newspapers are much concerned about "rail-roading" in which persons can be, and are wrongfully placed in an institution by relatives or other persons. I can assure you that it is the consensus of hospital psychiatrists that these occurrences are rare and are greatly over-emphasized. This is particularly true in this modern day when the psychiatric hospital has a social service staff to explore the social history and to interview relatives and friends, than it was formerly when the medical staff of the hospital was almost completely dependent upon the information supplied by the court and by the complaining witness. Our over-crowded state hospitals are not anxious to hold anyone who can be released, and I would assure you that our problem is much more frequently that of getting the improved or recovered patient out of the hospital rather than of holding an individual who is not sick. Such situations occasionally can occur and some safeguards are needed, but I do wish to point out that such safeguards should be held to a minimum and should not be so burdensome as to restrict the admission of the individual needing treatment. One of the recent suggestions here in our city is to expand the investigative function of the probate court in these cases, just as the probation department makes investigations for the criminal courts. It is my belief that this is a wise suggestion and that those rare situations where an injustice does occur might thus be prevented. At the present time our probate courts must accept the affidavit of the complaining witness, and where there is no information to the contrary, must—of course, act on the basis of the information provided. It is entirely possible under this situation that where there has been a family quarrel or where the complaining relative is quite paranoid, but is able to present a good appearance to the court officer, that an individual may be sent to the hospital, who is not ill. The more common occurrence however, is with the individual who is senile and who has undergone some physical deterioration requiring hospitalization, but in which either nursing home care or hospitalization in a general

hospital is not feasible. In these instances, the family and everyone concerned is so anxious to have the patient hospitalized that the symptoms of mental illness are exaggerated to the point that the court is led to believe that the patient is psychotic. Certainly, in this second kind of a situation, the availability of appropriate facilities will do more for the solution than will the efforts of the hospital social service staff or the suggested investigative branch of the probate court.

The second item I wish to comment upon is the traumatic character of the legal procedures, and particularly the attitudes of the police and the court personnel, which are so damaging to the patient and frequently delay and impair the treatment program. This is involved in the fact that our commitment procedure still parallels the procedures in criminal court in filing of the affidavit, the holding of the hearing, and finally the transportation of the patient (criminal) to the hospital by the police or the sheriff. It is certainly in accordance with good legal principles that a person, whose legal rights are being adjudicated, has a right to appear and to defend himself; therefore the patient is usually required to be present at the hearing. However, for many patients, particularly the paranoid individuals, the testimony of relatives or friends or physicians concerning his symptoms may only further convince him that he is being persecuted and that everyone is against him. Thus, it is not surprising that the patient comes to believe that the staff of the hospital are participants in this plot, and for this reason he is unable and unwilling to cooperate and to participate in the process of diagnosis and treatment. Even though probate court personnel are sympathetic, they must conform to legal requirements.

Finally, of course, is this question of the transportation of the patient to the hospital in a patrol wagon, frequently in some sort of restraint and accompanied by uniformed officers. It is a common experience for the psychiatrist, as the admitting officer, to have the accompanying officer remove the restraints and to find the patient to be entirely cooperative without the need for shackles. Fortunately, this practice is not as prevalent as it was a few years ago. Many of our patients come to the hospital voluntarily or are brought in by their relatives. However, there still is a fairly large number brought to us by the police department or by the sheriff's department, and restraint of these patients is only rarely necessary. I would hope that we would get to the point where this kind of handling would only be regarded as an

emergency, and that it would be dispensed with in all other handling of the mentally ill by the police or the sheriff's departments.

