

Basic Rights of the Mentally Handicapped

Right to Treatment

**Right to Compensation for
Institution-Maintaining Labor**

Right to Education

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Introduction

This booklet is designed to introduce the reader — the consumer, his family or friends, an administrator, or a mental health professional or paraprofessional — to some of the basic legal rights of the mentally ill and the mentally retarded. The booklet may also serve as a starting point for attorneys interested in the mental health law field. *

This booklet focuses upon three recently articulated rights of the mentally handicapped -- the right to treatment; the right to compensation for institution-maintaining labor; and the right to education. These three rights are receiving increasing attention from the courts. And many groups and individuals active in the mental health area are becoming increasingly concerned with the implications and potential of legal intervention. In the following chapters, specific cases in each of these three areas are presented to acquaint the reader both with the theoretical underpinnings of the right involved and with the way the litigation process works to vindicate such rights.

At the present time, there are over 300,000 persons in state and county mental hospitals alone (and another 300,000 in private hospitals).

*This booklet is basically substantive in nature and does not address the litigation process and civil procedure as a whole, or explain legal terminology. For those interested in a better understanding of legal procedures, please see the companion litigation booklet written by the Mental Health Law Project in connection with the State-Federal Information Clearinghouse for Exceptional Children. Inquiries should be addressed to Alan Abeson, Director, at the State-Federal Information Clearinghouse for Exceptional Children, 1411 South Jefferson Davis Highway, Suite 900, Arlington, Virginia 22202.

Of the 6 million persons labeled mentally retarded, approximately 250,000 are confined in residential institutions. Many of these persons receive inadequate or no treatment and others do not even receive safe custodial care. Thousands of involuntarily-confined residents daily perform institution maintaining labor — without any compensation — which would otherwise require the hiring of regular employees. It has further been estimated that of the 7 million children identified as handicapped, only 2,800,000 (or 40%) receive appropriate education. Despite sporadic improvements in their situation, the mentally handicapped have traditionally been relegated to second-class status in our society.

In recent years, it has become increasingly clear to mental health advocates around the country that educating the public and lobbying for increased mental health appropriations alone are insufficient to accomplish the large scale reforms necessary to improve the plight of the mentally handicapped. Simultaneously, lawyers and civil libertarians have begun to recognize that alleged mentally handicapped adults and children are one of the most profoundly victimized minorities in this country. The result has been an alliance of lawyers, professionals and other mental health advocates who have begun to view the delivery of services to the mentally handicapped as both a "consumer" and constitutional rights issue.

When other remedies prove ineffective in protecting the rights of a minority, litigation can be a valuable tool and catalyst. Litigation serves to heighten public consciousness, hold administrators accountable to objective and enforceable norms, and generally to keep a "window" on the plight of an otherwise forgotten group. It should be emphasized, however, that litigation is not a panacea. A good lawsuit is difficult, expensive and time-consuming; improperly prepared, it can backfire.

Final solutions to our mental health care problems must lie not with the courts, but with the legislative and administrative branches as increased public awareness and concern result in enlightened attitudes toward the mentally handicapped and ultimately in the re-ordering of fiscal priorities.

Nonetheless, the articulation of basic constitutional rights achieved by the prototype cases discussed in this booklet, and in follow-up cases currently being litigated around the country, is an important step in the process of change. It is to these cases that we now turn our attention.

Right to Treatment

WHAT IS THE RIGHT TO TREATMENT ?

The right to treatment is a concept which was first articulated in 1960 when Dr. Morton Birnbaum, attorney and physician, proposed that:

. . . the courts, under their traditional powers to protect the constitutional rights of our citizens begin to consider the problem of whether or not a person who has been institutionalized solely because he is sufficiently mentally ill to require institutionalization for care and treatment actually does receive adequate medical treatment so that he may regain his health, and therefore his liberty, as soon as possible; that the courts do this by means of recognizing and enforcing the right to treatment; and, that the courts do this, independent of any action by any legislature, as a necessary and overdue development of our present concept of due process of law. *

Birnbaum's original thesis was that litigation of right to treatment cases would result in favorable court decisions focusing public attention on the inadequacy of medical care in public mental institutions. Such attention would force legislative action to increase appropriations in order to provide adequate care and treatment.

*"The Right to Treatment" was printed in Volume 46, American Bar Association Journal, page 499, in 1960. A copy of this article may be readily obtained at no cost by writing to the Senate Subcommittee for a copy of the 1969 Hearings Before the Subcommittee on Constitutional Rights of the Committee on the Judiciary, United States Senate, which also includes excerpts from testimony of important mental health and legal experts in this area plus excerpts from important leading cases. This volume is entitled Constitutional Rights of the Mentally Ill.

WHAT WERE THE FIRST CASES SPECIFICALLY ADDRESSED TO THE RIGHT TO TREATMENT ISSUE?

Dr. Birnbaum's right to treatment writings generated commentary in the legal and medical communities and was first judicially recognized in 1966 in the case of Rouse v. Cameron, decided by the U. S. Court of Appeals for the District of Columbia. *

The plaintiff, Charles Rouse, charged with carrying a dangerous weapon — a misdemeanor carrying a one-year maximum sentence -- was found not guilty by reason of insanity and committed to St. Elizabeths Hospital. At the time the habeas corpus petition** was filed, Rouse had already been institutionalized for more than four years.

The District Court refused to consider the quality of treatment Rouse was receiving at the Hospital and denied the petition. On appeal, the United States Court of Appeals in an opinion by Chief Judge Bazelon articulated the issues:

The principal issues raised by this appeal are whether a person involuntarily committed to a mental hospital on being acquitted of an offense

* Rouse v. Cameron, 373 F. 2d 451 (1966). For those not familiar with case citations, this means that the opinion in the case in its entirety may be read at a law library in volume 373 of the Federal 2nd Series Reporter at page 451. A copy of this opinion is also included in the 1969 Hearings, page 451, mentioned previously on page 4.

** Referred to throughout history as the Great Writ, the phrase habeas corpus literally means "you have the body" and directly presents the issue to a court as to whether a person is being restrained of his liberty in violation of due process of law. Issuance of a writ of habeas corpus results in the release of a person from confinement or other restraint of liberty.

by reason of insanity has a right to treatment that is cognizable in habeas corpus and if so, how violation of this right may be established. The purpose of involuntary hospitalization is treatment, not punishment. The provision for commitment rests upon the supposed necessity for treatment of the mental condition which led to the acquittal by reason of insanity. Absent treatment, the hospital is 'transformed . . . into a penitentiary where one could be held indefinitely for no corrected offense, and this even though the offense of which he was previously acquitted because of doubt as to his sanity might not have been one of the more serious felonies' or might have been, as it was here, a misdemeanor.

The Court reasoned that Rouse could only have been incarcerated for up to one year if found guilty and criminally responsible, no matter how dangerous he might have been — the maximum for Rouse's crime was one year. In fact he was incarcerated four times longer than the maximum "and the end was not in sight. " Since the only rationale for the increased confinement was the need for treatment, failure to provide such treatment presented constitutional questions of due process, equal protection, and cruel and unusual punishment. * The Court, however, based the holding in the case on existing statutory law:

A person hospitalized in a public hospital for mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment. D. C. Code Title 21, Section 562 (1967).

Under Rouse, a trial court confronted with the question of inadequate treatment must decide not only whether the treatment meets

minimum professional standards, but also whether treatment is appropriate to the patient's individual needs. The case was remanded to the District Court for a factual hearing on the adequacy of Rouse's treatment. At this hearing the District Court held that Rouse was receiving adequate treatment. Since Rouse's release was ordered for other reasons, the Court of Appeals never reviewed that finding.

In a Massachusetts case, Nason v. Bridgewater, 233 N. E. 2d 908 (1968), a patient at the Bridgewater State Hospital, the Massachusetts facility for the dangerously insane, alleged that he was not receiving adequate treatment and sought transfer to a different institution where treatment would be available. At a hearing held before a specially appointed commissioner the patient's attorney presented expert testimony to show that the patient was not receiving adequate treatment -- only custodial care. The Commissioner found that the staffing at Bridgewater was grossly inadequate and that Nason was not receiving adequate treatment. The Supreme Judicial Court of Massachusetts, the highest state court, upheld the Commissioner's findings that ordered that a program for appropriate treatment be determined and followed, and retained jurisdiction of the case to assure compliance with their order.

WHAT WERE THE RESULTS OF THE EARLY RIGHT TO TREATMENT CASES?

While Rouse generated important debate within legal and mental health communities, the impact upon the treatment given mental patients has been almost imperceptible since Rouse. Although new efforts are now being made five years after Rouse, only a few other jurisdictions have recognized the right to treatment doctrine and even

in those jurisdictions there has been very little implementation. Few lawyers undertook to develop and expand the right to treatment concept or to provide representation to the mentally impaired who were denied adequate treatment. And, most discouraging of all, the level of treatment for mental hospital inmates did not improve.

HAVE THERE BEEN ANY CASES HOLDING THAT ENTIRE STATE MENTAL HEALTH SYSTEMS ARE CONSTITUTIONALLY INADEQUATE?

Yes. In Wyatt v. Stickney,* a right to treatment case brought in Federal District Court in Alabama in 1970, Judge Johnson held for the first time that persons involuntarily confined in institutions for the mentally ill and mentally retarded have a constitutional right to adequate treatment and habilitation. All right to treatment cases prior to Wyatt were individual actions in which one patient filed suit alleging inadequate treatment. Wyatt, on the other hand, was a class action brought by several patients both on their own behalf and for all others similarly situated. (For a further discussion of a class action see p. 20.)

The firing of 99 employees at Bryce Hospital, one of Alabama's two large mental hospitals, in September, 1970, focused attention on the inadequacy of treatment at Bryce. In October, the employees filed suit against the Mental Health Commissioner and hospital administrators in Federal District Court alleging that the lay-off threatened the quality of care at Bryce and denied patients their constitutional right to treatment.

* Now known as Wyatt v. Aderholt on appeal. Stickney was the Commissioner of Mental Health when the suit was first filed. The current Superintendent is Aderholt.

Subsequently, these employees found other employment and withdrew their request to be reinstated by the Alabama Mental Health Board before Judge Johnson's first Wyatt opinion in March, 1971. But patients and their guardians had also joined the suit on the treatment issue, suing as a class. Ricky Wyatt, a named plaintiff, was one of these patients.

HOW DID THE WYATT LAWSUIT DEVELOP INTO SUCH AN IMPORTANT DECISION?

There were three stages in the Wyatt litigation:

Articulation of the Constitutional Right

A hearing on conditions at Bryce Hospital, held prior to Judge Johnson's first ruling in the case, disclosed that the Hospital had approximately 5,000 patients, most of whom were involuntarily committed. Included in the patient population were 1,500 to 1,600 geriatric patients and approximately 1,000 mental retardates who were being provided only custodial care.

On the basis of the testimony elicited at the first hearing, Judge Johnson held:

This Court must, and does, find from the evidence that the programs of treatment in use at Bryce Hospital . . . were scientifically and medically inadequate. The programs of treatment failed to conform to any known minimums established for providing treatment for the mentally ill.

In the same Order and Opinion of March, 1971, Judge Johnson, applying the reasoning in Rouse to the situation at Bryce, stated:

There can be no legal (or moral) justification for the State of Alabama's failure to afford treatment — and adequate treatment from a

medical standpoint -- to the several thousand patients who have been civilly committed to Bryce's for treatment purposes. To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process. 325 F. Supp., 781, 785.

The Court gave the State six months to implement a meaningful treatment program for each involuntarily committed patient.

In August, 1971, the residents of the other state mental institution, Searcy Hospital, and Partlow State School and Hospital, a public institution housing the retarded, presenting many of the same issues as Bryce, joined in the action. The Court subsequently granted leave to several organizations -- the American Psychological Association, the American Ortho-psychiatric Association, the American Civil Liberties Union, and the American Association on Mental Deficiency — to serve as amici curiae* and to provide expert assistance in the case. The Court granted amici in Wyatt the unusual opportunity to participate fully in the proceedings by allowing them to present expert witnesses of their own and to cross-examine the witnesses of other participants in open hearing.

Hearings on Standards

On December 10, 1971, based upon a review of defendant's six month progress report concerning Bryce Hospital and plaintiffs' and amici's response to that report, the Court found that defendants had

*Amici curiae, (or the singular amicus curiae) literally means friend of the court and describes parties who are not direct litigants in the case, but have an interest or point of view relevant to the proceedings, and are allowed to articulate that point of view.

fulled to promulgate and effectuate minimum standards for adequate treatment:

In the matters presented to this Court by the parties there seem to be three fundamental conditions for adequate and effective treatment programs in public mental institutions. These three fundamental conditions are: (1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment, and (3) individualized treatment plans. The report filed by defendants with this Court, as well as the reports and objections of other parties who have studied the conditions at Bryce Hospital, demonstrates rather conclusively that the Hospital is deficient in all three of these fundamental aspects. 224 F. Supp. at 1343.

More specifically, the Court found that many conditions, such as non-therapeutic, uncompensated work assignments, and the absence of any atmosphere of privacy, constituted dehumanizing factors contributing to the loss of patient self-esteem. The physical facilities at Bryce were overcrowded and plagued by fire hazards. The Court also found that most staff were poorly trained and that staffing ratios were inadequate for effective treatment. The Court concluded that whatever treatment was provided at Bryce was grossly deficient and failed to satisfy minimum medical and constitutional standards. It must be kept in mind, "wrote the Court, "that plaintiffs' rights are present ones, and they must be not only declared but secured at the earliest practicable date. " 224 F. Supp. at 1344. Because of defendants' failure to formulate minimum medical and constitutional standards for the operation of their institution, the Court ordered additional hearings to allow the parties and amici to present expert testimony on minimum standards.

Prior to these hearings, plaintiffs, defendants, and amici met to discuss proposed standards developed by amici, and entered into a

number of agreements which were then presented to the Court. These standards were supported and supplemented by the many distinguished experts who testified at the latter two hearings held by the District Court in this case -- one on February 3-4, 1972 (re Bryce and Searcy) and the other on February 28 - March 1, 1972 (re Partlow). The broad agreements reached were very important as will become clear during later discussion.

It should be noted that the expert testimony established that inmates of Alabama's mental institutions were not only deprived of treatment, but even the most minimal stimulation, resulting in deterioration of their condition. The experts stated that although conditions in Alabama were very substandard, they were "no worse than those in many of our largest and richest states. " To choose an illustration from the testimony, Dr. Gunnar Dybwad testified as to the profoundly dehumanizing effects of confinement upon the residents of Partlow in the following terms:

I think if you walk through Partlow, you can see it; you can see the effect — the people who begin to become involved in eccentric mannerisms, the rocking back and forth, peculiar behavior mechanisms, the people who sit in a semi-stupor in a place, without any activity, the people who slowly deteriorate and turn to the simple elements of human behavior I can assure you that this kind of behavior is due to neglect and is not an outcome of the mental retardation, itself. . . . In other words, it is a deterioration. I would further now add to this from my own observations, but not at Partlow that we have ample documentation in this country that individuals who come to institutions and can walk stop walking, who come to institutions and can talk will stop talking, who come to institutions and can feed themselves will stop feeding themselves; in other words, in many other ways, a steady process of deterioration.

Testimony about Partlow established that inmates were constantly in danger from assaults from guards and other inmates and that in the recent past four inmates had died due to the negligence and lack of supervision by hospital staff.

As a result of this testimony, the Court issued an emergency order to protect the lives of Partlow inmates. The Court ordered the State to hire 300 new aide-level employees within 30 days. In the implementation of that order the State was told to bypass Civil Service or other formal procedures which would delay hiring. Within 10 days after the Order was made public, more than 1,000 persons had applied for jobs, and the quota was met. Other terms included making immediate changes to make the buildings fire safe and to control the distribution of drugs.

Standards of Adequate Treatment Ordered

On April 13, 1972, Judge Johnson handed down the third Wyatt Order and Opinion in two parts, one pertaining to Partlow and the other pertaining to Bryce and Searcy. * Although there are naturally some specific differences between them, both final orders and opinions set minimum standards for constitutionally and medically required adequate treatment, and establish a detailed procedure for implementation. Standards ordered for both the mental illness and mental retardation facilities include: a provision against uncompensated patient labor; a number of protections to insure a humane psychological environment; minimum staffing standards; detailed physical standards; minimum nutritional requirements; a provision for individualized evaluations of residents; treatment plans and programs; a provision to ensure that residents released from Alabama's institutions will be provided

* These final Orders and Opinions can be found at 344 F. Supp. 373 and 344 F. Supp. 387 (M.D. Ala. 1972) respectively.

with appropriate transitional care; and a requirement that every mentally impaired person has a right to the least restrictive setting necessary for treatment. (See Appendix A at the end of booklet for the full standards for Bryce and Searcy and Appendix B for the full Standards for Partlow.)

To implement this Order, the Court appointed a seven member "human rights committee" for each institution, including a resident on each committee. The human rights committee was to "review all research proposals and all rehabilitation programs, to insure that the dignity and human rights of patients are preserved. " It was also empowered to advise and assist patients who allege that their legal rights have been violated or that the Mental Health Board has failed to comply with judicially ordered guidelines. The Court further ordered that the State submit a compliance report with the Court on implementation of the Order within six months. Reasonable attorneys' fees to plaintiffs' lawyers to be taxed against the defendants were also awarded.

In emphasizing the need for immediate legislative action to remedy the situation, the Court expressed deep concern for the citizens of Alabama:

Not only are the lives of the patients currently confined at Bryce and Searcy at stake, but also at issue are the well-being and security of every citizen of Alabama. As is true in the case of any disease, no one is immune from the peril of mental illness. The problem, therefore, cannot be overemphasized and a prompt response from the Legislature, the Mental Health Board and other responsible State officials, is imperative.

WHAT ARE THE CONSTITUTIONAL ARGUMENTS FOR THE RIGHT TO TREATMENT?

There are three basic constitutional provisions which arguably establish a right to treatment:

Due Process— The 14th Amendment states that no person can be deprived of liberty without due process of law. This provision has been interpreted to require that governmental action affecting individual liberties be consistent with "fundamental fairness. " Applying the due process clause to the situation of a mentally handicapped person who had been involuntarily confined, the Supreme Court recently stated that the nature and duration of confinement must bear a reasonable relationship to the purpose of that commitment. Since a mentally handicapped person subject to civil commitment is denied the full range of procedural safeguards made available to criminal defendants, and since the mentally handicapped person can be confined for an indefinite term even though he has committed no criminal act, fundamental fairness requires that treatment and not mere custody be the necessary quid pro quo for his loss of liberty. As the District Court in Wyatt stated:

Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed 'into a penitentiary where one could be held indefinitely for no convicted offense.' 325 F. Supp. at 784. (citations ommitted).

Equal Protection of the Laws — The 14th Amendment also prohibits denial to any citizen or group of citizens equal protection of the laws. Under this constitutional provision, courts must scrutinize classifications of citizens to assure that classifications are reasonable. Classifying certain persons as "mentally handicapped" and subsequently depriving them of their liberty is reasonable only if

treatment is provided. Even in those states where the mentally ill must also be "dangerous" before commitment is authorized, treatment remains a necessary quid pro quo for involuntary commitment. If treatment is not afforded, then the entire system of classification is unreasonable and the mentally handicapped are denied equal protection, because they alone are picked out for "preventive detention" while all other dangerous people who have not actually committed criminal acts are allowed to remain free.

