C.2 Study Comm'n Reports

1973

REPORTS

OF THE

LEGISLATIVE RESEARCH COMMISSION

TO THE

GENERAL ASSEMBLY

OF

NORTH CAROLINA

MENTAL HEALTH

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1973 REPORTS

LEGISLATIVE RESEARCH COMMISSION

MENTAL HEALTH

1. MENTAL HEALTH SERVICES
2. THE "GEOGRAPHIC UNIT" CONCEPT

STATE OF NORTH CAROLINA

LEGISLATIVE RESEARCH COMMISSION

STATE LEGISLATIVE BUILDING

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TO THE MEMBERS OF THE 1973 GENERAL ASSEMBLY

The Legislative Research Commission herewith reports to the 1973 General Assembly its findings and recommendations concerning two areas of mental health. The first report is made pursuant to Senate Resolution 871 of the 1971 General Assembly, which directed the Commission to "make a complete in-depth study of the Department of Mental Health and related programs and to make recommendations to the General Assembly." The second report is made pursuant to House Joint Resolution 715 of the 1971 General Assembly, which directed the Commission to "study the 'geographical unit' concept within the State mental hospitals."

The reports were initiated by committees of the Legislative Research Commission; members of the two committees are listed in the individual reports.

Respectfully submitted,

Representative Philip P. Godwin Senator Gordon P. Allen
Co-Chairmen, Legislative Research Commission

1973 REPORT

LEGISLATIVE RESEARCH COMMISSION

MENTAL HEALTH SERVICES

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REPORT BY THE LEGISLATIVE RESEARCH COMMISSION

TO THE 1973 GENERAL ASSEMBLY

MENTAL HEALTH SERVICES

I. Introduction: The Origin and Task of the Committee on Mental Health

A. The Origin and Members of the Committee

The General Assembly's decision to direct the Legislative Research Commission to study the entire mental health area in depth was based on its observation that the demand for mental health care is increasing and that the General Assembly requires up-to-date information about "mental health programs, facilities, and needs of the State" (S.R. 871 of 1971). This resolution, reproduced in Appendix A of this report, directed the Commission to make an in-depth study of the subject and report its findings and recommendations to the 1973 General Assembly.

The Committee on Mental Health was created by the Legislative Research Commission to perform the study directed by S.R. 871. The Committee, whose members' names are listed in Appendix A, consisted of legislators from diverse parts of the state, with widely varying interests in and knowledge of mental health, who share a strong commitment to make mental health service of the highest possible quality available to the citizens of the state.

B. Scope and Limitations of the Committee's Work

The Committee's work has not included a detailed study of the internal management and organization of the North Carolina Department of Mental Health. The Committee believes that such a study can best be done by a team of recognized experts in the mental health service management field, and recommends that funds be provided for this purpose.

The scope of the Committee's work has included general policies in mental health service and the needs and problems of the present mental health system throughout the state. Its findings and recommendations chiefly concern the Department of Mental Health and associated community mental health programs, but also affect the Department of Public Education and the various schools of medicine and education in the state.

The Committee has found a need for comprehensive statutory change. The portions of the General Statutes which deal with incompetency, admission and commitment to mental hospitals, discharge therefrom, and mental illness as a defense to criminal charges are in a state of confusion. The few statutory changes recommended by the Committee in Section III(E) of this report have been virtually dictated by recent legal developments. Much more remains to be done. The Committee recommends that the 1973 General Assembly create a Mental Health Code Commission with the function of submitting proposed statutory revisions to the 1975 General Assembly. The scope of the work of the Mental Health Code Commission should include incompetency, admission and commitment to mental hospitals, discharge from mental hospitals, mental illness as a defense to criminal charges, and the desirability of adopting patients' rights legislation of the type recently adopted or proposed in the District of Columbia, California, Pennsylvania, and other jurisdictions. The funding of the Commission [see Section III(F) of this report] should be sufficient to permit the use of a qualified staff, including professionals in the fields of law, forensic mental health, medicine, psychiatry, and mental health administration.