For the past few years I have been quite vocal in my criticism of the Ohio statutes in making commitment an automatic adjudication of incompetence. Many of the other states have divided the issues of competency and hospitalization, but Ohio, unfortunately—has not seen fit to follow their example. In actual practice, some of the probate judges in Ohio consider that the hearing prescribed in Section 5123.23 is primarily to determine competency, and that if the patient is found to be incompetent then commitment follows automatically. There was a time, in one of our county probate courts, when the court psychiatrist regarded his examination of the patient as primarily an effort to determine the question of need of hospitalization without particular effort being made to establish diagnosis or prognosis, and specifically with no effort being made to determine competency. When he testified in the court that the patient needed hospitalization and recommended commitment because of this, the probate judge assumed that he was testifying that the patient was incompetent. This situation existed for some months before the court psychiatrist became aware of the judge's attitude. This particular problem is aggravated by the statute which governs the discharge from the hospital and its relation to the restoration to competency—Section 5123.50. When the patient is discharged as recovered, this operates as a restoration to competency. When discharged as improved, it does not operate as a restoration to competency. In addition to this, the discharge in either category does not operate as a termination of his legal guardianship, but it may be used as evidence in a hearing to terminate guardianship. Unfortunately, in most instances the medical staff of the hospital, in considering the discharge of the patient and evaluating his condition at the time of discharge, pays very little attention to the question of competency, and thus may create a situation which is unjust to the discharged patient. I will return to a further discussion of this problem, but at this point I would like to comment on the question of the psychiatrist's testimony before the court.

Professor Ross has suggested that the questions asked of the psychiatrist and the testimony relating to the patient's condition should be phrased in terms of social facts and predictions. I feel that this is an excellent suggestion and that, if it were

adopted, the physician's testimony would be much more meaningful. The physician is trained to speak in terms of diagnoses and prognoses and to the trained listener these terms are meaningful. Unfortunately, to the untrained hearer they are not so meaningful and, in fact, may be misinterpreted and misunderstood. The psychiatrist assumes that the court is thoroughly familiar with these technical terms. It would be much better if he would talk with the court in the same fashion as he explains the patient's condition to the relatives—namely, in terms of "what's wrong," "can the person be helped?," "what treatment is needed?," and "how long will it take?" As psychiatrists we need to avoid the pitfalls of using labels. They are frequently not well understood, even by our colleagues, and the risk is much greater with other persons. Let me point out several of the interpretations which I have found to be fairly common in dealing with lawyers and courts:

1—The diagnosis of psychoses and neuroses. The common impression is that the neuroses are mild and do not require hospitalization, while psychoses are severe and do require hospitalization. While this generalization is true, it is not inherent in the diagnoses and does not necessarily follow in every case. They are two separate categories of disorders and each individual patient must be considered on the basis of the problem involved. There are certain neurotics who are best handled by hospitalization, just as there are fairly large numbers of psychotics who can be handled without hospitalization.

2—The qualifying phrases "acute" and "chronic." Many lay persons react to these terms by assuming that the patient can be handled at home or in the psychiatric unit of a general hospital in the case of "acute illness," whereas it is assumed that hospitalization in a state hospital is required in chronic cases. While the type of onset and the duration of illness are factors in making the determination, the primary criteria used relates to the reversibility of pathology. If it appears, for example, that the brain will return to its normal state, the diagnosis of the illness may be classified as acute, even though it may be several weeks, or even months, in duration. On the other hand, if it is clear that there will be permanent damage, the illness will be classified as chronic, even though only a few days have elapsed since the illness became apparent. Under ordinary circumstances, of course, illness starts as an acute illness and then, after permanent

damage occurs, is classified as chronic as soon as the acute symptoms subside. However, the important point is not whether permanent damage has occurred, but that we need to determine the degree of damage and the level at which the patient can operate. There are many mild, chronic psychotics who show permanent irreversible pathology, but who do not require hospitalization and who are able to function in society, even though on a limited basis. This leads me to point out that the qualifying phrases—mild, moderate, and severe—are frequently much more meaningful in evaluating the need for hospitalization than whether the diagnosis is neurosis or psychosis, or whether it is acute or chronic. Further than this, such phrases are much better understood by the lay person.

From the above discussion, I think that it is clear that the testimony concerning the commitment would be much clearer to the court if the questions were not "Is the patient psychotic?", or "Is his illness chronic?", or "Is he competent or incompetent?", but rather, "Is this individual ill?" and if so, "What is the severity of his illness?". In predicting his future behavior, what should be recommended?