Cruel and Unusual Punishment — The 8th Amendment prohibits cruel and unusual punishment. The Supreme Court has held that punishing a sickness as if it were a criminal offense violates this prohibition. Since civil commitment of a mentally handicapped person without treatment amounts to punishing him for his sickness, such commitment violates the 8th Amendment.

A second, more narrowly framed, version of the 8th Amendment argument follows from analogous cases on prison conditions. The conditions in Alabama's mental institutions — the physical deprivation, the lack of basic sanitation, the over-crowding, the lack of physical exercise, the inadequate diet, the unchecked violence of inmates against each other and of employees against inmates, the lack of adequate medical care and psychiatric care, the abuse of solitary confinement and restraint — all bear a close resemblance to conditions which have been held to violate the 8th Amendment in cases involving the incarceration of convicted criminals and persons accused of crime. It follows, therefore, that these conditions would also constitute cruel and unusual punishment for persons who have committed no criminal acts and who are civilly confined because of their mental handicap.

HAVE THERE BEEN ANY RECENT CASES HOLDING THAT THERE IS NO RIGHT TO TREATMENT?

Yes. In Burnham v. State of Georgia (Civil Action No. 16385, N. D. Ga.), Judge Smith held that there is no constitutional right to treatment, and thus did not find it necessary to schedule a hearing on conditions in the Georgia mental institutions. Judge Smith suggested that the treatment of involuntary patients in mental institutions is not a "justiciable issue" — an issue capable of definition and resolution by a court. While Judge Smith was aware of the Wyatt decision, he stated, "this Court respectfully disagrees with the conclusion reached by that Court in finding an affirmative federal right to treatment absent a statute so requiring. "

WHAT IS HAPPENING TO THE WYATT AND BURNHAM CASES NOW?

The Wyatt case has been appealed by Governor Wallace and the Alabama Department of Mental Health. In December, 1972, the case was heard before the Fifth Circuit Court of Appeals in New Orleans together with an appeal by plaintiffs from the Burnham decision. In addition, a number of right to treatment cases have been filed in other states and are now awaiting decision. *

WHAT HAS HAPPENED TO DATE AS A RESULT OF WYATT?

While it is still too early to evaluate the final impact of Wyatt on the delivery of mental health care services in Alabama, some important developments have already occurred. The State Mental Health Board administrations of Partlow, Bryce and Searcy have attempted

* See first footnote, page 42.

to comply with the standards of treatment adopted by the Court, and claim to be moving in these directions: greatly increasing staff; seeking out sources of funds to cope with the much higher level of expenditure required; development of community transitional care programs; and reduction of the hospital population by release or transfer of patients who could be adequately cared for elsewhere.

Since the filing of the suit (and partly because of the publicity it has generated), the legislature has voluntarily made an unprecedented 38% increase in appropriations to the Mental Health Board. Daily per-resident expenditures at Bryce, Partlow and Searcy have increased from \$5.03 in 1967 to \$10.50 during 1972. *

WHAT IS THE ROLE OF EXPERTS IN CASES INVOLVING THE RIGHTS OF THE MENTALLY HANDICAPPED?

Experts are vital for many aspects of right to treatment litigation. Psychiatrists, psychologists, special educators, social workers, vocational rehabilitation specialists, and others are needed first to review hospital staffing ratios, budgets, etc. On the basis of this information alone, these experts may be able to conclude that the treatment is inadequate without having to tour the facilities.

However, experts must tour the institution when the factual situation is seriously at issue. During their tour, experts should interview staff and observe conditions with a view to presenting their observations and conclusions to the parties and ultimately testifying in court.

* Brief of Appellant Governor George C. Wallace, Fifth Circuit, #72-2634 -- Wyatt v. Aderholt, on appeal from the United States District Court for the Middle District of Alabama, Northern Division.

No case should be brought until substantial factual inquiry has been undertaken and, at least, a preliminary survey of expert opinion made.

If the court finds a violation of plaintiffs' rights, experts are indispensable in helping the court to develop treatment standards. In Wyatt, plaintiffs, defendants, and amici agreed to a large number of specific standards for adequate treatment, and experts then offered testimony explaining to the Court why certain standards were necessary to insure adequate treatment. The testimony and standards developed in Wyatt should be instructive and helpful in other treatment suits. The Court held that the standards stipulated to by plaintiffs, defendants, and amici were to be implemented as constitutionally required minimums.

WHY IS IT IMPORTANT TO DEVELOP FULLY THE FACTS CONCERNING CONDITIONS IN A MENTAL INSTITUTION?

Before bringing a legal action calculated to vindicate inmates' rights, it is vital to have as accurate a picture as possible about the conditions existing in the mental institution. Although in theory perhaps the law is abstract and absolute, in practice, no judge is able to divorce his legal opinion entirely from his own personal values and from a natural human sense of outrage at certain unjust conditions. In two recent right to treatment decisions, (Wyatt and Burnham) federal district court judges differed diametrically on the law. One judge held there is a constitutional right to adequate treatment for involuntarily confined patients, and the other judge held that although there might be an ethical or social right to treatment, this right was not specifically protected by the Constitution. The different decisions might be attributable in part to the factual preparation done prior to the filing of Wyatt. Careful fact investigation and presentation provide the incentive for a judge to take a certain view of the case legally. If, for example,

in a right to treatment suit, plaintiffs can demonstrate an inhumane psychological and physical environment, a total lack of individualized treatment plans and programs, and drastically inadequate staffing (as were shown to exist in the Wyatt case), the picture of these conditions and the effect of such institutionalization upon the inmates will inevitably be in the mind of the judge as he decides the basic legal issue of whether they have a constitutional right to treatment.

WHAT IS THE ADVANTAGE, IF ANY, OF A CLASS ACTION LIKE WYATT AS COMPARED WITH A PRIVATE ACTION SUCH AS ROUSE?

In bringing right to treatment cases, a class action such as Wyatt may be more effective in gaining relief for a large number of patients and affecting social policy than a patient-by-patient adjudication of rights. Rouse v. Cameron*, for example, was based on a habeas corpus petition on behalf of only one patient, Charles Rouse.

There are several reasons why it may be more desirable to bring a class action rather than a private one, particularly when the primary purpose is to secure a change in the practices of large institutions: (1) if the named plaintiff is dropped from the case, the whole action does not necessarily become "moot;" (2) any final relief granted by the court is for all members of the class, and is not limited to the named plaintiff; and (3) any member of the class can initiate contempt proceedings if the order is not carried out with respect to him.

A class action may be the most efficient way of getting relief for a large number of persons because similar claims can be settled in one lawsuit rather than a host of individual actions which are both time-consuming and costly.

* Discussed at p. 5.

A class action may be brought on behalf of residents of all the state's mental institutions; all residents of one institution; or a smaller group of residents, such as the residents of a particular unit. This decision will depend on whether inadequate treatment is a system-wide problem or one that is particularly acute in a few units within the system.

A class action may be brought on behalf of the mentally ill or the mentally retarded, separately, or the two groups may be treated as a single class. In view of the differences in what constitutes an adequate treatment program for the two groups, it will often be preferable to keep the two groups distinct.

It should be noted, however, that if a class action is lost, it may be much more difficult for others in the class to bring another suit on the same issues involving the same circumstances.

HAVE MONEY DAMAGES EVER BEEN AWARDED TO A PATIENT BECAUSE OF A FAILURE TO PROVIDE HIM WITH ADEQUATE TREATMENT?

In Donaldson v. O'Connor Civ. Action No. 1693, (N. D. Fla., decided Nov. 28, 1972), a recent decision in the Federal District Court in Tallahassee, Florida, damages were awarded to a patient who was kept in a state hospital for many years without adequate treatment. Damages of \$38,000 were assessed against the Superintendent of Florida State Hospital and a staff psychiatrist at that hospital individually -- not against the State.

In its charge to the jury, the Court instructed that "the burden was upon the plaintiff to establish by a preponderance of the evidence that the defendant doctors confined plaintiff against his will, knowing that he was not mentally ill or dangerous, or knowing that if mentally ill he was not receiving treatment for his alleged mental illness. "

The Court also instructed the jury "that a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such individual treatment as will give him a realistic opportunity to be cured or to improve his or her mental condition."

Finally, the Court instructed the jury that in order to recover, the plaintiff did not have to prove that defendants acted in bad faith or maliciously. He simply had to establish that he was not dangerous, and received only custodial care, all of which was known to defendants.

WHAT ABOUT THE ARGUMENT THAT TREATMENT IS TOO COMPLEX AND DIFFICULT A CONCEPT FOR A COURT TO DEAL WITH AND SHOULD BE LEFT TO THE DISCRETION OF PROFESSIONALS?

The Burnham Court wrote that the treatment issue does not provide "judicially ascertainable and manageable standards." In other words, vindication of plaintiffs' alleged right to treatment would be so difficult and complex that courts cannot consider their complaint. But, this task is not as impossible as the Burnham Court suggests. It is important to remember that in the Wyatt case, agreement was reached among plaintiffs, defendants, and amici on almost all of the minimum standards for adequate treatment ordered by the District Court. These stipulated standards were supported and supplemented by testimony of numerous expert witnesses. There was a striking degree of consensus among the experts, including defendants' own experts, as to the minimum standards for adequate treatment. The Wyatt Court, with the expert assistance provided by the parties and amici, found it quite possible to develop "judicially ascertainable and manageable standards." Even on appeal in the Wyatt case, the defendants do not challenge any of the standards of adequate treatment adopted by the District Court and are only asking for a ruling on whether there is a constitutional

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One criticism of the Wyatt case has been that the establishment and policing of individual treatment cannot be done by a court and should be left to the discretion of the professionals rendering the services. Defendants in Wyatt argued that a court should not and cannot choose among various psycho-therapies in order to assure that constitutionally adequate treatment is provided. But, this objection involves a misunderstanding of the Wyatt approach. The emphasis in Wyatt was in assuring the existence of those conditions, which are a precondition to any kind of therapy - - a humane physical and psychological environment, adequate staff, and individualized treatment plans. In this context, the court does not choose a specific treatment, but makes possible a range of treatment alternatives which persons rendering direct services can choose from.

It is further important to emphasize that the standards developed in Wyatt are minimums. In ordering the implementation of the standards, the Court stressed that:

These standards are, indeed, both medical and constitutional minimums and should be viewed as such. The Court urges that once the order is effectuated, defendants not become complacent and self-satisfied. Rather, they should dedicate themselves to providing physical conditions and treatment programs at Alabama's mental institutions that substantially exceed medical and constitutional minimums.

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Another criticism which has been lodged against the set of objective standards set forth in Wyatt is that the standards may become obsolete and lock the operation of an institution into outmoded treatment methods. This objection, however, is easily accommodated. In setting measurable standards, the courts do not intend that such standards remain inflexible; quite the contrary, any standards developed by the courts should be in keeping with social and medical advances and should be reviewed and modified when necessary. In Wyatt, for example, changes in the recommended staffing ratios are specifically permitted "upon a clear and convincing demonstration that the proposed deviation from this staffing structure will enhance the treatment of the patients."

However, in cases where the constitutional rights of patients are being violated, the courts must step in and impose basic minimum standards which reflect the best present knowledge, even while recognizing that specific standards may eventually become outmoded.

WHAT IF THE STATE OF ALABAMA LACKS THE FISCAL RESOURCES TO IMPLEMENT THE COURT-ORDERED CONSTITUTIONALLY REQUIRED MINIMUM STANDARDS FOR ADEQUATE TREATMENT?

Before tackling this very difficult question, it is appropriate to point out that, as in the case in Alabama, very often mental health administrators and hospital directors know that their level of care and/or treatment is woefully inadequate. Their hands are tied, however, because the legislature has not provided sufficient funding to institute needed programs. In this situation, the mental health professional is caught in the middle of a frustrating dilemma. Hopefully, with the passage of time and the help of favorable court decisions, public opinion may persuade legislatures to voluntarily increase appropriations sufficiently to make it possible to provide adequate care and treatment.

Recognizing, however, that the lack of financial resources might be cited as a justification by administrators for failing to implement its order, the Wyatt Court emphasized that "failure by defendants to comply with this decree cannot be justified by a lack of operating funds. . . . the unavailability of neither funds, nor staff and facilities, will justify a default by defendants in the provision of suitable treatment for the mentally ill. "

With regard to the excuse that there is not enough money to implement a program which provides adequate treatment for the mentally impaired, one can only stress that what is being dealt with in cases like Wyatt are constitutional rights -- rights which exist now and which must be promptly vindicated. As Judge Johnson stated:

The responsibility for appropriate funding ultimately must fall, of course, upon the State Legislature and, to a lesser degree, upon the defendant Mental Health Board of Alabama. For the present time, the Court will defer to those bodies in hopes that they

number of agreements which were then presented to the Court. These standards were supported and supplemented by the many distinguished experts who testified at the latter two hearings held by the District Court in this case -- one on February 3-4, 1972 (re Bryce and Searcy) and the other on February 28 - March 1, 1972 (re Partlow). The broad agreements reached were very important as will become clear during later discussion.

It should be noted that the expert testimony established that inmates of Alabama's mental institutions were not only deprived of treatment, but even the most minimal stimulation, resulting in deterioration of their condition. The experts stated that although conditions in Alabama were very substandard, they were "no worse than those in many of our largest and richest states. " To choose an illustration from the testimony, Dr. Gunnar Dybwad testified as to the profoundly dehumanizing effects of confinement upon the residents of Partlow in the following terms:

I think if you walk through Partlow, you can see it; you can see the effect — the people who begin to become involved in eccentric mannerisms, the rocking back and forth, peculiar behavior mechanisms, the people who sit in a semi-stupor in a place, without any activity, the people who slowly deteriorate and turn to the simple elements of human behavior I can assure you that this kind of behavior is due to neglect and is not an outcome of the mental retardation, itself. . . . In other words, it is a deterioration. I would further now add to this from my own observations, but not at Partlow that we have ample documentation in this country that individuals who come to institutions and can walk stop walking, who come to institutions and can talk will stop talking, who come to institutions and can feed themselves will stop feeding themselves; in other words, in many other ways, a steady process of deterioration.

Testimony about Partlow established that inmates were constantly in danger from assaults from guards and other inmates and that in the recent past four inmates had died due to the negligence and lack of supervision by hospital staff.

As a result of this testimony, the Court issued an emergency order to protect the lives of Partlow inmates. The Court ordered the State to hire 300 new aide-level employees within 30 days. In the implementation of that order the State was told to bypass Civil Service or other formal procedures which would delay hiring. Within 10 days after the Order was made public, more than 1,000 persons had applied for jobs, and the quota was met. Other terms included making immediate changes to make the buildings fire safe and to control the distribution of drugs.

Standards of Adequate Treatment Ordered

On April 13, 1972, Judge Johnson handed down the third Wyatt Order and Opinion in two parts, one pertaining to Partlow and the other pertaining to Bryce and Searcy. * Although there are naturally some specific differences between them, both final orders and opinions set minimum standards for constitutionally and medically required adequate treatment, and establish a detailed procedure for implementation. Standards ordered for both the mental illness and mental retardation facilities include: a provision against uncompensated patient labor; a number of protections to insure a humane psychological environment; minimum staffing standards; detailed physical standards; minimum nutritional requirements; a provision for individualized evaluations of residents; treatment plans and programs; a provision to ensure that residents released from Alabama's institutions will be provided

* These final Orders and Opinions can be found at 344 F. Supp. 373 and 344 F.Supp. 387 (M.D.Ala. 1972) respectively.

with appropriate transitional care; and a requirement that every mentally impaired person has a right to the least restrictive setting necessary for treatment. (See Appendix A at the end of booklet for the full standards for Bryce and Searcy and Appendix B for the full Standards for Partlow.)

To implement this Order, the Court appointed a seven member "human rights committee" for each institution, including a resident on each committee. The human rights committee was to "review all research proposals and all rehabilitation programs, to insure that the dignity and human rights of patients are preserved. " It was also empowered to advise and assist patients who allege that their legal rights have been violated or that the Mental Health Board has failed to comply with judicially ordered guidelines. The Court further ordered that the State submit a compliance report with the Court on implementation of the Order within six months. Reasonable attorneys' fees to plaintiffs' lawyers to be taxed against the defendants were also awarded.

In emphasizing the need for immediate legislative action to remedy the situation, the Court expressed deep concern for the citizens of Alabama:

Not only are the lives of the patients currently confined at Bryce and Searcy at stake, but also at issue are the well-being and security of every citizen of Alabama. As is true in the case of any disease, no one is immune from the peril of mental illness. The problem, therefore, cannot be overemphasized and a prompt response from the Legislature, the Mental Health Board and other responsible State officials, is imperative.

WHAT ARE THE CONSTITUTIONAL ARGUMENTS FOR THE RIGHT TO TREATMENT?

There are three basic constitutional provisions which arguably establish a right to treatment:

Due Process— The 14th Amendment states that no person can be deprived of liberty without due process of law. This provision has been interpreted to require that governmental action affecting individual liberties be consistent with "fundamental fairness. " Applying the due process clause to the situation of a mentally handicapped person who had been involuntarily confined, the Supreme Court recently stated that the nature and duration of confinement must bear a reasonable relationship to the purpose of that commitment. Since a mentally handicapped person subject to civil commitment is denied the full range of procedural safeguards made available to criminal defendants, and since the mentally handicapped person can be confined for an indefinite term even though he has committed no criminal act, fundamental fairness requires that treatment and not mere custody be the necessary quid pro quo for his loss of liberty. As the District Court in Wyatt stated:

Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed 'into a penitentiary where one could be held indefinitely for no convicted offense.' 325 F. Supp. at 784. (citations omitted).

Equal Protection of the Laws -- The 14th Amendment also prohibits denial to any citizen or group of citizens equal protection of the laws. Under this constitutional provision, courts must scrutinize classifications of citizens to assure that classifications are reasonable. Classifying certain persons as "mentally handicapped" and subsequently depriving them of their liberty is reasonable only if

treatment is provided. Even in those states where the mentally ill must also be "dangerous" before commitment is authorized, treatment remains a necessary quid pro quo for involuntary commitment. If treatment is not afforded, then the entire system of classification is unreasonable and the mentally handicapped are denied equal protection, because they alone are picked out for "preventive detention" while all other dangerous people who have not actually committed criminal acts are allowed to remain free.

Cruel and Unusual Punishment — The 8th Amendment prohibits cruel and unusual punishment. The Supreme Court has held that punishing a sickness as if it were a criminal offense violates this prohibition. Since civil commitment of a mentally handicapped person without treatment amounts to punishing him for his sickness, such commitment violates the 8th Amendment.

A second, more narrowly framed, version of the 8th Amendment argument follows from analogous cases on prison conditions. The conditions in Alabama's mental institutions — the physical deprivation, the lack of basic sanitation, the over-crowding, the lack of physical exercise, the inadequate diet, the unchecked violence of inmates against each other and of employees against inmates, the lack of adequate medical care and psychiatric care, the abuse of solitary confinement and restraint — all bear a close resemblance to conditions which have been held to violate the 8th Amendment in cases involving the incarceration of convicted criminals and persons accused of crime. It follows, therefore, that these conditions would also constitute cruel and unusual punishment for persons who have committed no criminal acts and who are civilly confined because of their mental handicap.

HAVE THERE BEEN ANY RECENT CASES HOLDING THAT THERE IS NO RIGHT TO TREATMENT?

Yes. In Burnham v. State of Georgia (Civil Action No. 16385, N. D. Ga.), Judge Smith held that there is no constitutional right to treatment, and thus did not find it necessary to schedule a hearing on conditions in the Georgia mental institutions. Judge Smith suggested that the treatment of involuntary patients in mental institutions is not a "justiciable issue" — an issue capable of definition and resolution by a court. While Judge Smith was aware of the Wyatt decision, he stated, "this Court respectfully disagrees with the conclusion reached by that Court in finding an affirmative federal right to treatment absent a statute so requiring. "

WHAT IS HAPPENING TO THE WYATT AND BURNHAM CASES NOW?

The Wyatt case has been appealed by Governor Wallace and the Alabama Department of Mental Health. In December, 1972, the case was heard before the Fifth Circuit Court of Appeals in New Orleans together with an appeal by plaintiffs from the Burnham decision. In addition, a number of right to treatment cases have been filed in other states and are now awaiting decision. *

WHAT HAS HAPPENED TO DATE AS A RESULT OF WYATT?

While it is still too early to evaluate the final impact of Wyatt on the delivery of mental health care services in Alabama, some important developments have already occurred. The State Mental Health Board administrations of Partlow, Bryce and Searcy have attempted

* See first footnote, page 42.

to comply with the standards of treatment adopted by the Court, and claim to be moving in these directions: greatly increasing staff; seeking out sources of funds to cope with the much higher level of expenditure required; development of community transitional care programs; and reduction of the hospital population by release or transfer of patients who could be adequately cared for elsewhere.

Since the filing of the suit (and partly because of the publicity it has generated), the legislature has voluntarily made an unprecedented 38% increase in appropriations to the Mental Health Board. Daily per-resident expenditures at Bryce, Partlow and Searcy have increased from \$5.03 in 1967 to \$10.50 during 1972. *

WHAT IS THE ROLE OF EXPERTS IN CASES INVOLVING THE RIGHTS OF THE MENTALLY HANDICAPPED?

Experts are vital for many aspects of right to treatment litigation. Psychiatrists, psychologists, special educators, social workers, vocational rehabilitation specialists, and others are needed first to review hospital staffing ratios, budgets, etc. On the basis of this information alone, these experts may be able to conclude that the treatment is inadequate without having to tour the facilities.

However, experts must tour the institution when the factual situation is seriously at issue. During their tour, experts should interview staff and observe conditions with a view to presenting their observations and conclusions to the parties and ultimately testifying in court.

*** Brief of Appellant Governor George C. Wallace, Fifth Circuit, #72-2634 -- Wyatt v. Aderholt, on appeal from the United States District Court for the Middle District of Alabama, Northern Division.**

No case should be brought until substantial factual inquiry has been undertaken and, at least, a preliminary survey of expert opinion made.

If the court finds a violation of plaintiffs' rights, experts are indispensable in helping the court to develop treatment standards. In Wyatt, plaintiffs, defendants, and amici agreed to a large number of specific standards for adequate treatment, and experts then offered testimony explaining to the Court why certain standards were necessary to insure adequate treatment. The testimony and standards developed in Wyatt should be instructive and helpful in other treatment suits. The Court held that the standards stipulated to by plaintiffs, defendants, and amici were to be implemented as constitutionally required minimums.

WHY IS IT IMPORTANT TO DEVELOP FULLY THE FACTS CONCERNING CONDITIONS IN A MENTAL INSTITUTION?

Before bringing a legal action calculated to vindicate inmates' rights, it is vital to have as accurate a picture as possible about the conditions existing in the mental institution. Although in theory perhaps the law is abstract and absolute, in practice, no judge is able to divorce his legal opinion entirely from his own personal values and from a natural human sense of outrage at certain unjust conditions. In two recent right to treatment decisions, (Wyatt and Burnham) federal district court judges differed diametrically on the law. One judge held there is a constitutional right to adequate treatment for involuntarily confined patients, and the other judge held that although there might be an ethical or social right to treatment, this right was not specifically protected by the Constitution. The different decisions might be attributable in part to the factual preparation done prior to the filing of Wyatt. Careful fact investigation and presentation provide the incentive for a judge to take a certain view of the case legally. If, for example,

in a right to treatment suit, plaintiffs can demonstrate an inhumane psychological and physical environment, a total lack of individualized treatment plans and programs, and drastically inadequate staffing (as were shown to exist in the Wyatt case), the picture of these conditions and the effect of such institutionalization upon the inmates will inevitably be in the mind of the judge as he decides the basic legal issue of whether they have a constitutional right to treatment.

WHAT IS THE ADVANTAGE, IF ANY, OF A CLASS ACTION LIKE WYATT AS COMPARED WITH A PRIVATE ACTION SUCH AS ROUSE?

In bringing right to treatment cases, a class action such as Wyatt may be more effective in gaining relief for a large number of patients and affecting social policy than a patient-by-patient adjudication of rights. Rouse v. Cameron*, for example, was based on a habeas corpus petition on behalf of only one patient, Charles Rouse.

There are several reasons why it may be more desirable to bring a class action rather than a private one, particularly when the primary purpose is to secure a change in the practices of large institutions: (1) if the named plaintiff is dropped from the case, the whole action does not necessarily become "moot;" (2) any final relief granted by the court is for all members of the class, and is not limited to the named plaintiff; and (3) any member of the class can initiate contempt proceedings if the order is not carried out with respect to him.

A class action may be the most efficient way of getting relief for a large number of persons because similar claims can be settled in one lawsuit rather than a host of individual actions which are both time-consuming and costly.

* Discussed at p. 5.

A class action may be brought on behalf of residents of all the state's mental institutions; all residents of one institution; or a smaller group of residents, such as the residents of a particular unit. This decision will depend on whether inadequate treatment is a system-wide problem or one that is particularly acute in a few units within the system.

A class action may be brought on behalf of the mentally ill or the mentally retarded, separately, or the two groups may be treated as a single class. In view of the differences in what constitutes an adequate treatment program for the two groups, it will often be preferable to keep the two groups distinct.

It should be noted, however, that if a class action is lost, it may be much more difficult for others in the class to bring another suit on the same issues involving the same circumstances.

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The responsibility for appropriate funding ultimately must fall, of course, upon the State Legislature and, to a lesser degree, upon the defendant Mental Health Board of Alabama. For the present time, the Court will defer to those bodies in hopes that they

will proceed with the realization and understanding that what is involved in this case is not representative of ordinary governmental functions such as paving roads and maintaining buildings. Rather, what is so inextricably intertwined with how the Legislature and Mental Health Board respond to the revelations of this litigation is the very preservation of human life and dignity.
(Emphasis added)

SINCE THE ORDER IN WYATT , HAS ALABAMA LOCATED ANY NEW FUNDS FOR IMPLEMENTATION?

A major assist for the decision's implementation has been the location of a large source of Federal funds. It is hoped that with the aid of several million dollars of Federal funds to be channelled through the State of Alabama Department of Pensions and Security a number of programs can be carried out: improvement in overall conditions at Alabama's mental institutions in compliance with Judge Johnson's standards; development of Regional Centers; sub-contracting of alternatives to living in the institution such as community placement centers; establishment of day care centers and sheltered workshops; and the signing of a diagnostic and evaluation contract, partly with the University of Alabama, in order to provide intensive testing on admission and periodically thereafter. For example, on June 7, 1972, the State Department of Pensions and Security under provisions of the Social Security Act, agreed to purchase services from the Mental Health Department for retarded persons who are current, former, or potential public assistance recipients. Under this contract, day care services will ultimately be provided for nearly 9,000 retarded children in various centers scattered throughout the state. The purpose of this program is to provide a way to help these children reach their full potential, in the

hopes that costly institutionalization will be avoided. Hopefully, the program will result in eventual placement of trainees in special education programs.

It was thought at one time that the federal funds available to Alabama for use in its mental health program might be as high as \$150 million. However, recent Congressional action on appropriations resulted in new ceilings on HEW expenditures which will cut the Alabama sources of funds down to about \$38 million. State officials are naturally disappointed at this turn of events. But even the much smaller grant of money available represents a sizeable increase in the funds available to mental health administrators in Alabama. Moreover, in addition to these other monies, the Court Order has been an impetus for the State to increase its own mental health budget substantially.

In the long run, the success of the ambitious undertakings suggested in Wyatt will depend heavily on the State's commitment of funds. Judge Johnson has stated that he will not let the inaction of the State Legislature defeat implementation of the Order. But final effectiveness of the Wyatt lawsuit will not be evident for some time.

IS THE RIGHT TO BE TREATED IN THE LEAST RESTRICTIVE SETTING AN ELEMENT IN RIGHT TO TREATMENT?

In Wyatt v. Stickney the District Court held that the right to be treated in the least restrictive setting necessary was an important element of the right to adequate and effective treatment. This means a person should not be hospitalized, with the drastic curtailment of liberty involved, if he can be treated in the community, at outpatient clinics, or community mental health centers.

Evidence indicates that long-term institutionalization in itself, leads to deterioration and can cripple the committed person in his

struggle to be released and to cope successfully with the more stressful outside world. The right to be treated in a setting less restrictive than an institution, however, not only makes sense from a therapeutic viewpoint, but is also required by the constitutional principle of "the least drastic means." The Constitution requires that whenever a government is going to restrict a person's liberty against his will in order to accomplish a legitimate governmental objective, it must impose the least drastic restriction necessary to accomplish the legitimate governmental objective.

This approach is set forth in early cases decided by the United States Court of Appeals for the District of Columbia Circuit. Lake v. Cameron, 364 F. 2d 657 (D.C. Cir. 1966), concerned a 60-year-old woman who had been found "wandering about" by a policeman. Mrs. Lake was admitted to St. Elizabeths Hospital for observation in connection with pending commitment proceedings. At both the commitment hearing where she was judged insane and a subsequent hearing, Mrs. Lake testified that she felt able to be at liberty. Psychiatric evidence presented found that Mrs. Lake was mentally ill and was suffering from a "chronic brain syndrome" associated with aging -- that she was somewhat senile; demonstrated poor memory; and was a "danger to herself in that she has a tendency to wander about the streets, and is not competent to care for herself." The Court of Appeals ruled that before committing Mrs. Lake to an institution, the District Court was required to inquire into less restrictive alternatives.

As the Court explained, in limiting the freedom of ill persons solely because of the danger to themselves, the Court should not go beyond what is necessary. In Mrs. Lake's case the complete restriction of liberty resulting from commitment to St. Elizabeths Hospital as a person of "unsound mind" did not seem necessary. The Court commented

This confirms the view of the Department of Health, Education and Welfare that the entire spectrum of science should be made available, including outpatient treatment, foster care, halfway_houses, day hospitals, nursing homes, etc. in interpreting the new D. C. Hospitalization of the Mentally Ill Act/.

The court's duty to explore alternatives in such a case as this is related also to the obligation of the state to bear the burden of exploration of possible alternatives an indigent cannot bear. This appellant . . . would not be confined in St. Elizabeths if her family were able to care for her or pay for the care she needs.

And . . . earnest effort should be made to review and exhaust available resources of the community in order to provide care reasonably suited to her needs.

AN another related case makes clear, the mentally ill or mentally retarded citizen's right to be treated in the least restrictive setting necessary to accomplish legitimate state goals requires the Court to canvass the range of possible dispositions within as well as without hospital Covington v. Harris, 419 F. 2d 617 (D. C. Cir. 1969). Applying the least restrictive alternative approach would assure release of inappropriately confined patients from hospitals. Hence, hospitals would be freed to treat those who really need treatment in an inpatient setting.

ISN'T ALL THIS GOING TO JUST LEAD TO BIGGER AND BETTER INSTITUTIONS?

Hopefully not. Standards such as were developed in Wyatt are costly in terms of both financial and manpower resources. Therefore, the full implementation of such standards should provide a disincentive to state systems to maintain the large institutions which exist today. This in turn should lead to greater investment in smaller facilities which keep patients closer to the community — which would be consistent both with sound fiscal and treatment policy as well as constitutional principles. The "Community Mental Health Centers Movement," begun in the early 1960's, has already made significant gains in this direction and furthers the principle of the less restrictive alternative approach.

RIGHT TO TREATMENT
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Right to Compensation for Institution—Maintaining Labor *

In many state mental institutions large numbers of residents (patients) are used as laborers in all menial aspects of hospital work. Cleaning, laundering, kitchen work, waiting tables and preparing food, maintenance housekeeping, and patient care are all performed in greater or lesser part by working residents. In exchange for this labor, working residents may be given open ward privileges or some other "symbolic" reward; they are virtually never paid the prevailing wage. This systematic exploitation of residents, the very people mental hospitals are intended to "treat," is known as "institutional peonage."

Institutional peonage exists in part because, given their meager appropriations, our mental institutions can't afford to pay regular employees for the work necessary to run the institutions.

HOW ARE RESIDENTS FORCED TO WORK?

Technically, most mental institutions would maintain that they do not force their residents to work. Incentives for work are substan-

***Throughout this chapter, institution-maintaining labor is used to describe labor which is needed for the operation or maintenance of the institution or work for which the institution is under contract with another organization. Institution-maintaining labor is to be distinguished from vocational training tasks not involving the operation or maintenance of the institution and from personal housekeeping tasks, such as the making of one's own bed.**

tial, however, and serve to coerce residents to conform to the institutional work norm. A resident's refusal to work often results in staff antagonism, restrictions on mobility and other privileges, or increased ----- It is not uncommon for the resident to be labeled uncooperative with negative effects on his efforts to be released when he fails to participate in the "Voluntary" work program.

Lewis Bartlett, M. D., a psychiatrist who has worked in mental hospitals and has written extensively about institutional peonage, has described the non-voluntary attributes of patient work programs as follows:

The work performed by state mental hospital patients is often described as voluntary. However, when such a patient "volunteers" for work that is by any standard degrading or boring, he is in reality surrendering to the compulsions of his institutional environment. Defenders of the system claim the patients "would rather work than sit on their hands all day," and this is true of those who are chosen to work and acquiesce. Yet patients who respond otherwise — the hostile, combative, and uncooperative individual on the disturbed ward and the listless, unresponsive one who, in effect, do sit on their hands — may be viewed as more prideful human beings than their leaf-raking colleagues of many years.

AREN'T ALL WORK ASSIGNMENTS THERAPEUTIC?

As the American Psychiatric Association (APA) recognizes under Standard 32 of its Standards for Psychiatric Facilities (1969), a clear distinction between therapeutic and nontherapeutic work assignments is essential. Under the APA guidelines, every possible safeguard is used to avoid the exploitation of residents. And it is recognized that programs that provide payment for work performed may contribute significantly to a resident's rehabilitation. Menial work assignments

made primarily for the convenience of the institution are in many cases antitherapeutic. Most ironically of all, a good work record may result in prolonging the patient's institutionalization rather than hastening his return to the outside. As Dr. Bartlett explains:

In other words, state hospitals need "good patients" who are useful, valuable, and expediently indispensable. But these relatively less ill patients, instead of being helped to overcome their illness, as is normally expected on behalf of the patients in any other medical care facility, are doomed by the institutional needs of the state mental hospital to the pathological dependency characteristic of "good patients."

HOW MANY RESIDENTS ACTUALLY WORK?

Thousands of residents in almost every state perform non-therapeutic work in mental institutions and facilities for retarded persons. In a study of state institutions by Pennsylvania's Department of Public Health in 1969, it was estimated that 11,905 residents were working. If the state could no longer rely on working residents, 3,302 new employees would have to be hired, an increase of 28% of the paid staff. The cost of this extra staff was estimated to be slightly more than \$11 million.

WHAT CAN BE DONE TO STOP THIS EXPLOITATION?

There are three legal approaches which are now being used in different states to remedy these conditions.

The Legislative Approach

A bill is pending in the Pennsylvania General Assembly to abolish institutional peonage. The proposed act would set up an administrative board to design a schedule of occupational classifications and

remuneration levels for categories of work which would then be applied to all working residents performing services for which the institution would have to hire a regular employee were resident labor unavailable. This bill would ensure that the therapeutic value of the resident's activities primary concern of the staff, with institutional needs clearly subordinated.

the Thirteenth Amendment Approach

A constitutional challenge to institutional peonage has recently been made. In a New York suit brought by the Mental Health Law Project on behalf of a former mental patient at Harlem Valley State Hospital for back wages and interest. Mrs. Long* the plaintiff, was admitted to Harlem Valley State Hospital in New York with a diagnosis of alcoholism. For the next sixteen years, she performed menial tasks in the kitchens < if of the hospital the sewing room on a regular basis, six and some-time* seven days a week.

Mrs. Long's suit is based upon the Thirteenth Amendment to the U. S. Constitution which forbids slavery and involuntary servitude except as punishment for convicted criminals. The State of New York's defense to this suit is that the work performed by Mrs. Long was "therapy" for her and thus could not fairly be characterized as "involuntary servitude" within the meaning of the Thirteenth Amendment. Mrs. Long's basic position is that any involuntary or coerced work — whether it is therapeutic or not — violates the Thirteenth Amendment's prohibition. But she has also sought to discredit the State of New York's defense that all her work was "therapy. "

During three days of hearings before the New York State Court of Claims, expert witnesses testified that the work performed by Mrs. Long during her institutionalization was exploitation of a patient in order to run the institution, and not therapy for her. These expert opinions

* This is a pseudonym.

were based upon the absence in this case of any evidence of the use of professional discretion or therapeutic motive in the assignment of work to Mrs. Long. The experts noted that Mrs. Long's work assignments in the kitchen, laundry and in various janitorial capacities were not entered into her record; were not formulated after a careful physical and mental examination and diagnosis; were not tailored to her individual needs; were not part of a larger, integrated treatment plan and active treatment program; were not properly supervised; were not periodically reviewed and adjusted if necessary; were not compensated; and were for the hospital's benefit and not the patient's.

The Fair Labor Standards Act Approach

Another legal approach to abolishing institutional peonage is based upon statutory grounds. Judge Johnson's Final Order in Wyatt v. Stickney * contains a standard on resident labor which specifically refers to the minimum wage provisions of the Fair Labor Standards Act (29 U. S. C. Sec. 201 et.seq.) and which requires all three of Alabama's mental institutions to pay voluntary working residents for institution-maintaining labor.

In addition, several pending cases rely upon the 1966 Amendments to the Fair Labor Standards Act of 1938, which extend minimum wage coverage to all non-federal hospital employees. These class action suits against responsible state officials include a claim for an injunction to force state officials to pay mental patients minimum wages for their work as covered employees of covered employers pursuant to the Fair Labor Standards Act. The plaintiff class also requests back wages for work performed since coverage became effective for state hospital employees.

*See Appendix A, Paragraph 18.

Another suit currently under consideration by the National association for Mental Health, the American Association on Mental deficiency and some individual parties would be aimed at requiring theUS. Labor Department itself to start enforcing the Fair Labor standards Act for all working residents of state institutions.

Right to Education

The purpose of this chapter is to set forth some of the major legal activity concerning the right of mentally and socially handicapped children to an appropriate education. This right is relatively broad, involving many educational and civil rights issues pertaining to a diverse group of handicapped children.

Seven million of today's children will need special education services. Only 2.8 million are now receiving them (40%); and 1 million are being totally excluded from any education which is publicly supported. *

IS THERE A RIGHT TO EDUCATION?

Education is not mentioned in the United States Constitution, which does, however, entitle persons to due process and equal protection of the laws. These are the constitutional underpinnings of the claimed right to a publicly supported education suited to the needs of each handicapped child.