Now, let me return to my discussion of the discharge process and point out where our own usage of words from a medical standpoint rather than a legal standpoint produces injustice: Section 5123:50 states that a discharge as recovered operates as a restoration to competency; a discharge as improved (anything less than recovery) does not so operate. The statute equates recovery and competence, improvement with incompetence. In the medical usage of the term "recovered" this is taken to mean that the patient is able to return to the previous level of function before the illness. Our manual (the A. P. A. Manual) by which we code our discharges, for example, says that we should evaluate the patient in terms of his condition and the level of function before he entered the hospital. Now in two hypothetical cases, how does this work out?

1—Mr. A, a very responsible business man, in an executive position, has a cerebral accident (stroke) and because of his confusion and other symptoms, he is committed to X State Hospital. After three months, he has improved remarkably, is able to leave the hospital and return to his job and perform adequately, although his employer says he still has difficulty in finding words and phrases to express himself properly and he still has a mild, residual,

one-sided paralysis. Because of this, he cannot be classified as recovered, but only as improved, so that his competency is not restored upon discharge, even though, in fact, he can be considered competent.

- 2—Mr. B, a workman, who has always made a border-line adjustment on his job and whose family says he has always been an isolated person, who made a poor social adjustment, suddenly became upset at home and creates a sufficient disturbance so that he is committed to the same state hospital. After three months he too is able to leave the hospital, go back to his home and return to work. His family says that he is much the same as he was prior to his hospitalization except that he no longer resents his parents' advice to him as to how to handle his pay-check and his expenditures. The hospital staff feels that in all likelihood, he was a chronic schizophrenic before he was hospitalized, and that he has returned to his former mild state and is able to make a border-line social and economic adjustment. Because of this, since he had attained such a level, he is classified as recovered, and this discharge operates to restore him to competency, even though he probably was not competent before being hospitalized.

In my opinion, the only way this sort of situation can be limited and controlled is to completely separate the issues of hospitalization and competency. The determination of competency should be a legal problem and it should not be determined by the medical staff, nor should it be linked to either the question of hospitalization or discharge.

Let us now turn to a discussion of the patients' rights while he is within the hospital. Many states have statutes on the qualified privileges of correspondence and visitation. There are only two states which give the patient an absolute statutory privilege of writing to anyone without censorship. As a matter of general policy, our hospitals in Ohio permit correspondence and visiting, and the restrictions on these privileges are individually applied only when it has been demonstrated that such correspondence or visiting are harmful to the health and welfare of the patient. As an example, the patients in our hospital send and receive their mail uncensored. Other hospitals do censor both incoming and outgoing mail, but the patients can send and receive it. Visit-

ing is permitted on certain hours and certain days, with the regulations designed primarily to control traffic and to avoid interference with normal treatment activities rather than any effort to restrict visiting. It should be pointed out that the patient's physician, attorney or minister is permitted to visit the patient at any time, and these three classes are not restricted to specific visiting hours. Exceptions to the regular visiting hours are also made for relatives or friends who come from a considerable distance and who could not conveniently visit during regular visiting hours. Section 5123.03 provides the basis for this policy by stating that patients may freely correspond with their relatives, friends, physicians and regular legal advisors, and that they may also receive visits from them except when that is termed inadvisable by the Superintendent (medical staff), and in such instances the Superintendent shall place on file, subject to inspection, a written assignment of the reason for not permitting such correspondence, writing or visits. The same section says that the patient's personal or family physician shall be admitted at all times.

After a patient has been observed in our hospital for several days, the majority of them are permitted the privilege of using the telephone at specifically designated times. It should be pointed out that this is not customary in other hospitals and that this example is cited to illustrate that the elaborate restrictions formerly thought necessary for mental patients are needed only occasionally. Because of the relatively small number of patients and the more intensive treatment program at this hospital, such a practice is feasible, whereas in some of the other hospitals, with a much larger patient load and smaller staff, such a practice might create administrative problems.