Due Process

There are two kinds of due process — substantive and procedural. Substantive due process requires government action to be reasonable in purpose, method and impact. Procedural due process requires the government to proceed in a fair manner. This has often

***Weintraub, Frederick J., and Alan Abeson, "Appropriate Education for All Handicapped Children: A Growing Issue," Syracuse Law Review, Symposium Issue, Vol. 24, No. 4, December, 1972.**

required a hearing where the individual must be given the opportunity to present evidence, cross-examine and be represented by counsel.

the equal Protection

The equal protection provision prohibits the government from unfairly discriminating against an individual or a group of individuals. Thus when government undertakes to provide education for all, it cannot discriminate against a handicapped child by excluding or postponing his or her education. Furthermore, actions taken by government, as well as governmentally-devised procedures for handling objections to such actions, must be in accord with fundamental concepts of fairness. The "Right-to-Education Movement" has relied upon these arguments to further the principle that society must provide every child with the opportunity to be educated to his maximum capacity — whatever that may be or however that may be achieved by distribution of resources.

HOW IMPORTANT IS AN EDUCATION?

We have long recognized educational opportunity as the primary vehicle for social and economic advancement. More fundamentally, without access to education, other rights — such as the freedoms of speech, religion and association, and the right to peaceably assemble and petition the government — are diminished, perhaps to the point of nonexistence. As the Supreme Court held in its famous decision in *Brown v. Board of Education*:

Today, education is perhaps the most important function of state and local governments. Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society. It is required in the performance of our most basic public responsibilities, even service in the armed forces. It is the very foundation of good citizenship. Today, it is a principle

instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him to adjust normally to his environment. In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education. 347 U.S. 483, 493 (1954)_/

The Court was not considering the problems of handicapped children in the Brown case; yet, its rationale, as applied to such children, becomes even more compelling since the handicapped child may be completely dependent on skills which only an education can provide.

ARE HANDICAPPED CHILDREN BEING EXCLUDED FROM A PUBLICLY SUPPORTED EDUCATION UNDER STATE LAWS?

Every state has constitutional provisions for education and compulsory attendance laws. Under the latter, however, certain children may be excluded. The language in the District of Columbia's statute is typical:

The District of Columbia board of education may issue a certificate excusing a child from attendance if the child is found mentally or physically unable to profit from attendance in school, upon examination ordered by the board. If the examination shows that the child may benefit from specialized instruction adapted to his needs, he shall attend if such instruction is available. (Sec. 31-203 Rev. Stats.)

As one might have suspected, the effect of such provisions has been compulsory non-attendance for the handicapped child. The parent, allowed to remove his or her child from public school, has no correlative right to demand placement. *

*In fact, such a demand in North Carolina can be punishable as a misdemeanor.

Moreover, If the parent does not do the removing, the system government has a well-equipped arsenal at its disposal with which to rid the problem. " Exclusion, suspension, postponement, inappropriate placement, and reassignment and transfer are available and In most places, are unchecked by the protections of due process. their, •exclusion may be grounded in the assertion that the child is emotionally disturbed, mentally retarded or hyperactive; in the failure to satisfy an assumed level of behavioral performance (such as being toilet trained or, in the inability to "pass" a standardized test.

Subtler means are also available — such as the determination by the system) that special education is needed, followed by placement on a waiting list. The wait, however, often accompanied by "temporary" suspension, may be for months or years. Why? Not enough special education programs in the school system. The same situation exists •WHEN the wait is for tuition grants for private education. Why? No money any handicapped children are suspended from school because the untrained school employee sees the undiagnosed behavior as a problem of discipline. Others are placed in inappropriate programs, often without proper evaluation and without notice to the parents.

All of this adds up to the denial of an equal opportunity for education -- bureaucratically legal but, nonetheless, unconstitutional. Till* is what current legal activism is aimed against.

WHAT DO THE LEADING RIGHT TO EDUCATION CASES SAY?

Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania (PARC), 334 F. Supp. 1257 (E.D. Pa. 1971) and Mills v. Board of Education of the District of Columbia, Civ. Action No. 1039-71 (D. D. C. 1972) are the two landmark cases in this area and

and are being relied upon by lawyers throughout the country who are now litigating on behalf of handicapped children. *

In the PARC case, decided October 7, 1971, a three-judge federal district court, pursuant to a consent agreement by the parties, ** ordered that all mentally retarded children in Pennsylvania be accorded access to a free public program of education appropriate to their learning capacities. This provided the first important legal breakthrough in securing the right of mentally retarded persons to an education.

The plaintiffs in this class action*** were the Pennsylvania Association for Retarded Children, fourteen named retarded children who were denied an appropriate education at public expense in Pennsylvania, and all others similarly situated. The defendants were the Commonwealth of Pennsylvania, the Secretary of the Department of Education, the State Board of Education, the Secretary of the Department of Public Welfare, certain school districts and intermediate units in the Commonwealth of Pennsylvania, their officers, employees, agents and successors.

*For additional information about other right-to-education cases, see (1) A Continuing Summary of Pending and Completed Litigation Regarding the Education of Handicapped Children, available from the Council for Exceptional Children, 1411 S. Jefferson Davis Highway, Suite 900, Arlington, Virginia, 22202; and (2) Mental Retardation and the Law, available from the Office of Mental Retardation Coordination, Department of Health, Education and Welfare, Room 3744, North Building, 330 Independence Avenue, S.W., Washington, D. C. 20201.

**A consent agreement is an agreement between the parties on what needs to be done regarding a particular issue. The agreement is not final or binding until the court approves it and orders its implementation.

***See page 20 in the Right to Treatment Section for a discussion and explanation of a class action.

Articulation of the Constitutional Right

After an initial complaint was filed on January 7, 1971, the parties agreed to certain findings and conclusions and to relief to be proffered to the named plaintiffs and members of the class.

A stipulation approved and ordered into effect by the Court on June 18, 1971, focused on due process. The Court's order specifically required that no child alleged to be mentally retarded be denied admission to a public school program or have his educational status changed without first being accorded notice and the opportunity for a hearing. The order set forth due process requirements in detail, beginning with provisions to ensure notice to parents that their child is being considered for a change in educational status and ending with detailed provisions for a formal hearing, including representation by legal counsel; the right to examine the child's record before the hearing, present evidence and cross-examine other witnesses; the right to independent medical, psychological and educational evaluation; the right to a transcribed record of the hearing; and the right to a decision on the record.

Further agreements by the parties were ordered into effect on October 7, 1971. Under this order, defendants could no longer, in violation of the Fourteenth Amendment Equal Protection Clause, deny any mentally retarded child access to a free public program of education and training. The consent agreement states that:

Expert testimony in this action indicates that all mentally retarded persons are capable of benefiting from the program of education and training; the greatest number of retarded persons, given such education and training, are capable of achieving self-sufficiency, and the remaining few, with such education and training, are capable of achieving some degree of self-care; that the earlier such education and training begins, the more thoroughly and the

more efficiently the mentally retarded person will benefit from it; and, whether begun early or not, that a mentally retarded person can benefit at any point in his life and development from the program of education and training. . . . It is the Commonwealth's obligation to place each mentally retarded child in a free, public program of education and training appropriate to the child's capacity within the context of a presumption that, among the alternative programs of education and training required by statute to be available, placement in a regular public school class is preferable to placement in a special public school class, and placement in a special public school class is preferable to placement in any other type of program of education and training.

The defendants were ordered to re-evaluate the named plaintiffs immediately and as soon as possible but in no event later than October 13, 1971, to provide each with a free public program of education and training appropriate to his learning capacities.

The defendants were also ordered to provide every retarded person between the ages of 6 and 21 years with a free public program of education and training appropriate to his capacities as soon as possible, but in no event later than September 1, 1972.

The Court's order requires the State Department of Education to supervise educational programs within state institutions for the retarded, and to automatically re-evaluate all children placed on homebound instruction every three months.

To implement the relief described above and to assure its extension to all members of the class, the Court appointed two masters for the purpose of overseeing the process of identification, evaluation, notification, and compliance. Defendants were given a time schedule within which to formulate and submit to the masters for approval a plan for the implementation of the consent agreement.

the final Opinion

On May 5, 1972, the Court entered its final opinion, rejecting arguments by members of the defendant class who were not parties to the earlier stipulations that the Court lacked jurisdiction to decide this case and/or should abstain from deciding the case until a state court had first had opportunity to hear and decide plaintiffs' claim. The Court retained jurisdiction of the matter pending the final report of the masters on or before October 15, 1972.

HOW DOES THE MILLS CASE EXPAND THE PRINCIPLES OF PARC?

Mills v. Board of Education secures the right to an individually appropriate public education not only for the mentally retarded but for all children suffering or alleged to be suffering from mental, behavioral, emotional or physical handicaps or deficiencies. And, while PARC rested upon a consent agreement between the parties, Mills provides a constitutional holding reached by a federal judge in a contested case, and is thus of even stronger precedential value.

This decision is now final and not appealable. The history of the Mills decision is briefly as follows:

Articulation of the Constitutional Right

The named plaintiffs in Mills had been denied schooling because of alleged mental, behavioral, physical, or emotional handicaps or deficiencies. They sued on behalf of a class of children who were or would be residents of the District of Columbia, were of an age so as to be eligible for publicly supported education, and were then, were during the 1970-71 school year, or would be excluded, suspended, expelled or otherwise denied a full and suitable education. They asked the Court to declare their rights and to stop defendants from excluding them from

the District of Columbia Public Schools and/or from denying them publicly supported education and from failing to provide them with immediate and adequate education and educational facilities in the public schools or alternative placement at public expense, and also to give them additional relief to help effectuate the primary relief. Defendants in this case were the Board of Education and its members, the Mayor, the Director of the Department of Human Resources, the Director of the Social Security Administration, and various administrators of the District of Columbia School system. The defendants' answer to the complaint conceded their legal "duty to provide a publicly supported education to each resident of the District of Columbia who is capable of benefiting from such instruction. " Defendants' reason for failing to provide such an education was the lack of necessary fiscal resources.

Judge Joseph C. Waddy entered an interim order in December, 1971, requiring defendants to place the named plaintiffs in school and to make outreach efforts to identify other members of the plaintiff class. Defendants failed to comply with the order, and in January 1972, plaintiffs filed for summary judgment. At an open hearing on March 24th, Judge Waddy orally granted summary judgment for the plaintiffs but delayed issuance of his order. On April 7, the Board of Education and its employees submitted a proposed form of order and other materials. (Plaintiffs' proposed order had been previously filed.)

On August 1, 1972, Judge Waddy's final order and opinion were handed down. The Court stated that there was no genuine issue of material fact as to the District's responsibilities because Congress had set forth the responsibility for administering this system according to law, including the responsibility for providing education to all "exceptional" children. Although defendants admitted their affirmative duty, the Court noted that "throughout the proceedings it has been obvious to

the Court that the defendants have no common program or plan for the alleviation of the problems posed by this litigation and that this lack of communication, cooperation, and plan is typical and contributes to the problem." The Court based plaintiffs' entitlement to relief on applicable District of Columbia statutes and regulations and the United States constitution. The District of Columbia Code requires that parents or guardians enroll children between seven and sixteen in school and sets criminal penalties for parents' failure to comply. "The Court need not labor the fact that requiring parents to see that their children attend school under pain of criminal penalties presupposes that an educational opportunity will be made available to the children. "

Judge Waddy found plaintiffs' right to education within the due process of the Fifth Amendment, and cited Brown v. Board of Education outlawing school segregation, and Hobson v. Hansen, 269 F.SUPP 401 (D. C. D. C. 1967), abolishing the so-called track system in the District. The Court held that the defendants' conduct here, denying plaintiffs and their class not just an equal publicly supported education to which they are entitled, but many are suspended or expelled from regular schooling or specialized instruction or reassigned without any prior hearing and are given no periodic review thereafter. due process of law requires a hearing prior to exclusion, termination or classification into a special program. "

Judge Waddy further held that defendants' failure to fulfill their constitutionally-required duty could not be excused by a claim of insufficient funds:

If sufficient funds are not available to finance all of the services and programs that are needed in the system then the available funds must be expended equitably in such a manner that no child is entirely excluded from a publicly supported education consistent with his needs and ability to benefit therefrom.

The Final Opinion

To implement its decision, the Court placed responsibility with the Board of Education and warned that a special master with educational expertise would be appointed if a dispute arose between the Board and the District Government, or if there were inaction, delay, or failure by the defendants to implement the order within the time specified. The Court retained jurisdiction of the case to assure prompt implementation,

The Court ordered the District to offer all identified plaintiffs educational facilities within 30 days; directed the School System to establish elaborate hearing procedures under which no pupil could be placed in a special education program or be suspended from school for more than two days without a hearing;*and required the School Board to develop a comprehensive written plan for providing special education services and to identify those children who need such services within forty-five days.

WHAT ARE THE OTHER LEGAL AVENUES FOR PROTECTING THE EDUCATIONAL RIGHTS OF HANDICAPPED CHILDREN?

Negotiation

Although not strictly a legal solution, negotiation is an important option for concerned laymen and/or professionals either with or without a lawyer, to approach school officials with requests for reform. Where political power is amassed in support of such requested reform, the chances that changes can be negotiated are all the greater.

Attorney General's Opinions

If the attorney general of a state issues an opinion on a question of law, the various departments of the state will normally come into compliance with such opinions. For example, the right to education for all exceptional children was established in the State of New Mexico

* See Appendix C for court-ordered hearing and notice provisions.

In December, 1971, when Attorney General David L. Norman issued
the following opinion:

In providing equal learning opportunities for all children, the state, in our opinion, is required to offer equal educational opportunities to all children in the state. Thus, children who qualify for special education are entitled to a free public school education The state's obligation is to provide equal educational opportunities to all children in the state, regardless of their physical or mental capabilities.

Legislation

Legislative action, ultimately necessary to design comprehensive schemes and to provide necessary appropriations, is much more **likely** to occur after judicial decisions have delineated the rights of handicapped children. Constitutional principles articulated by a court of **law** can be referred to and used as leverage by a sympathetic legislator. It is one thing to stand on the legislative floor and say, "I think we should do so and so;" it is quite a different posture, however, to be able to say "If you do not pass this bill, you will be depriving the **mentally** handicapped of their constitutional rights."

In 1971, 899 bills addressing education for the handicapped were **Introduced** in state legislatures; 237 were enacted into law. * A bill signed into law in Tennessee (Public Chapter 839, 1972) in April, 1972, **Adopts** the major provisions of the Model Compulsory School Attendance Law and provides many of the same protections ordered in the PARC

***Marland, Sydney P., Jr., "Education of the Handicapped: Closer in Equality,"** Speech before the 50th Anniversary Convention, CEC, March, 1972.

****The Model Compulsory School Attendance Law is found in State Law and Education of Handicapped Children: Issues & Recommendations, Frederick Weintraub, Alan Abeson, David Braddock, Council for Exceptional Children, 1971, p. 110.**

and Mills cases. The Tennessee statute is an example of how similar results can be achieved by different strategies — in this case, legislation and litigation. In its opening sections, the statute provides:

SECTION 1: It is the policy of this state to provide, and to require school districts to provide, as an integral part of free school education, special education services sufficient to meet the needs and maximize the capabilities of handicapped children. The timely implementation of this policy to the end that all handicapped children actually receive the special education services necessary to their proper development is declared to be an integral part of the policy of this state. This section applies to all handicapped children regardless of the schools, institutions or programs by which such children are served.

SECTION 2B: To the maximum extent practicable, handicapped children shall be educated along with children who do not have handicaps and shall attend regular classes. Impediments to learning and to the normal functioning of handicapped children in the regular school environment shall be overcome by the provision of special aids and services rather than by separate schooling for the handicapped. Special classes, separate schooling or other removal of handicapped children from the regular educational environment, shall occur only when, and to the extent that the nature of severity of the handicap is such that education in regular classes, even with the use of supplementary aids and services, cannot be accomplished satisfactorily.

The statute also provides for full due process of law before a child can be excluded, suspended or transferred from a regular school program.

ARE THERE ANY OTHER SPECIAL CONSIDERATIONS OF WHICH CONCERNED CITIZENS AND POLICY-MAKERS SHOULD BE AWARE?

Before concluding the right-to-education chapter, it is important to note that there are many other issues which have not been addressed here, but which should be pursued by those concerned with the education of the handicapped. Three of these issues include: the appropriate education of children in institutions; the placement of handicapped children in special education programs; and the enforcement of state laws and court orders.

DO CHILDREN IN INSTITUTIONS POSSESS A RIGHT TO EDUCATION?

Throughout this document the importance of being provided an appropriate educational opportunity has been heavily stressed. But what about children who reside in institutions? Are they entitled to the same rights as children who live at home?

In Willowbrook, a state-run institution for the mentally retarded in New York, it has been charged that 80% of the residents do not participate in any type of educational program. * This is not an uncommon pattern in many state-run institutions which are responsible for the welfare of children and young adults.

In Wyatt v. Stickney, ** a recent right-to-treatment case involving three Alabama institutions, the Court ordered that:

Residents shall have a right to receive suitable educational services regardless of chronological age, degree of retardation or accompanying disabilities or handicaps School

***New York State Association for Retarded Children, et al. v. Rockefeller, et al., 72 Civ. Action No. 356 (E.D. New York), consolidated with Patricia Parisi, et al. v. Rockefeller, et al.**

****Now, Wyatt v. Aderholt (See page 8 for a fuller discussion of this case.)**

age residents shall be provided with a full and suitable educational program and such programs shall meet prescribed minimal standards.

Children cannot be deprived of their right to an education because they happen to live in an institution. In fact, the standards governing the operation of educational programs in institutions must be of the same high caliber as those required of all public schools within the relevant state system. Moreover, education of an institutionalized child does not have to take place within the confines of the institution. With special transportation, children who reside in institutions can participate in the regular classes of the local public schools, enabling the child to maintain normal community ties and enhancing his reintegration into society.

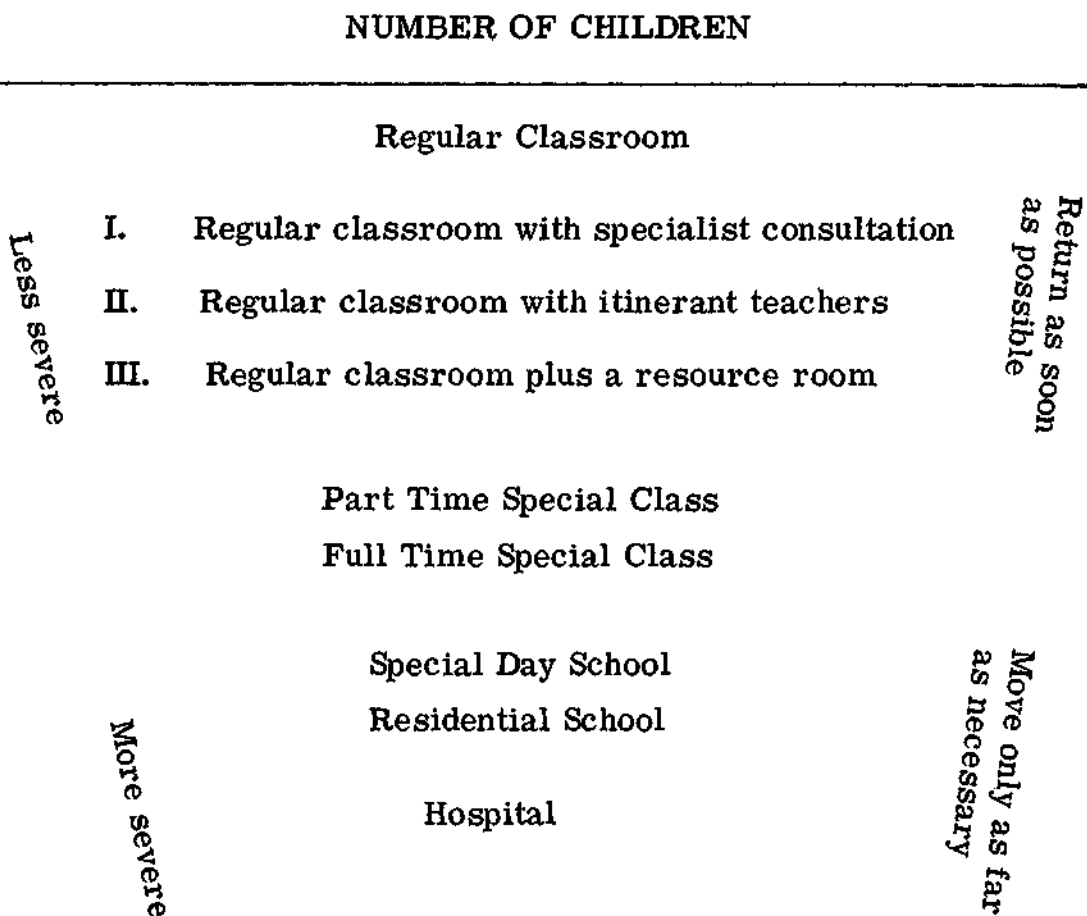
MUST ALL HANDICAPPED CHILDREN BE PLACED IN SPECIAL EDUCATION PROGRAMS?

Before answering this question, it is important to note that the issue of special education programs becomes particularly important when one considers the increased number of children being referred to these programs (largely from lower socio-economic groups), the influx of federal and state monies for such programs, and the rising demands from parents for more special education. In 1965, for example, Mackie reported that during the previous decade most states had doubled and in some cases tripled the number of teachers and related personnel in special education. *

By defining an "appropriate" education as one which is directed towards the abilities, needs, and limitations of the individual child, it

*Mackie, R. P., "Spotlight Advances in Special Education," *Exceptional Children*, 1965, Vol. 32, pp. 77-81.

follows that special or self-contained classes are not the appropriate placement for all handicapped children. The concept of special educational services includes a continuum of services, progressing from minimal to maximal amounts of special resources needed, and progressing from the least to the most restrictive setting necessary to accomplish legitimate state goals. One such proposed model is the "Cascade System:"*



*Reynolds, M., "A Framework for Considering Some Issues in Special Education," Exceptional Children, 1962, Vol. 28, pp. 367-370.

It is now recognized that there are probably many handicapped children who do not need any special education programs. For example, elimination of architectural barriers and appropriate scheduling has enable&physically handicapped children on crutches and in wheel-chairs to totally participate in regular educational programs. Thus, there simply is no basis for the assumption that every handicapped child requires special educational services.

If a child does require some type of special or adjunctive services during his educational career, as the Cascade Model implies, he should be moved "down" the cascade only as far as necessary and should be moved "back up" the cascade as soon as possible. Because it is impossible to accurately predict the learning or behavioral ceiling for any child, no placement decision can be final.

DO STATE LAWS AND COURT ORDERS GUARANTEE THAT HANDICAPPED CHILDREN WILL BE PROVIDED AN APPROPRIATE EDUCATION?

It is important for concerned citizens and policy-makers to remind the public that they cannot become complacent because, in their state, laws may have already been enacted mandating educational programs for the handicapped or court orders issued.

Approximately 70% of the states have mandatory provisions for the education of the handicapped. But having the **laws** on the books does not guarantee that they will be observed and implemented. For example, the Massachusetts State Law (Chapter 81, Section **46a**) makes it clear that the school system has the responsibility **to ensure the** education of the handicapped child, and to determine yearly **the number** of school-age handicapped children who reside in a **particular district** and to evaluate and provide for their educational **needs**. **As Congressman**

Vanik noted: *

Boston is a flagrant violation of the Massachusetts State Law in its virtual exclusion of the handicapped children from the public school system.

In general, crippled children in Boston are not allowed to attend school. And, except for isolated instances, they are prevented from attending school altogether. No one seems to know what happens to crippled children in Boston. No person, no agency knows how many crippled children there are, where they are, or what happens to them once they are rejected from the Boston school system. Not only does Boston exclude handicapped children from the public schools, but also does not follow up on the placement or nonplacement of the children. . . . The Boston school system's abdication of responsibility in this area has created an educational vacuum which no institution or agency is able to fill. A high cost in human suffering is being paid for the failure to provide educational services for those children. The greatest suffering is being borne by the children themselves.

The Boston situation is typical of that in many school districts which, in theory, operate under mandatory state law requiring the provision of educational services for the handicapped.

Judicial intervention is not a guarantee either. It will still be some time (perhaps years) before the PARC and Mills orders can be effectuated; and constant monitoring will be necessary to ensure that proper governmental action is taking place.

Legal activity, the catalyst and leverage for necessary change, is not a final solution. Because post-litigation complacency is always a danger, persons committed to the goal that all children receive an

¹Congressional Record, 92nd Congress, February 7, 1972.

education suited to their individual needs must bear the responsibility of keeping the issues alive and moving, and seeing that the right to education is not, because of apathy, rendered meaningless.

HAS PROGRESS BEEN MADE IN PROVIDING BETTER EDUCATIONAL SERVICES FOR HANDICAPPED CHILDREN?

There is no doubt that great progress has been made in providing appropriate educational services for handicapped children. This is reflected in public awareness, fiscal priorities, legal activity, and recognition of professional responsibility. But there is not yet cause for relaxation of effort. As one expert has commented:*

We can look at our accomplishments and be proud of the progress we have made; but satisfaction with the past does not assure progress in the future A growing child cannot remain static — he either grows or dies. We cannot become satisfied with a job one-third done. We have a long way to go before we can rest assured that the desires of the parents and the educational needs of handicapped children are being fulfilled.

Access to an appropriate education for the handicapped child is not a negotiable item. Nor can we accept the kinds of trade-offs which allow such things as tennis courts for the non-handicapped child while the handicapped child is denied an educational opportunity on the claimed ground that it will cost too much to provide the special services needed.

In sum, the issue at hand today is not how many handicapped children can be educated but when will all children be provided the educational opportunity which is their right.

*Graham, Ray, "Special Education for the Sixties," Illinois Education Study Unit, 1960, No. 23, pp. 1-4.

RIGHT TO EDUCATION
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Throughout this booklet, it has been shown that litigation can be an effective tool for vindicating the rights of the mentally handicapped. Test cases have heightened public consciousness about important legal rights of the mentally handicapped and have also changed the image and self-image of mentally handicapped persons themselves. Instead of begging for favors, these consumers are now demanding their constitutional rights.

As litigation has begun to focus public attention on the plight of the mentally handicapped, it has been tempting to put the blame on the other fellow. But the situation cannot be alleviated by finger-pointing or simply by tracing historical reasons for the existence of the worst kind of prejudice towards those who are the most vulnerable. Legislators could have legislated; mental health professionals and administrators could have been more aggressive in meeting the needs of their wards; the legal profession could have devoted itself far more earnestly to the constitutional issues at stake, and all of us could have been more aware and sympathetic.

In looking forward rather than backward, the Mental Health Law Project believes that the situation of the mentally handicapped will only be meaningfully improved when all of us have fully accepted the notion that the mentally handicapped have the same basic constitutional rights as everyone else and have begun to work in concert to see that such rights are realized.*

*** For a description of the Mental Health Law Project, see Appendix D.**

APPENDIX A

COURT-ORDERED STANDARDS FOR BRYCE AND SEARCY HOSPITALS

I. Definitions:

- a. "Hospital" — Bryce and Searcy Hospitals.
- b. "Patients" — all persons who are now confined and all persons who may in the future be confined at Bryce and Searcy Hospitals pursuant to an involuntary civil commitment procedure.
- c. "Qualified Mental Health Professional" --
 - (1) a psychiatrist with three years of residency training in psychiatry;
 - (2) a psychologist with a doctoral degree from an accredited program;
 - (3) a social worker with a master's degree from an accredited program and two years of clinical experience under the supervision of a Qualified Mental Health Professional;
 - (4) a registered nurse with a graduate degree in psychiatric nursing and two years of clinical experience under the supervision of a Qualified Mental Health Professional.
- d. "Non-Professional Staff Member" — an employee of the hospital, other than a Qualified Mental Health Professional, whose duties require contact with or supervision of patients.
- n. Human psychological and Physical Environment
 - 1. Patients have a right to privacy and dignity.
 - 2. Patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment.
 - 3. No person shall be deemed incompetent to manage his affairs,

to contract, to hold professional or occupational or vehicle operator's licenses, to marry and obtain a divorce, to register and vote, or to make a will solely by reason of his admission or commitment to the hospital.

4. Patients shall have the same rights to visitation and telephone communications as patients at other public hospitals, except to the extent that the Qualified Mental Health Professional responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued. Patients shall have an unrestricted right to visitation with attorneys and with private physicians and other health professionals.

5. Patients shall have an unrestricted right to send sealed mail. Patients shall have an unrestricted right to receive sealed mail from their attorneys, private physicians, and other mental health professionals, from courts, and government officials. Patients shall have a right to receive sealed mail from others, except to the extent that the Qualified Mental Health Professional responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions on receipt of sealed mail. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued.

6. Patients have a right to be free from unnecessary or excessive medication. No medication shall be administered unless at the written order of a physician. The superintendent of the hospital and the attending physician shall be responsible for all medication given or administered to a patient. The use of medication shall not exceed standards of use that are advocated by the United States Food and

Drug Administration. Notation of each individual's medication shall be kept in his medical records. At least weekly the attending physician shall review the drug regimen of each patient under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the patient's treatment program.

7. Patients have a right to be free from physical restraint and isolation. Except for emergency situations, in which it is likely that patients could harm themselves or others and in which less restrictive means of restraint are not feasible, patients may be physically restrained or placed in isolation only on a Qualified Mental Health Professional's written order which explains the rationale for such action. The written order may be entered only after the Qualified Mental Health Professional has personally seen the patient concerned and evaluated whatever episode or situation is said to call for restraint or isolation. Emergency use of restraints or isolation shall be for no more than one hour, by which time a Qualified Mental Health Professional shall have been consulted and shall have entered an appropriate order in writing. Such written order shall be effective for no more than 24 hours and must be renewed if restraint and isolation are to be continued. While in restraint or isolation the patient must be seen by qualified ward personnel who will chart the patient's physical condition (if it is compromised) and psychiatric condition every hour. The patient must have bathroom privileges every hour and must be bathed every 12 hours.

8. Patients shall have a right not to be subjected to experimental research without the express and informed consent of the patient, if the patient is able to give such consent, and of his guardian or next of

kin, after opportunities for consultation with independent specialists and with legal counsel. Such proposed research shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought. Prior to such approval the Committee shall determine that such research complies with the principles of the Statement on the Use of Human Subjects for Research of the American Association on Mental Deficiency and with the principles for research involving human subjects required by the United States Department of Health, Education and Welfare for projects supported by that agency.

9. Patients have a right not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatment, aversive reinforcement conditioning or other unusual or hazardous treatment procedures without their express and informed consent after consultation with counsel or interested party of the patient's choice.

10. Patients have a right to receive prompt and adequate medical treatment for any physical ailments.

11. Patients have a right to wear their own clothes and to keep and use their own personal possessions except insofar as such clothes or personal possessions may be determined by a Qualified Mental Health Professional to be dangerous or otherwise inappropriate to the treatment regimen.

12. The hospital has an obligation to supply an adequate allowance of clothing to any patients who do not have suitable clothing of their own. Patients shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the patient's throughout his stay in the hospital.

13. The hospital shall make provision for the laundering of patient clothing.

14. Patients have a right to regular physical exercise several times a week. Moreover, it shall be the duty of the hospital to provide facilities and equipment for such exercise.

15. Patients have a right to be outdoors at regular and frequent intervals, in the absence of medical considerations.

16. The right to religious worship shall be accorded to each patient who desires such opportunities. Provisions for such worship shall be made available to all patients on a nondiscriminatory basis. No individual shall be coerced into engaging in any religious activities.

17. The institution shall provide, with adequate supervision, suitable opportunities for the patient's interaction with members of the opposite sex.

18. The following rules shall govern patient labor:

A. Hospital Maintenance No patient shall be required to perform labor which involves the operation and maintenance of the hospital or for which the hospital is under contract with an outside organization. Privileges or release from the hospital shall not be conditioned upon the performance of labor covered by this provision. Patients may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U. S. C. Sec. 206 as amended, 1966.

B. Therapeutic Tasks and Therapeutic Labor

(1) Patients may be required to perform therapeutic tasks which do not involve the operation and maintenance of the hospital, provided the specific task or any change in assignment is:

- a. An integrated part of the patient's treatment plan and approved as a therapeutic activity by a Qualified Mental Health Professional responsible for supervising the patient's treatment; and

- b. Supervised by a staff member to oversee the therapeutic aspects of the activity.

(2) Patients may voluntarily engage in therapeutic labor for which the hospital would otherwise have to pay an employee, provided the specific labor or any change in labor assignment is:

- a. An integrated part of the patient's treatment plan and approved as a therapeutic activity by a Qualified Mental Health Professional responsible for supervising the patient's treatment; and
- b. Supervised by a staff member to oversee the therapeutic aspects of the activity; and
- c. Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U. S. C. Sec. 206 as amended, 1966.

C. Personal Housekeeping Patients may be required to perform tasks of a personal housekeeping nature such as the making of one's own bed.

D. Payment to patients pursuant to these paragraphs shall not be applied to the costs of hospitalization.

19. Physical Facilities A patient has a right to a humane psychological and physical environment within the hospital facilities. These facilities shall be designed to afford patients with comfort and safety, promote dignity, and ensure privacy. The facilities shall be designed to make a positive contribution to the efficient attainment of the treatment goals of the hospital.

A. Resident Unit

The number of patients in a multi-patient room shall not exceed six persons. There shall be allocated a minimum of 80 square feet of floor space per patient in a multi-patient room. Screens or

curtains shall be provided to ensure privacy within the resident unit. Single rooms shall have a minimum of 100 square feet of floor space. Each patient will be furnished with a comfortable bed with adequate changes of linen, a closet or locker for his personal belongings, a chair, and a bedside table.

B. Toilets and Lavatories

There will be one toilet provided for each eight patients and one lavatory for each six patients. A lavatory will be provided with each toilet facility. The toilets will be installed in separate stalls to ensure privacy, will be clean and free of odor, and will be equipped with appropriate safety devices for the physically handicapped.

C. Showers

There will be one tub or shower for each 15 patients. If a central bathing area is provided, each shower area will be divided by curtains to ensure privacy. Showers and tubs will be equipped with adequate safety accessories.

D. Day Room

The minimum day room area shall be 40 square feet per patient. Day rooms will be attractive and adequately furnished with reading lamps, tables, chairs, television and other recreational facilities. They will be conveniently located to patients' bedrooms and shall have outside windows. There shall be at least one day room area on each bedroom floor in a multi-story hospital. Areas used for corridor traffic cannot be counted as day room space; nor can a chapel with fixed pews be counted as a day room area.

E. Dining Facilities

The minimum dining room area shall be ten square feet per patient. The dining room shall be separate from the kitchen and will be furnished with comfortable chairs and tables with hard, washable surfaces.

F. Linen Servicing and Handling

The hospital shall provide adequate facilities and equipment for handling clean and soiled bedding and other linen. There must be frequent changes of bedding and other linen, no less than every seven days to assure patient comfort.

G. Housekeeping

Regular housekeeping and maintenance procedures which will ensure that the hospital is maintained in a safe, clean, and attractive condition will be developed and implemented.

H. Geriatric and Other Nonambulatory Mental Patients

There must be special facilities for geriatric and other non-ambulatory patients to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit nonambulatory patients to communicate their needs to staff.

I. Physical Plant

(1) Pursuant to an established routine maintenance and repair program, the physical plant shall be kept in a continuous state of good repair and operation in accordance with the needs of the health, comfort, safety and well-being of the patients.

(2) Adequate heating, air conditioning and ventilation systems and equipment shall be afforded to maintain temperatures and air changes which are required for the comfort of patients at all times and the removal of undesired heat, steam and offensive odors. Such facilities shall ensure that the temperature in the hospital shall not exceed 83°F nor fall below 68°F.

(3) Thermostatically controlled hot water shall be provided in adequate quantities and maintained at the required temperature for patient or resident use (110 F at the fixture) and for mechanical dishwashing and laundry use (180°F at the equipment).

(4) Adequate refuse facilities will be provided so that solid waste, rubbish and other refuse will be collected and disposed of in a manner which will prohibit transmission of disease and not create a nuisance or fire hazard or provide a breeding place for rodents and insects.

(5) The physical facilities must meet all fire and safety standards established by the state and locality. In addition, the hospital shall meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to hospitals.

19A. The hospital shall meet all standards established by the state for general hospitals, insofar as they are relevant to psychiatric facilities.

20. Nutritional Standards

Patients, except for the non-mobile, shall eat or be fed in dining rooms. The diet for patients will provide at a minimum the Recommended Daily Dietary Allowances as developed by the National Academy of Sciences. Menus shall be satisfying and nutritionally adequate to provide the Recommended Daily Dietary Allowances. In developing such menus, the hospital will utilize the Low Cost Food Plan of the Department of Agriculture. The hospital will not spend less per patient for raw food, including the value of donated food, than the most recent per person costs of the Low Cost Food Plan for the Southern Region of the United States, as compiled by the United States Department of Agriculture, for appropriate groupings of patients, discounted for any savings which might result from institutional procurement of such food. Provisions shall be made for special therapeutic diets and for substitutes at the request of the patient, or his guardian or next of kin, in accordance with the religious requirements of any patient's faith. Denial of a nutritionally adequate diet shall not be used as punishment.

III. Qualified Staff in Numbers Sufficient to Administer Adequate Treatment.

21. Each Qualified Mental Health Professional shall meet all licensing and certification requirements promulgated by the State of Alabama for persons engaged in private practice of the same profession elsewhere in Alabama. Other staff members shall meet the same licensing and certification requirements as persons who engage in private practice of their speciality elsewhere in Alabama.

- 22. a. All Non-Professional Staff Members who have not had prior clinical experience in a mental institution shall have a substantial orientation training,
- b. Staff members on all levels shall have regularly scheduled in-service training.

23. Each Non-Professional Staff Member shall be under the direct supervision of a Qualified Mental Health Professional.

24. Staffing Ratios

The hospital shall have the following minimum numbers of treatment personnel per 250 patients. Qualified Mental Health Professionals trained in particular disciplines may in appropriate situations perform services or functions traditionally performed by members of other disciplines. Changes in staff deployment may be made with prior approval of this Court upon a clear and convincing demonstration that the proposed deviation from this staffing structure will enhance the treatment of the patients.

<u>Classification</u>	<u>Number of Employees</u>
Unit Director	1
Psychiatrist (3 years' residency training in psychiatry)	2
MD (Registered physicians)	4
Nurses (RN) 12	
Licensed Practical Nurses	6

<u>Classification (Cont'd)</u>	<u>Number of Employees</u>
Aide III	6
Aide II	16
Aide I	70
Hospital Orderly	10
Clerk Stenographer II	3
Clerk Typist II	3
Unit Administrator	1
Administrative Clerk	1
Psychologist (Ph. D.) (doctoral degree from accredited program)	1
Psychologist (M. A.)	1
Psychologist (B. S.)	2
Social Worker (MSW) (from accredited program)	2
Social Worker (B. A.)	5
Patient Activity Therapist (M. S.)	1
Patient Activity Aide	10
Mental Health Technician	10
Dental Hygienist	1
Chaplain	.5
Vocational Rehabilitation Counselor	1
Volunteer Services Worker	1
Mental Health Field Representative	1
Dietitian	1
Food Service Supervisor	1
Cook II	2
Cook I	3
Food Service Worker	15
Vehicle Driver	1
Housekeeper	10
Messenger	1
Maintenance Repairman	2

IV. Individualized Treatment Plans

25. Each patient shall have a comprehensive physical and mental examination and review of behavioral status within 48 hours after admission to the hospital.