Ohio has no provisions in its statutes concerning the use of restraints. Some other states do have such regulations, which require that the patients who are in restraint must be reported, that they must be seen by the staff at certain regular intervals, and that the restraint is removed at certain intervals. With the advent of the newer treatment methods, particularly the tranquilizing drugs, the need for such mechanical restraint has largely disappeared. I would offer the opinion that statutory provisions in this regard are unnecessary today.

Section 5123.03 also provides that before proceeding with any major operation "the Superintendent shall notify the patient's personal or family physician, spouse, parent, guardian or next of

kin." Note that it does not state that consent is required. This particular provision must be evaluated in connection with Section 5123.43, which provides that the Superintendent shall have exclusive custody and control of the person of the patient during the time he is detained, whether or not a guardian has been appointed. The effect of this Section is to clothe the staff of the hospital with authority equivalent to that of guardianship of the person. Again, as a matter of policy, our hospital requests permission for all types of treatment, including surgery. If permission is not obtained, then a decision must be reached as to whether treatment will be given in spite of objection. This decision is usually based on the patient's condition and the type of treatment under consideration. For example, if consent was refused for elective surgery, the surgery would not be performed. However, if the patient is acutely ill and it is felt that the treatment is strongly indicated, it would be done in spite of the lack of consent. This most frequently occurs in connection with shock treatment. If the patient is a voluntary admission, however, the patient's consent is obtained and no treatment would be given without such consent. This policy is based upon the presumption that the voluntary admission retains competency and that Section 5123.43 does not apply, even though the language of the statute is sufficiently embracing to cover all patients and makes no exceptions.

The committed patient loses among other rights—the right to buy, sell, or hold property, the right to make contracts, to vote, and to hold office, to marry or divorce. Section 5123.57, which states that the patient is incompetent, with the exception of sane epileptics, voluntary patients, and the Medical Certificate patients under Section 5125.32, refers to "any agreement, or execute a contract, deed, or other instrument." It also provides that such instruments can be approved and allowed by the committing court; but to my knowledge this provision is seldom used.

One of the more highly prized privileges of our modern culture is that of holding a driver's license. In many instances, for the patient who is admitted to a receiving hospital for short term treatment, the Bureau of Motor Vehicles is not notified, and the license is not suspended or revoked. In those cases, if the patient is discharged in a short time, he is able to resume driving upon release. When the Bureau is notified, the license is suspended. Inquiries to the hospital concerning civil rights upon discharge involve the question of drivers' licenses more fre-

quently than any other item. This is particularly true for the committed patients released from the long-term hospital, since they are usually released on a trial visit basis, and thus are not discharged nor restored to competency. In such instances the Bureau of Motor Vehicles will frequently accept a statement from the staff of the hospital, and restore the license. Many times it is necessary for the patient to have a driver's license in order to return to work.

Since over 50% of our patients are voluntary admissions, our policy in relation to the release of information about patients is similar to that of general hospitals. Most of our inquiries come from physicians, insurance companies, and other social agencies. The waiver form signed by the patient is required for our files before the information is released. In the case of committed patients, the information which has been filed in the court is of public record, so that we are not involved in a breach of privilege. Even so, we give out an absolute minimum of information in these cases. When the inquiry comes from another hospital or professional person, complete information is given.

Occasionally requests for release of information are received which do not conform to ordinary standards and policy. One of these, which is encountered in psychiatric hospitals, is the request by the patient for a copy of his record, purely for his own information. Our policy here is to individualize these cases, and our decision is usually based on the symptomatology of the case. In the paranoid patient (and this group is the one most frequently encountered) the request is refused, on the ground that such information will further aggravate the patient's mental condition.

In the case of the committed patient who has not been discharged, one of the problems is that of deciding whether the signing of the waiver for release of information is valid. The vast majority of cases do not have guardians appointed, and the waiver will be signed by a relative. Usually, the decision is made on the basis of whether any benefit will accrue to the patient, rather than on the question as to the validity of the signature.

Finally, I would like to emphasize again that the problems in regard to the civil rights of patients hospitalized for mental illness usually arise either at time of admission, or at discharge, and seldom while the patient is in the hospital.