26. Each patient shall have an individualized treatment plan. This plan shall be developed by appropriate Qualified Mental Health Professionals, including a psychiatrist, and implemented as soon as possible - in any event no later than five days after the patient's

admission. Each individualized treatment plan shall contain:

- a. a statement of the nature of the specific problems and specific needs of the patient;
- b. a statement of the least restrictive treatment conditions necessary to achieve the purposes of commitment;
- c. a description of intermediate and long-range treatment goals, with a projected timetable for their attainment;
- d. a statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;
- e. a specification of staff responsibility and a description of proposed staff involvement with the patient in order to attain these treatment goals;
- f. criteria for release to less restrictive treatment conditions, and criteria for discharge;
- g. a notation of any therapeutic tasks and labor to be performed by the patient in accordance with Standard 18.

27. As part of his treatment plan, each patient shall have an individualized post-hospitalization plan. This plan shall be developed by a Qualified Mental Health Professional as soon as practicable after the patient's admission to the hospital.

28. In the interests of continuity of care, whenever possible, one Qualified Mental Health Professional (who need not have been involved with the development of the treatment plan) shall be responsible for supervising the implementation of the treatment plan, integrating the various aspects of the treatment program and recording the patient's progress. This Qualified Mental Health Professional shall also be responsible for ensuring that the patient is released, where appropriate, into a less restrictive form of treatment.

29. The treatment plan shall be continuously reviewed by the Qualified Mental Health Professional responsible for supervising the

implementation of the plan and shall be modified if necessary. Moreover, at least every 90 days, each patient shall receive a mental examination from, and his treatment plan shall be reviewed by, a Qualified Mental Health Professional other than the professional responsible for supervising the implementation of the plan.

30. In addition to treatment for mental disorders, patients confined at mental health institutions also are entitled to and shall receive appropriate treatment for physical illnesses such as tuberculosis 1-/ In providing medical care, the State Board of Mental Health shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the patient's treatment for mental illness with his medical treatment.

31. Complete patient records shall be kept on the ward in which the patient is placed and shall be available to anyone properly authorized in writing by the patient. These records shall include:

- a. Identification data, including the patient's legal status;
- b. A patient history, including but not limited to:
 - (1) family data, educational background, and employment record;
 - (2) prior medical history, both physical and mental, including prior hospitalization;
- c. The chief complaints of the patient and the chief complaints of others regarding the patient;
- d. An evaluation which notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the patient's assets in

^{1/} Approximately 50 patients at Bryce-Searcy are tubercular as also are approximately four residents at Partlow.

descriptive, not interpretative, fashion;

- e. A summary of each physical examination which describes the results of the examination;
- f. A copy of the individual treatment plan and any modifications thereto;
- g. A detailed summary of the findings made by the reviewing Qualified Mental Health Professional after each periodic review of the treatment plan which analyzes the successes and failures of the treatment program and directs whatever modifications are necessary;
- h. A copy of the individualized post-hospitalization plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;
- i. A medication history and status, which includes the signed orders of the prescribing physician. Nurses shall indicate by signature that orders have been carried out;
- j. A detailed summary of each significant contact by a Qualified Mental Health Professional with the patient;
- k. A detailed summary on at least a weekly basis by a Qualified Mental Health Professional involved in the patient's treatment of the patient's progress along the treatment plan;
- l. A weekly summary of the extent and nature of the patient's work activities described in Standard 18, supra, and the effect of such activity upon the patient's progress along the treatment plan;
- m. A signed order by a Qualified Mental Health Professional for any restrictions on visitations and communication, as provided in Standards 4 and 5, supra;

- n. A signed order by a Qualified Mental Health Professional for any physical restraints and isolation, as provided by Standard 7, supra;
- o. A detailed summary of any extraordinary incident in the hospital involving the patient to be entered by a staff member noting that he has personal knowledge of the incident or specifying his other source of information, and initialed within 24 hours by a Qualified Mental Health Professional;
- p. A summary by the superintendent of the hospital or his appointed agent of his findings after the 15-day review provided for in Standard 33, infra.

32. In addition to complying with all the other standards herein, a hospital shall make special provisions for the treatment of patients who are children and young adults. These provisions shall include but are not limited to:

- a. Opportunities for publicly supported education suitable to the educational needs of the patient. This program of education must, in the opinion of the attending Qualified Mental Health Professional, be compatible with the patient's mental condition and his treatment program, and otherwise be in the patient's best interest.
- b. A treatment plan which considers the chronological, maturational, and developmental level of the patient;
- c. Sufficient Qualified Mental Health Professionals, teachers, and staff members with specialized skills in the care and treatment of children and young adults;
- d. Recreation and play opportunities in the open air where possible and appropriate residential facilities;

- e. Arrangements for contact between the hospital and the family of the patient.

33. No later than 15 days after a patient is committed to the hospital, the superintendent of the hospital or his appointed, professionally qualified agent shall examine the committed patient and shall determine whether the patient continues to require hospitalization and whether a treatment plan complying with Standard 26 has been implemented. If the patient no longer requires hospitalization in accordance with the standards for commitment, or if a treatment plan has not been implemented, he must be released immediately unless he agrees to continue with treatment on a voluntary basis.

34. The Mental Health Board and its agents have an affirmative duty to provide adequate transitional treatment and care for all patients released after a period of involuntary confinement. Transitional care and treatment possibilities include, but are not limited to, psychiatric day care, treatment in the home by a visiting therapist, nursing home or extended care, out-patient treatment, and treatment in the psychiatric ward of a general hospital.

V. Miscellaneous

35. Each patient and his family, guardian, or next friend shall promptly upon the patient's admission receive written notice, in language he understands, of all the above standards for adequate treatment. In addition a copy of all the above standards shall be posted in each ward.

APPENDIX B

COURT-ORDERED STANDARDS FOR PARTLOW STATE SCHOOL AND HOSPITAL

I. Definitions

The terms used herein below are defined as follows:

- a. "Institution" — Partlow State School and Hospital.
- b. "Residents" — All persons who are now confined and all persons who may in the future be confined at Partlow State School and Hospital.
- c. "Qualified Mental Retardation Professional" —
 - (1) a psychologist with a doctoral or master's degree from an accredited program and with specialized training or one year's experience in treating the mentally retarded;
 - (2) a physician licensed to practice in the State of Alabama, with specialized training or one year's experience in treating the mentally retarded;
 - (3) an educator with a master's degree in special education from an accredited program;
 - (4) a social worker with a master's degree from an accredited program and with specialized training or one year's experience in working with the mentally retarded;
 - (5) a physical, vocational or occupational therapist licensed to practice in the State of Alabama who is a graduate of an accredited program in physical, vocational or occupational therapy, with specialized training or one year's experience in treating the mentally retarded;
 - (6) a registered nurse with specialized training or one year of experience treating the mentally retarded under the

supervision of a Qualified Mental Retardation Professional.

- d. "Resident Care Worker" — an employee of the institution, other than a Qualified Mental Retardation Professional, whose duties require regular contact with or supervision of residents.
- e. "Habilitation" — the process by which the staff of the institution assists the resident to acquire and maintain those life skills which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental, and social efficiency. Habilitation includes but is not limited to programs of formal, structured education and treatment.
- f. "Education" — the process of formal training and instruction to facilitate the intellectual and emotional development of residents.
- g. "Treatment" — the prevention, amelioration and/or cure of a resident's physical disabilities or illnesses.
- h. "Guardian" -- a general guardian of a resident, unless the general guardian is missing, indifferent to the welfare of the resident or has an interest adverse to the resident. In such a case, guardian shall be defined as an individual appointed by an appropriate court on the motion of the superintendent, such guardian not to be in the control or in the employ of the Alabama Board of Mental Health.
- i. "Express and Informed Consent" — the uncoerced decision of a resident who has comprehension and can signify assent or dissent.

II. Adequate Habilitation of Residents

1. Residents shall have a right to habilitation, including medical treatment, education and care, suited to their needs, regardless of age, degree of retardation or handicapping condition.
2. Each resident has a right to a habilitation program which will maximize his human abilities and enhance his ability to cope with his environment. The institution shall recognize that each resident, regardless of ability or status, is entitled to develop and realize his fullest potential. The institution shall implement the principle of normalization so that each resident may live as normally as possible.
3.
 - a. No person shall be admitted to the institution unless a prior determination shall have been made- that residence in the institution is the least restrictive habilitation setting feasible for that person.
 - b. No mentally retarded person shall be admitted to the institution if services and programs in the community can afford adequate habilitation to such person.
 - c. Residents shall have a right to the least restrictive conditions necessary to achieve the purposes of habilitation. To this end, the institution shall make every attempt to move residents from (1) more to less structured living; (2) larger to smaller facilities; (3) larger to smaller living units; (4) group to individual residence; (5) segregated from the community to integrated into the community living; (6) dependent to independent living.

^{1/} See Standard 7, infra.

4. No borderline or mildly mentally retarded person shall be a resident of the institution. For purposes of this standard, a borderline retarded person is defined as an individual who is functioning between one and two standard deviations below the mean on a standardized intelligence test such as the Stanford Binet Scale and on measures of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale. A mildly retarded person is defined as an individual who is functioning between two and three standard deviations below the mean on a standardized intelligence test such as the Stanford Binet Scale and on a measure of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale.
5. Residents shall have a right to receive suitable educational services regardless of chronological age, degree of retardation or accompanying disabilities or handicaps.
 - a. The institution shall formulate a written statement of educational objectives that is consistent with the institution's mission as set forth in Standard 2, supra, and the other standards proposed herein.
 - b. School-age residents shall be provided a full and suitable educational program. Such educational programs shall meet the following minimum standards:

	<u>Mild^{4/}</u>	<u>Moderate</u>	<u>Severe/Profound</u>
(1) Class Size	12	9	6

2/ As is reflected in Standard 4, supra, it is contemplated that no mildly retarded persons be residents of the institution. However, until those mildly retarded who are presently residents are removed to more suitable locations and/or facilities, some provision must be made for their educational program.

(continued)	<u>Mild</u>	<u>Moderate</u>	<u>Severe/Profound</u>
(2) Length of school year (in months)	9-10	9-10	11-12
(3) Minimum length of school day (in hours)	6	6	6

6. Residents shall have a right to receive prompt and adequate medical treatment for any physical ailments and for the prevention of any illness or disability. Such medical treatment shall meet standards of medical practice in the community.

HI. Individualized Habilitation Plans

7. Prior to his admission to the institution, each resident shall have a comprehensive social, psychological, educational, and medical diagnosis and evaluation by appropriate specialists to determine if admission is appropriate.
 - a. Unless such preadmission evaluation has been conducted within three months prior to the admission, each resident shall have a new evaluation at the institution to determine if admission is appropriate.
 - b. When undertaken at the institution, preadmission diagnosis and evaluation shall be completed within five days.
8. Within 14 days of his admission to the institution, each resident shall have an evaluation by appropriate specialists for programming purposes.
9. Each resident shall have an individualized habilitation plan formulated by the institution. This plan shall be developed by appropriate Qualified Mental Retardation Professionals and implemented as soon as possible but no later than 14 days after the resident's admission to the institution. An interim

program of habilitation, based on the preadmission evaluation conducted pursuant to Standard 7, supra, shall commence promptly upon the resident's admission. Each individualized habilitation plan shall contain:

- a. a statement of the nature of the specific limitations and specific needs of the resident;
 - b. a description of intermediate and long-range habilitation goals with a projected timetable for their attainment;
 - c. a statement of, and an explanation for, the plan of habilitation for achieving these intermediate and long-range goals;
 - d. a statement of the least restrictive setting for habilitation necessary to achieve the habilitation goals of the resident;
 - e. a specification of the professionals and other staff members who are responsible for the particular resident's attaining these habilitation goals;
 - f. criteria for release to less restrictive settings for habilitation, including criteria for discharge and a projected date for discharge.
10. As part of his habilitation plan, each resident shall have an individualized post-institutionalization plan. This plan shall be developed by a Qualified Mental Retardation Professional who shall begin preparation of such plan prior to the resident's admission to the institution and shall complete such plan as soon as practicable. The guardian or next of kin of the resident and the resident, if able to give informed consent, shall be consulted in the development of such plan and shall be informed of the content of such plan.

11. In the interests of continuity of care, one Qualified Mental Retardation Professional shall be responsible for supervising the implementation of the habilitation plan, integrating the various aspects of the habilitation program, and recording the resident's progress as measured by objective indicators. This Qualified Mental Retardation Professional shall also be responsible for ensuring that the resident is released when appropriate to a less restrictive habilitation setting.
12. The habilitation plan shall be continuously reviewed by the Qualified Mental Retardation Professional responsible for supervising the implementation of the plan and shall be modified if necessary. In addition, six months after admission and at least annually thereafter, each resident shall receive a comprehensive psychological, social, educational and medical diagnosis and evaluation, and his habilitation plan shall be reviewed by an interdisciplinary team of no less than two Qualified Mental Retardation Professionals and such resident care workers as are directly involved in his habilitation and care.
13. In addition to habilitation for mental disorders, people confined at mental health institutions also are entitled to and shall receive appropriate treatment for physical illnesses such as tuberculosis.^{3/} In providing medical care, the State Board of Mental Health shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the resident's habilitation for

3/ Approximately 50 patients at Bryce-Searcy are tubercular as also are approximately four residents at Partlow.

mental retardation with his medical treatment.

14. Complete records for each resident shall be maintained and shall be readily available to Qualified Mental Retardation Professionals and to the resident care workers who are directly involved with the particular resident. All information contained in a resident's records shall be considered privileged and confidential. The guardian, next of kin, and any person properly authorized in writing by the resident, if such resident is capable of giving informed consent, or by his guardian or next of kin, shall be permitted access to the resident's records. These records shall include:
 - a. Identification data, including the resident's legal status;
 - b. The resident's history, including but not limited to:
 - (1) family data, educational background, and employment record;
 - (2) prior medical history, both physical and mental, including prior institutionalization;
 - c. The resident's grievances if any;
 - d. An inventory of the resident's life skills;
 - e. A record of each physical examination which describes the results of the examination;
 - f. A copy of the individual habilitation plan and any modifications thereto and an appropriate summary which will guide and assist the resident care workers in implementing the resident's program;
 - g. The findings made in periodic reviews of the habilitation plan (see Standard 12, supra), which findings shall include an analysis of the successes and failures of the habilitation program and shall direct whatever modifications are necessary;

IV. humane Physical and Psychological Environment

15. **Residents** shall have a right to dignity, privacy and humane care.
16. Residents shall lose none of the rights enjoyed by citizens of Alabama and of the United States solely by reason of their admission or commitment to the institution, except as expressly determined by an appropriate court.
17. No person shall be presumed mentally incompetent solely by reason of his admission or commitment to the institution.
18. The opportunity for religious worship shall be accorded to each resident who desires such worship. Provisions for religious worship shall be made available to all residents on a nondiscriminatory basis. No individual shall be coerced into engaging in any religious activities.
19. Residents shall have the same rights to telephone communication as patients at Alabama public hospitals, except to the extent that a Qualified Mental Retardation Professional responsible for formulation of a particular resident's habilitation plan (see Standard 9, supra) writes an order imposing special restrictions and explains the reasons for any such restrictions. The written order must be renewed semiannually if any restrictions are to be continued. Residents shall have an unrestricted right to visitation, except to the extent that a Qualified Mental Retardation Professional responsible for formulation of a particular resident's habilitation plan (see Standard 9, supra) writes an order imposing special restrictions and explains the reasons for any such restrictions. The written order must be renewed semiannually if any restrictions are to be continued.

- h. A copy of the post-institutionalization plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;
- i. A medication history and status, pursuant to Standard 22, infra;
- j. A summary of each significant contact by a Qualified Mental Retardation Professional with the resident;
- k. A summary of the resident's response to his program, prepared by a Qualified Mental Retardation Professional involved in the resident's habilitation and recorded at least monthly. Such response, wherever possible, shall be scientifically documented.
- l. A monthly summary of the extent and nature of the resident's work activities described in the Standard 33(b), infra and the effect of such activity upon the resident's progress along the habilitation plan;
- m. A signed order by a Qualified Mental Retardation Professional for any physical restraints, as provided in Standard 26 (a) (1), infra;
- n. A description of any extraordinary incident or accident in the institution involving the resident, to be entered by a staff member noting personal knowledge of the incident or accident or other source of information, including any reports of investigations of resident mistreatment, as required by Standard 28, infra;
- o. A summary of family visits and contacts;
- p. A summary of attendance and leaves from the institution;
- q. A record of any seizures, illnesses, treatments thereof, and immunizations.

20. Residents shall be entitled to send and receive sealed mail. Moreover, it shall be the duty of the institution to facilitate the exercise of this right by furnishing the necessary materials and assistance.
21. The institution shall provide, under appropriate supervision, suitable opportunities for the resident's interaction with members of the opposite sex, except where a Qualified Mental Retardation Professional responsible for the formulation of a particular resident's habilitation plan writes an order to the contrary and explains the reasons therefor.
22. Medication:
 - a. No medication shall be administered unless at the written order of a physician.
 - b. Notation of each individual's medication shall be kept in his medical records (Standard 14 (i) supra). At least weekly the attending physician shall review the drug regimen of each resident under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days.
 - c. Residents shall have a right to be free from unnecessary or excessive medication. The resident's records shall state the effects of psycho-active medication on the resident. When dosages of such are changed or other psychoactive medications are prescribed, a notation shall be made in the resident's record concerning the effect of the new medication or new dosages and the behavior changes, if any, which occur.
 - d. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a habilitation program, or in quantities that interfere with the resident's habilitation program.

- e. Pharmacy services at the institution shall be directed by a professionally competent pharmacist licensed to practice in the State of Alabama. Such pharmacist shall be a graduate of a school of pharmacy accredited by the American Council on Pharmaceutical Education. Appropriate officials of the institution, at their option, may hire such a pharmacist or pharmacists fulltime, or, in lieu thereof, contract with outside pharmacists.
- f. Whether employed fulltime or on a contract basis, the pharmacist shall perform duties which include but are not limited to the following:
 - (1) Receiving the original, or direct copy, of the physician's drug treatment order;
 - (2) Reviewing the drug regimen, and any changes, for potentially adverse reactions, allergies, interactions, contraindications, rationality, and laboratory test modifications and advising the physician of any recommended changes, with reasons and with an alternate drug regimen;
 - (3) Maintaining for each resident an individual record of all medications (prescription and nonprescription) dispensed, including quantities and frequency of refills;
 - (4) Participating, as appropriate, in the continuing interdisciplinary evaluation of individual residents for the purposes of initiation, monitoring, and follow-up of individualized habilitation programs.
- g. Only appropriately trained staff shall be allowed to administer drugs.

23. Seclusion, defined as the placement of a resident alone in a locked room, shall not be employed. Legitimate "time out" procedures may be utilized under close and direct professional supervision as a technique in behavior-shaping programs.
24. Behavior modification programs involving the use of noxious or aversive stimuli shall be reviewed and approved by the institution's Human Rights Committee and shall be conducted only with the express and informed consent of the affected resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such behavior modification programs shall be conducted only under the supervision of and in the presence of a Qualified Mental Retardation Professional who has had proper training in such techniques.
25. Electric shock devices shall be considered a research technique for the purpose of these standards. Such devices shall only be used in extraordinary circumstances to prevent self-mutilation leading to repeated and possibly permanent physical damage to the resident and only after alternative techniques have failed. The use of such devices shall be subject to the conditions prescribed in Standard 24, supra, and Standard 29, infra , and shall be used only under the direct and specific order of the superintendent.
26. Physical restraint shall be employed only when absolutely necessary to protect the resident from injury to himself or to prevent injury to others. Restraint shall not be employed as punishment, for the convenience of staff, or as a substitute for a habilitation program. Restraint shall be applied

only if alternative techniques have failed and only if such restraint imposes the least possible restriction consistent with its purpose.

a. Only Qualified Mental Retardation Professionals may authorize the use of restraints.

(1) Orders for restraints by the Qualified Mental Retardation Professionals shall be in writing and shall not be in force for longer than 12 hours.

(2) A resident placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, and a record of such checks shall be kept.

(3) Mechanical restraints shall be designed and used so as not to cause physical injury to the resident and so as to cause the least possible discomfort.

(4) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which restraint is employed.

(5) Daily reports shall be made to the superintendent by those Qualified Mental Retardation Professionals ordering the use of restraints, summarizing all such uses of restraint, the types used, the duration, and the reasons therefor.

b. The institution shall cause a written statement of this policy to be posted in each living unit and circulated to all staff members.

27. Corporal punishment shall not be permitted.

28. The institution shall prohibit mistreatment, neglect or abuse in any form of any resident.

- a. Alleged violations shall be reported immediately to the superintendent and there shall be a written record that:
 - (1) Each alleged violation has been thoroughly investigated and findings stated;
 - (2) The results of such investigation are reported to the superintendent and to the commissioner within 24 hours of the report of the incident. Such reports shall also be made to the institution's Human Rights Committee monthly and to the Alabama Board of Mental Health at its next scheduled public meeting.
 - b. The institution shall cause a written statement of this policy to be posted in each cottage and building and circulated to all staff members.
29. Residents shall have a right not to be subjected to experimental research without the express and informed consent of the resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such proposed research shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought. Prior to such approval the institution's Human Rights Committee shall determine that such research complies with the principles of the Statement on the Use of Human Subjects for Research of the American Association on Mental Deficiency and with the principles for research involving human subjects required by the United States Department of Health, Education and Welfare for projects supported by that agency.

30. Residents shall have a right not to be subjected to any unusual or hazardous treatment procedures without the express and informed consent of the resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and legal counsel. Such proposed procedures shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought.
31. Residents shall have a right to regular physical exercise several times a week. It shall be the duty of the institution to provide both indoor and outdoor facilities and equipment for such exercise.
32. Residents shall have a right to be outdoors daily in the absence of contrary medical considerations.
33. The following rules shall govern resident labor:
 - a. Institution Maintenance
 - (1) No resident shall be required to perform labor which involves the operation and maintenance of the institution or for which the institution is under contract with an outside organization. Privileges or release from the institution shall not be conditioned upon the performance of labor covered by this provision. Residents may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U. S. C. Sec. 206 as amended, 1966.

- (2) No resident shall be involved in the care (feeding, clothing, bathing), training, or supervision of other residents unless he:
 - (a) has volunteered;
 - (b) has been specifically trained in the necessary skills;
 - (c) has the humane judgment required for such activities;
 - (d) is adequately supervised; and
 - (e) is reimbursed in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U. S. C. Sec. 206 as amended, 1966.

b. Training Tasks and Labor

- (1) Residents may be required to perform vocational training tasks which do not involve the operation and maintenance of the institution, subject to a presumption that an assignment of longer than three months to any task is not a training task, provided the specific task or any change in task assignment is:
 - (a) An integrated part of the resident's habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation;
 - (b) Supervised by a staff member to oversee the habilitation aspects of the activity.
- (2) Residents may voluntarily engage in habilitative labor at nonprogram hours for which the institution

would otherwise have to pay an EMPLOYEE, provided the specific labor or any change in labor is:

- (a) An integrated part of the resident habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation;
- (b) Supervised by a staff member to oversee the habilitation aspects of the activity; and
- (c) Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U. S. C. Sec. 206 as amended, 1966.

- c. Personal Housekeeping Residents may be required to perform tasks of a personal housekeeping nature such as the making of one's own bed.
- d. Payment to residents pursuant to this paragraph shall not be applied to the costs of institutionalization.
- e. Staffing shall be sufficient so that the institution is not dependent upon the use of residents or volunteers for the care, maintenance or habilitation of other residents or for income-producing services. The institution shall formulate a written policy to protect the residents from exploitation when they are engaged in productive work.

A nourishing, well-balanced diet shall be provided each resident.

- a. The diet for residents shall provide at a minimum the Recommended Daily Dietary Allowance as developed by the National Academy of Sciences. Menus shall be satisfying and shall provide the Recommended Daily

dietary allowances. In developing such menus, the **institution** shall utilize the Moderate Cost Food Plan of the United States Department of Agriculture. The institution shall not spend less per patient for raw food, including the value of donated food, than the most recent per person costs of the Moderate Cost Food Plan for the Southern Region of the United States, as compiled by the United States Department of Agriculture, for appropriate groupings of residents, discounted for any savings which might result from institutional procurement of such food.

- b. Provisions shall be made for special therapeutic diets and for substitutes at the request of the resident, or his guardian or next of kin, in accordance with the religious requirements of any resident's faith.
- c. Denial of a nutritionally adequate diet shall not be used as punishment.
- d. Residents, except for the non-mobile, shall eat or be fed in dining rooms.

Each resident shall have an adequate allowance of neat, clean, suitably fitting and seasonable clothing,

- a. Each resident shall have his own clothing, which is properly and inconspicuously marked with his name, and he shall be kept dressed in this clothing. The institution has an obligation to supply an adequate allowance of clothing to any residents who do not have suitable clothing of their own. Residents shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the resident's throughout his stay in the institution.

- b. Clothing both in amount and type shall make it possible for residents to go out of doors in inclement weather, to go for trips or visits appropriately dressed, and to make a normal appearance in the community.
 - c. Nonambulatory residents shall be dressed daily in their own clothing, including shoes, unless contraindicated in written medical orders.
 - d. Washable clothing shall be designed for multiply handicapped residents being trained in self-help skills, in accordance with individual needs.
 - e. Clothing for incontinent residents shall be designed to foster comfortable sitting, crawling and/or walking, and toilet training.
 - f. A current inventory shall be kept of each resident's personal and clothing items.
 - g. The institution shall make provision for the adequate and regular laundering of the residents' clothing.
36. Each resident shall have the right to keep and use his own personal possessions except insofar as such clothes or personal possessions may be determined to be dangerous, either to himself or to others, by a Qualified Mental Retardation Professional.
37. a. Each resident shall be assisted in learning normal grooming practices with individual toilet articles, including soap and toothpaste, that are available to each resident,
- b. Teeth shall be brushed daily with an effective dentifrice. Individual brushes shall be properly marked, used and stored.

«\ Each resident shall have a shower or tub bath at least daily, unless medically contraindicated.

d. Residents shall be regularly scheduled for hair cutting and styling, in an individualized manner, by trained personnel.

e. For residents who require such assistance, cutting of toenails and fingernails shall be scheduled at regular intervals.

38. Physical Facilities A resident has a right to a humane physical environment within the institutional facilities. These facilities shall be designed to make a positive contribution to the efficient attainment of the habilitation goals of the institution.

a. Resident Unit All ambulatory residents shall sleep in single rooms or in multi-resident rooms of no more than six persons. The number of nonambulatory residents in a multi-resident room shall not exceed ten persons. There shall be allocated a minimum of 80 square feet of floor space per resident in a multi-resident room. Screens or curtains shall be provided to ensure privacy. Single rooms shall have a minimum of 100 square feet of floor space. Each resident shall be furnished with a comfortable bed with adequate changes of linen, a closet or locker for his personal belongings, and appropriate furniture such as a chair and a bedside table, unless contraindicated by a Qualified Mental Retardation Professional who shall state the reasons for any such restriction.

b. Toilets and Lavatories There shall be one toilet and one lavatory for each six residents. A lavatory shall

be provided with each toilet facility. **Thretoilets shall** be installed in separate stalls for **ambulatory residents**, or in curtained areas for nonambulatory **residents**, to ensure privacy, shall be clean and free **of odor**, and shall be equipped with appropriate safety devices **for** the physically handicapped. Soap and towels **and/or** drying mechanisms shall be available in each **lavatory**. Toilet paper shall be available in each toilet facility.

- c. Showers There shall be one tub or shower for each eight residents. If a central bathing area is provided, each tub or shower shall be divided by curtains to ensure privacy. Showers and tubs shall be equipped with adequate safety accessories.
- d. Day Room The minimum day room area shall be 40 square feet per resident. Day rooms shall be attractive and adequately furnished with reading lamps, tables, chairs, television, radio and other recreational facilities. They shall be conveniently located to residents' bedrooms and shall have outside windows. There shall be at least one day room area on each bedroom floor in a multi-story facility. Areas used for corridor traffic shall not be counted as day room space; nor shall a chapel with fixed pews be counted as a day room area.
- e. Dining Facilities The minimum dining room area shall be ten square feet per resident. The dining room shall be separate from the kitchen and shall be furnished with comfortable chairs and tables with hard, washable surfaces.
- f. Linen Servicing and Handling The institution shall

provide adequate facilities and equipment for the expeditious handling of clean and soiled bedding and other linen. There must be frequent changes of bedding and other linen, but in any event no less than every seven days, to assure sanitation and resident comfort. After soiling by an incontinent resident, bedding and linen must immediately be changed and removed from the living unit. Soiled linen and laundry shall be removed from the living unit daily.

- g. Housekeeping Regular housekeeping and maintenance procedures which will ensure that the institution is maintained in a safe, clean and attractive condition shall be developed and implemented.
- h. Nonambulatory Residents There must be special facilities for nonambulatory residents to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit nonambulatory residents to communicate their needs to staff.
- i. Physical Plant
 - (1) Pursuant to an established routine maintenance and repair program, the physical plant shall be kept in a continuous state of good repair and operation so as to ensure the health, comfort, safety and well-being of the residents and so as not to impede in any manner the habilitation programs of the residents.
 - (2) Adequate heating, air conditioning and ventilation systems and equipment shall be afforded to maintain temperatures and air changes which are

required for the comfort **of residents at** all times. Ventilation systems shall be **adequate to** remove steam and offensive odors or **to mask such** odors. The temperature in the institution **shall not** exceed 83 degrees F nor fall below 68 degrees F.

- (3) Thermostatically controlled hot water **shall** be provided in adequate quantities and maintained **at** the required temperature for resident use (110 degrees F at the fixture) and for mechanical dishwashing and laundry use (180 degrees F at the equipment). Thermostatically controlled hot water valves shall be equipped with a double valve system that provides both auditory and visual signals of valve failures.
- (4) Adequate refuse facilities shall be provided so that solid waste, rubbish and other refuse will be collected and disposed of in a manner which will prohibit transmission of disease and not create a nuisance or fire hazard or provide a breeding place for rodents and insects.
- (5) The physical facilities must meet all fire and safety standards established by the state and locality. In addition, the institution shall meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to it.

V. Qualified Staff in Numbers Sufficient to Provide Adequate Habilitation

- 39. Each Qualified Mental Retardation Professional and each physician shall meet all licensing and certification require-

ments promulgated by the State of Alabama for persons engaged in private practice of the same profession elsewhere in Alabama. Other staff members shall meet the same licensing and certification requirements as persons who engage in private practice of their specialty elsewhere in Alabama.

- a. All resident care workers who have not had prior clinical experience in a mental retardation institution shall have suitable orientation training.
- b. Staff members on all levels shall have suitable, regularly scheduled in-service training.

40. Each resident care worker shall be under the direct professional supervision of a Qualified Mental Retardation Professional.

41. Staffing Ratios

- a. Qualified staff in numbers sufficient to administer adequate habilitation shall be provided. Such staffing shall include but not be limited to the following fulltime professional and special services. Qualified Mental Retardation Professionals trained in particular disciplines may in appropriate situations perform services or functions traditionally performed by members of other disciplines. Substantial changes in staff deployment may be made with the prior approval of this Court upon a clear and convincing demonstration that the proposed deviation from this staffing structure would enhance the habilitation of the residents. Professional staff shall possess the qualifications of Qualified Mental Retardation Professionals as defined herein unless expressly stated otherwise.

b. Unit	Mild ^{4/}	Moderate	Severe/Profound
	60	60	60
(1) Psychologists	1:60	1:60	1:60
(2) Social Workers	1:60	1:60	1:60
(3) Special Educators (shall include an equal number of master's degree and bachelor's degree holders in special education)	1:15	1:10	1:30
(4) Vocational Therapists	1:60	1:60	--
(5) Recreational Therapists (shall be master's degree graduates from an accredited program)	1:60	1:60	1:60
(6) Occupational Therapists	--	--	1:60
(7) Registered Nurses	1:60	1:60	1:12
(8) Resident Care Workers	1:2.5	1:1.25	1:1

The following professional staff shall be fulltime employees of the institution who shall not be assigned to a single unit but who shall be available to meet the needs of any resident of the institution:

^{4/} See n. 2, supra.

Physicians	1:200
Physical Therapists	1:100
Speech & Hearing Therapists	1:100
Dentists^	1:200
Social Workers (shall be principally involved in the placement of residents in the community and shall include bachelor's degree graduates from an accredited program in social work)	1:80
Chaplains-'	1:200

- c. Qualified medical specialists of recognized professional ability shall be available for specialized care and consultation. Such specialist services shall include a psychiatrist on a one-day per week basis, a psychologist on a two-day per week basis, and any other medical or health-related speciality available in the community.

VI. Miscellaneous

42. The guardian or next of kin of each resident shall promptly upon resident's admission receive a written copy of all the above standards for adequate habilitation. Each resident, if the resident is able to comprehend, shall promptly upon his admission be orally informed in clear language of the above standards and, where appropriate, be provided with a written copy.

5/ Defendants may, in lieu of employing fulltime dentists, contract outside the institution for dental care. In this event the dental services provided the residents must include (a) complete dental examinations and appropriate corrective dental work for each resident each six months and (b) a dentist on call 24 hours per day for emergency work.

6/ Defendants may, in lieu of employing fulltime chaplains, recruit, upon the ratio shown above, interfaith volunteer chaplains.

43. The superintendent shall report in **writing to the next** of kin or guardian of the resident at **least every six months** **on** the resident's educational, vocational **and living skills** progress and medical condition. Such **report shall also** state any appropriate habilitation program **which has not** been afforded to the resident because of **inadequate habilitation** resources.
44. a. No resident shall be subjected to a behavior **modification** program designed to eliminate a particular **pattern** of behavior without prior certification by a physician that he has examined the resident in regard to **behavior** to be extinguished and finds that such behavior is not caused by a physical condition which could be corrected by appropriate medical procedures,
- b. No resident shall be subjected to a behavior modification program which attempts to extinguish socially appropriate behavior or to develop new behavior patterns when such behavior modifications serve only institutional convenience.
45. No resident shall have any of his organs removed for the purpose of transplantation without compliance with the procedures set forth in Standard 30, supra, and after a court hearing on such transplantation in which the resident is represented by a guardian ad litem. This standard shall apply to any other surgical procedure which is undertaken for reasons other than therapeutic benefit to the resident.
46. Within 90 days of the date of this order, each resident of the institution shall be evaluated as to his mental, emotional, social, and physical condition. Such evaluation or reevaluation shall be conducted by an interdisciplinary team of

Qualified Mental Retardation Professionals who shall use **professionally** recognized tests and examination procedures. **Each** resident's guardian, next of kin or legal representative shall be contacted and his readiness to make provisions for the resident's care in the community shall be ascertained. Each resident shall be returned to his family, if adequately habilitated, or assigned to the least restrictive habilitation setting.

47. Each resident discharged to the community shall have a program of transitional habilitation assistance.
48. The institution shall continue to suspend any new admissions of residents until all of the above standards of adequate habilitation have been met.
49. No person shall be admitted to any publicly supported residential institution caring for mentally retarded persons unless such institution meets the above standards.

APPENDIX C

COURT-ORDERED HEARING AND NOTICE PROVISIONS FOR THE DISTRICT OF COLUMBIA SCHOOL SYSTEM

Hearing Procedures

a. Each member of the plaintiff class is to be provided with a publicly-supported educational program suited to his needs, within the context of a presumption that among the alternative programs of education, placement in a regular public school class with appropriate ancillary services is preferable to placement in a special school class.

b. Before placing a member of the class in such a program, defendants shall notify his parent or guardian of the proposed educational placement, the reasons therefor, and the right to a hearing before a Hearing Officer if there is an objection to the placement proposed. Any such hearing shall be held in accordance with the provisions of Paragraph e., below.

c. Hereinafter, children who are residents of the District of Columbia and are thought by any of the defendants, or by officials, parents or guardians, to be in need of a program of special education, shall neither be placed in, transferred from or to, nor denied placement in such a program unless defendants shall have first notified their parents or guardians of such proposed placement, transfer or denial, the reasons therefor, and of the right to a hearing before a Hearing Officer if there is an objection to the placement, transfer or denial of placement. Any such hearings shall be held in accordance with the provisions of Paragraph e., below.

d. Defendants shall not, on grounds of discipline, cause the exclusion, suspension, expulsion, postponement, inter-school transfer, or

any other denial of access to regular instruction in the public schools to any child for more than two days without first notifying the child's parent or guardian of such proposed action, the reasons therefor, and of the hearing before a Hearing Officer in accordance with the provisions of Paragraph f., below.

e. Whenever defendants take action regarding a child's placement, denial of placement, or transfer, as described in Paragraphs b. or c., above, the following procedures shall be followed.

- (1) Notice required hereinbefore shall be given in writing by registered mail to the parent or guardian of the child.
- (2) Such notice shall:
 - (a) describe the proposed action in detail;
 - (b) clearly state the specific and complete reasons for the proposed action, including the specification of any tests or reports upon which such action is proposed;
 - (c) describe any alternative educational opportunities available on a permanent or temporary basis;
 - (d) inform the parent or guardian of the right to object to the proposed action at a hearing before a Hearing Officer;
 - (e) inform the parent or guardian that the child is eligible to receive, at no charge, the services of a federally or locally funded diagnostic center for an independent medical, psychological and educational evaluation and shall specify the name, address and telephone number of an appropriate local diagnostic center;

- (f) inform the parent **or gurdainofthe right** to be represented at the hearing by legal counsel; **to** examine the child's school record before the hearing, including any tests or reports **uponwhich** proposed action may be based, to present evidence, including expert medical, **psychologi and educa-**tional testimony; and, to confront and cross-examine any school official, employee, **or agent of the** school district or public department who **may** have evidence upon which the proposed action was **baited**
- (3) The hearing shall be at a time and place reasonably convenient to such parent or guardian.
- (4) The hearing shall be scheduled not sooner than twenty (20) days waivable by parent or child, nor later than forty-five (45) days after receipt of a request from the parent or guardian.
- (5) The hearing shall be a closed hearing unless the parent or guardian requests an open hearing.
- (6) The child shall have the right to a representative of his own choosing, including legal counsel. If a child is unable, through financial inability, to retain counsel, defendants shall advise child's parents or guardians of available voluntary legal assistance including the Neighborhood Legal Services Organization, the Legal Aid Society, the Young Lawyers Section of the D. C. Bar Association, or from some other organization.
- (7) The decision of the Hearing Officer shall be based solely upon the evidence presented at the hearing.

- (8) Defendants shall bear the burden of proof as to all facts and as to the appropriateness of any placement, denial of placement or transfer.
- (9) A tape recording or other record of the hearing shall be made and transcribed and, upon request, made available to the parent or guardian or his representative.
- (10) At a reasonable time prior to the hearing, the parent or guardian, or his counsel, shall be given access to all public school system and other public office records pertaining to the child, including any tests or reports upon which the proposed action may be based.
- (11) The independent Hearing Officer shall be an employee of the District of Columbia, but shall not be an officer, employee or agent of the Public School System.
- (12) The parent or guardian, or his representative, shall have the right to have the attendance of any official, employee or agent of the public school system or any public employee who may have evidence upon which the proposed action may be based and to confront, and to cross-examine any witness testifying for the public school system.
- (13) The parent or guardian, or his representative, shall have the right to present evidence and testimony, including expert medical, psychological or educational testimony.
- (14) Within thirty (30) days after the hearing, the Hearing Officer shall render a decision in writing. Such decision shall include findings of fact and conclusions of law and shall be filed with the Board of Education and the Department of Human Resources and sent by registered mail to the parent or guardian and his counsel.

- (15) Pending a determination by the Hearing Officer, defendants shall take no action described in Paragraphs b. or c., above, if the child's parent or guardian objects to such action. Such objection must be in writing and postmarked within five (5) days of the date of receipt of notification hereinabove described,

f. Whenever defendants propose to take action described in Paragraph d., above, the following procedures shall be followed.

- (1) Notice required hereinabove shall be given in writing and shall be delivered in person or by registered mail to both the child and his parent or guardian.
- (2) Such notice shall
 - (a) describe the proposed disciplinary action in detail, including the duration thereof;
 - (b) state specific, clear and full reasons for the proposed action, including the specification of the alleged act upon which the disciplinary action is to be based and the reference to the regulation subsection under which such action is proposed;
 - (c) describe alternative educational opportunities to be available to the child during the proposed suspension period;
 - (d) inform the child and the parent or guardian of the time and place at which the hearing shall take place;
 - (e) inform the parent or guardian that if the child is thought by the parent or guardian to require special education services, that such child is eligible to receive, at no charge, the services of a public or private agency for a diagnostic medical, psychological or educational evaluation;

- (f) inform the child and his parent or guardian of the right to be represented at the hearing by legal counsel; to examine the child's school records before the hearing, including any tests or reports upon which the proposed action may be based; to present evidence of his own; and to confront and cross-examine any witnesses or any school officials, employees or agents who may have evidence upon which the proposed action may be based.
- (3) The hearing shall be at a time and place reasonably convenient to such parent or guardian.
- (4) The hearing shall take place within four (4) school days of the date upon which written notice is given, and may be postponed at the request of the child's parent or guardian for no more than five (5) additional school days where necessary for preparation.
- (5) The hearing shall be a closed hearing unless the child, his parent or guardian requests an open hearing.
- (6) The child is guaranteed the right to a representative of his own choosing, including legal counsel. If a child is unable, through financial inability, to retain counsel, defendants shall advise child's parents or guardians of available voluntary legal assistance including the Neighborhood Legal Services Organization, the Legal Aid Society, the Young Lawyers Section of the D. C. Bar Association, or from some other organization.
- (7) The decision of the Hearing Officer shall be based solely upon the evidence presented at the hearing.
- (8) Defendants shall bear the burden of proof as to all facts and as to the appropriateness of any disposition and of

the alternative educational opportunity to be provided during any suspension.

- (9) A tape recording or other record of the hearing shall be made and transcribed and, upon request, made available to the parent or guardian or his representative.
- (10) At a reasonable time prior to the hearing, the parent or guardian, or the child's counsel or representative, shall be given access to all records of the public school system and any other public office pertaining to the child, including any tests or reports upon which the proposed action may be based.
- (11) The independent Hearing Officer shall be an employee of the District of Columbia, but shall not be an officer, employee or agent of the Public School System.
- (12) The parent or guardian, or the child's counsel or representative, shall have the right to have the attendance of any public employee who may have evidence upon which the proposed action may be based and to confront and to cross-examine any witness testifying for the public school system.
- (13) The parent or guardian, or the child's counsel or representative, shall have the right to present evidence and testimony.
- (14) Pending the hearing and receipt of notification of the decision, there shall be no change in the child's educational placement unless the principal (responsible to the Superintendent) shall warrant that the continued presence of the child in his current program would endanger the

physical well-being of himself or others. In such exceptional cases, the principal shall be responsible for insuring that the child receives some form of educational assistance and/or diagnostic examination during the interim period prior to the hearing.

- (15) No finding that disciplinary action is warranted shall be made unless the Hearing Officer first finds, by clear and convincing evidence, that the child committed a prohibited act upon which the proposed disciplinary action is based. After this finding has been made, the Hearing Officer shall take such disciplinary action as he shall deem appropriate. This action shall not be more severe than that recommended by the school official initiating the suspension proceedings.
- (16) No suspension shall continue for longer than ten (10) school days after the date of the hearing, or until the end of the school year, whichever comes first. In such cases, the principal (responsible to the Superintendent) shall be responsible for insuring that the child receives some form of educational assistance and/or diagnostic examination during the suspension period.
- (17) If the Hearing Officer determines that disciplinary action is not warranted, all school records of the proposed disciplinary action, including those relating to the incidents upon which such proposed action was predicated, shall be destroyed.
- (18) If the Hearing Officer determines that disciplinary action is warranted, he shall give written notification of his findings and of the child's right to appeal his decision to the

Board of Education, to the child, the parent or guardian, and the counsel or representative of the child, within three (3) days of such determination.

- (19) An appeal from the decision of the Hearing Officer shall be heard by the Student Life and Community Involvement Committee of the Board of Education which shall provide the child and his parent or guardian with the opportunity for an oral hearing, at which the child may be represented by legal counsel, to review the findings of the Hearing Officer. At the conclusion of such hearing, the Committee shall determine the appropriateness of and may modify such decision. However, in no event may such Committee impose added or more severe restrictions on the child.

Whenever the foregoing provisions require notice to a parent or guardian, and the child in question has no parent or duly appointed guardian, notice is to be given to any adult with whom the child is actually living, as well as to the child himself, and every effort will be made to assure that no child's rights are denied for lack of a parent or duly appointed guardian. Again, provision for such notice to non-readers will be made.

Jursidiction of this matter is retained to allow for implementation, modification and enforcement of this Judgment and Decree as may be required.

APPENDIX D

THE MENTAL HEALTH LAW PROJECT

The Mental Health Law Project, made up of attorneys and mental health professionals, is engaged in an effort to define and implement **the** rights of the mentally ill and the mentally retarded through litigation and other techniques. Few areas in the law have been so neglected. The person who is involuntarily committed can lose his liberty for an indefinite term with only the most cursory procedures. Treatment, which is the alleged justification for such commitment, is most often a hollow fiction. There has been little attention focused on the process by which people are labelled mentally ill or mentally retarded, the consequences of such labelling, and the discrimination regularly suffered by the mentally retarded and the mentally ill in the community.

The Project was organized in January 1972. Among its organizers were Bruce Ennis, Paul Friedman and Charles Halpern, attorneys who were then actively engaged in the practice of mental health law. The Project is sponsored by the Center for Law and Social Policy, the American Orthopsychiatric Association, and the American Civil Liberties Union Foundation. The Center for Law and Social Policy is a public interest law firm in Washington, D. C., founded three years ago to provide representation to unrepresented groups and interests in major issues of public policy. The American Orthopsychiatric Association is a multi-disciplinary professional organization including among its members psychiatrists, psychologists, social workers and others concerned with the problems of the mentally impaired. The American Civil Liberties Union Foundation has a long-standing interest in protecting and expanding the civil rights of those alleged to be mentally impaired.

The three sponsoring organizations agreed that there was an urgent need for systematic involvement of lawyers and mental health

professionals in the area of law and mental health. Concern in the past has been sporadic at best. Too often, important judicial decisions have been handed down without the implementation efforts necessary to give constitutional principles practical significance. Legislative declarations of legal rights have often **been** rendered meaningless because of the unavailability of legal representation for the mentally ill and retarded; and the expertise of mental health professionals which would enrich legal consideration of mental health issues has rarely been presented.

With strong ties **in the mental** health professions, the Project is in a position to mobilize **professional** organizations and individual experts to provide assistance **to courts and other** decision-making bodies. Moreover, with a staff of lawyers **experienced** in the mental health field, the Project can select problems **of greatest** importance and develop long-range strategies for **developing solutions**.

The Project will **undertake a program** of litigation, education of the bar and the public, and **related activities**.

I. Program and Activities

Litigation

Test case litigation **will be a primary tool** used by the Project to identify and implement **the rights of the mentally** impaired. Two landmark legal decisions **in which Project attorneys** have already participated indicate the nature of **this activity**.

Wyatt v. Stickney -- Since the summer of 1971 Project attorneys have been actively involved in **Wyatt v. Stickney**, a right to treatment case in the federal **district court In Alabama**. The district court held that mentally ill and **mentally retarded** persons involuntarily confined in state mental institutions **have a** constitutional right to adequate treatment. Project attorneys **helped mobilize** professional organizations to

participate in the case and marshalled expert testimony to assist the court in assessing the adequacy of treatment and defining standards of adequate treatment in the State mental institutions in Alabama.

The court found conditions so shocking in one institution that it ordered immediate remedy of conditions which posed immediate danger to the health and safety of inmates. This included hiring 300 new employees to meet acute staff shortage. Project attorneys are playing an active role in assuring that the standards of adequate treatment are effectively implemented. The case has been appealed to the Court of Appeals for the Fifth Circuit, and Project attorneys will participate in oral argument scheduled for early December.

Project attorneys have made numerous speeches to professional groups to interpret the significance and impact of the Wyatt decision. The Project has also consulted with lawyers and others stimulated by the Wyatt litigation to consider judicial remedies for inadequacy of treatment in mental institutions in other states.

Mills v. Board of Education for the District of Columbia — A Project attorney served as co-counsel for a class of "exceptional" children who had been excluded from District of Columbia public schools. The suit contended that such exclusion was unconstitutional and also sought a revision of the school system's suspension procedures. The district court held:

That no child eligible for publicly supported education in the District of Columbia public schools shall be excluded from a regular public school assignment by rule, policy, or practice of the Board or its agents unless the child is provided: (a) adequate alternative educational services suited to the child's needs, which may include special education or tuition grants; and (b) a constitutionally adequate prior hearing and periodic review of his status, progress and the adequacy of any educational alternative.

The court held that plaintiffs could not be excluded because of insufficient funds and that even the most severely retarded child has a right to a suitable educational opportunity. The court stated that a special master would be appointed in the event of inaction, delay, or failure in implementation of the order. Project attorneys are now devoting their energies to meaningfully implementing this decree.

Other cases handled by the Project and matters under consideration include:

Jackson v. Indiana— Project attorneys, working with Professor Robert Burt of the University of Michigan Law School, submitted an amicus curiae brief in the Supreme Court. In holding that the indefinite confinement of a person found incompetent to stand trial was unconstitutional, the court's opinion adopted many of the arguments set forth by amici.

New York State Association for Retarded Children v. Rockefeller — challenging the adequacy of treatment afforded to retarded residents at the Willowbrook School in New York.

Dale v. New York — seeking damages on behalf of a former mental patient for violations of the Thirteenth Amendment's guarantee against involuntary servitude. The patient was forced to work for 16 years at non-therapeutic tasks.

Terrenzio v. Kessler — challenging the state's right to bill an adult citizen and his parents for the cost of his involuntary hospitalization where the hospitalization was opposed by all three.

Dale v. Hahn— challenging the constitutionality of a short-cut procedure for declaring a person incompetent, where his funds are entrusted to a "committee, " without notice, hearing, or counsel.

Donaldson v. O'Connor — In this ground-breaking case, money damages were for the first time awarded where a patient was held without treatment.

Morales v. Turman — brought on behalf of juveniles incarcerated in training schools in Texas, seeking to protect juveniles from physical abuse, indiscriminate administration of powerful tranquilizers and other oppressive conditions of confinement, and to establish their affirmative right to needed programs for successful reintegration into the community.

Project attorneys are considering also litigation or other activity to:

- develop the right of patients to be treated in the least restrictive setting necessary to accomplish legitimate state goals, and the corresponding duty of states to create a range of alternatives — including special education classes, halfway houses, nursing homes, and community mental health centers;

- establish appropriate protections for persons targeted for behavior modification programs and psychosurgery;

- require the Civil Service Commission to delete from its federal employment questionnaire questions about past history of "nervous breakdowns;"

- r- challenge inadequate procedural protections at the commitment hearings of allegedly mentally impaired persons. At a minimum such due process protections should include a hearing, the assignment of counsel to represent indigents, the right to specific notice of the allegations justifying commitment, the right to cross-examine all those who recommend commitment, and the right to subpoena lay and expert witnesses at public expense.

- require the U.S. Department of Labor to begin enforcing the 1966 Amendments to the Fair Labor Standards Act, which extended the right to the fair minimum wage to working residents in State Mental Institutions.

Information Clearinghouse and Litigation Back-up Center

In addition to providing representation, the Project will provide ACLU-affiliated lawyers, OEO-funded lawyers and other interested lawyers around the country specialized back-up assistance. Project staff will disseminate materials developed in Project litigation and provide expert advice and technical assistance where necessary. Project attorneys will work closely with groups like the District of Columbia Public Defenders Office which has a special section representing people in the civil commitment process.

Development of a Mental Health Bar

For half-year periods law students will be integrated into the Project's program, under the individual supervision of staff attorneys. These students will be drawn from the Center for Law and Social Policy's clinical education program, which is comprised of approximately fifteen students per semester from the law schools Pennsylvania, Michigan, Stanford, UCLA, and Yale. Students in the clinical program will work on every facet of legal proceedings and will also play an active role in the Project's development of policy. It is anticipated that the law students who receive specialized training with the Project will continue to be involved in the mental health field after they enter practice. In working with other attorneys, we also hope to develop more sophistication in the bar about mental health matters.

Public Education

(a) As part of its public education program, the Project will produce and distribute two consumer handbooks. The first will discuss the legal theories and leading cases in the right-to-treatment, right-to-education areas, in addition to the legal issues posed by the widespread use of uncompensated patient labor for the maintenance of mental

institutions. The second handbook will be procedural in character and will explain for interested laymen legal terminology and the litigation process with illustrations from important mental health law cases. Both of these documents should be printed and distributed in early 1973;

(b) The Project will continue to provide speakers to various mental health consumer and professional organizations such as the National Association for Mental Health, the National Association for Retarded Children, the Council for Exceptional Children, the American Association on Mental Deficiency, the American Psychological Association, and the American Orthopsychiatric Association;

(c) Project staff are participating in the planning of a conference on the legal rights of the mentally retarded sponsored by the President's Committee on Mental Retardation and other conferences concerning the rights of the mentally impaired;

(d) Project staff will continue to write articles concerning the rights of the mentally impaired and to encourage the discussion of relevant issues in the media.

Legislative Counselling

To an extent consistent with its tax-exempt status, Project staff will provide technical information and advice to legislators concerned with the rights of the mentally handicapped and to professional groups involved in the legislative process. For example, the Project may provide assistance in the revision of model commitment legislation.

Information and Research Programs

The Mental Health Law Project will attempt to collect data and marshal information necessary for intelligent policy decisions. Two areas in which such work might be undertaken are the reliability of various criteria for the prediction of dangerousness and the impact of litigation on treatment delivery systems.

Project Staff

Bruce J. Ennis is a graduate of Dartmouth College and the University of Chicago Law School. Mr. Ennis was law clerk to Chief Judge William E. Miller of the United States District Court for the Middle District of Tennessee and an associate of the law firm of Chadbourne, Parke, Whiteside and Wolff in New York City. He has written several articles in the mental health field and a new book, Prisoners of Psychiatry. Another book on the rights of mental patients will be published shortly. Mr. Ennis has been for the past two years Director of the Civil Liberties and Mental Illness Project of the New York Civil Liberties Union. Mr. Ennis will devote approximately one-third of his time to Project activities.

Paul R. Friedman is managing attorney of the Project. He is a graduate of Princeton University, Trinity College, Cambridge (MA) and Yale Law School. Mr. Friedman came to the Center for Law and Social Policy as a Fellow in 1971 after serving as law clerk to Judge J. Skelly Wright of the United States Court of Appeals for the District of Columbia. For the past fifteen months he has worked on organization of the Project and mental health test case litigation. Mr. Friedman is the first lawyer to be admitted for training at the Baltimore-District of Columbia Institute for Psychoanalysis.

Charles R. Halpern, past Director of the Center for Law and Social Policy, was formerly associated with the law firm of Arnold and Porter. A graduate of Harvard College and Yale Law School, Mr. Halpern was law clerk to Judge George T. Washington of the United States **Court** of Appeals **for** the District of Columbia Circuit. He has had **extensive exprience in** litigation involving the rights of mental **patients and has lectured and written** on law and mental illness. Mr. Halpern **will devoto approximately** one-third of his time to Project activities.

Gail Marker is a graduate of Indiana University and the University of Michigan School of Social Work. She has served as a caseworker and acting unit director of social services at Wichita Falls State Hospital, Texas. Prior to joining the Project, she was a student intern at the Brookings Institution. Ms. Marker is the co-author of several articles on mental health and social policy.

Lawrence H. Schwartz is a graduate of the University of Michigan, the University of Chicago Law School, and Georgetown Law Center (LL.M.). He served as a law clerk to Chief Judge Morris Miller in the District of Columbia Juvenile Court. Mr. Schwartz is an adjunct professor at the Georgetown University Law Center. Prior to joining the Project, Mr. Schwartz was Chief of the Family Division of the Public Defender Service for the District of Columbia, where he had extensive litigation experience in juvenile and criminal cases.

Patricia M. Wald is a graduate of Connecticut College for Women and Yale Law School. Her experience includes law clerk to Judge Jerome Frank, a member of the President's Commission on Crime in the District of Columbia, co-director of the Ford Foundation Drug Abuse Research Project, member of the Sloan Commission on Cable Communication, and an attorney with Neighborhood Legal Services and the Center for Law and Social Policy. Ms. Wald has published numerous scholarly articles and is a member of the Board of Trustees of the Ford Foundation.

Fellows from the Center for Law and Social Policy and several law students will participate in Project activities. In addition, Project staff will regularly consult with mental health professionals who have relevant experience.

III. Structure of the Mental Health Law Project

Affairs of the Project are under the over-all supervision of a Board of Trustees composed of lawyers and mental health professionals. Three members will be selected by each of the sponsoring organizations and three additional members by the Board itself.

Close working relationships have been established with leading mental health organizations including the American Psychological Association, the National Association for Mental Health, the American Association on Mental Deficiency, and the Council for Exceptional Children. It is anticipated that the Project will also work closely with other legal groups interested in this area.

The Project is a nonprofit, District of Columbia Corporation which will seek an exception from Federal taxes under Section 501(c)(3) of the Internal Revenue Code. Grants for Project activity have thus far been received from the Edna McConnell Clark Foundation, Joint Foundation Support, Norman Fund, and Playboy Foundation.

The Project shares offices with the Center for Law and Social Policy at 1600 Twentieth Street, N.W., Washington, D. C., 20009. As of January 7, 1973, the office will move to 1751 N Street, N.W., Washington, D. C. 20036. The New York Project office is headed by Bruce Ennis and is located at 84 Fifth Avenue, New York, New York 10011.