C. Sources of Information

The members of the Committee visited (in some cases more than once) every one of the state facilities for mental illness, mental retardation,

and alcoholism. These visits were an important source of information, and the Committee is appreciative of the time taken by the staff of the various institutions to inform the Committee about their work and their problems and needs. The Committee's thinking owes much to testimony at its meetings[1] and in oral and written communications received by its members and wishes to thank all the professional and lay persons who have contributed to its understanding of the problems of mental health. Other sources of information were the publications of the Department of Mental Health, the figures prepared by the DMH Statistics Division, and the Report of the State Bureau of Investigation on Cherry Hospital.

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[1]A list of persons who testified and the subject covered by each is given in Appendix B.

II. Current Trends in the Department of Mental Health.

The recently adopted statutory policies favoring community and area mental health programs[1] are reflected in a rapid increase in client intake and costs at the community level, accompanied by a slowdown of intake rates at large state institutions. The table on the next page covering actual DMH expenditures over the last ten years indicates that while the largest single item, mental hospitals, has decreased in relative share from 72% to 53%, and mental retardation's share has remained nearly constant, the dollars allocated to community mental health programs have increased from zero to nine percent of the total. At the present, time, admissions to the state facilities are stabilizing or decreasing, whereas community program intake is still rapidly increasing. Dr. Eugene Hargrove, Commissioner of Mental Health, told the Committee that total admissions to the four regional mental hospitals (Broughton, Cherry, Umstead, and Dix) was stabilizing at about 15,000 per year, with an average daily census of about 6,800. The four state mental retardation centers (Murdoch, Western Carolina, O'Berry, and Caswell), he said, are levelling off at about 400 total admissions per year, with an average daily census of about 5,000, and admissions to the three state alcoholic rehabilitation centers (Black Mountain, Butner, and Jones), having reached 2,840 in fiscal 1971, will probably experience a reduction to 2,500 in fiscal 1972 and continue to drop due to the increasing role of community alcoholism programs. [The average daily census at the three state alcoholic facilities is now about 300.] In contrast to the situation at state institutions, total intake of community programs serving all 100 counties in the state has increased rapidly to 33,000 in fiscal 1972 and will probably reach 40,000 in fiscal 1973.

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[1] See G.S. 122-35.1 (1964), G.S. 122-35.2, .3 (Supp. 1971), and G.S. 122-35.19, .20 (Supp. 1971).

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

ANALYSIS OF ANNUAL EXPENDITURES

FISCAL YEAR 1962 thru FISCAL YEAR 1972

	1961-62	1962-63	1963-64	1964-65	1965-66	1966-67	1967-68	1968-69	1969-70	1970-71	1971-72
MENTAL HOSPITALS											
Broughton Hospital	4,553,598	4,731,563	5,289,080	5,393,863	6,106,999	6,041,029	6,792,351	7,557,935	9,954,398	11,067,138	12,114,894
Cherry Hospital	3,635,807	4,181,496	4,688,224	5,092,322	5,784,755	6,014,633	6,913,791	7,492,781	9,651,969	10,853,412	11,281.676
Dorothea Oix Hospital	4,924,272	5,030,063	5,463,031	5,729,474	6,380,172	6,588,985	7,585,067	8,046,475	10,495,363	11,895,152	13,093,148
John Umstead Hospital	3,887,537	4,155,076	4,444,892	4,875,342	5,417,410	5,556,468	6,144,724	6,586,185	8,183,429	8,831,633	9,537,122
	17,001,214	18,098,198	19,885,227	21,091,001	23,689,336	24,201,115	27,435,933	29,683,376	38,285,759	42,647,335	46,026,840
	72%	70%	67%	63%	63%	61%	60%	58%	56%	55%	53%
MENTAL RETARDATION CENTERS											
Caswell Center	2,759,062	2,914,457	3,173,670	3,557,634	3,986,862	4,231,111	4,560,015	4,856,391	6,387,312	6,971,812	7,582,847
Murdoch Center	2,572,452	2,936,039	3,038,536	3,362,321	3,886,255	4,259,981	5,031,233	5,321,550	6,834,441	7,540,893	8,146,135
O'Berry Center	1,104,044	1,410,604	1,720,895	1,960,300	2,376,364	2,508,519	3,193,724	3,426,353	4,433,546	5,066,570	5,673,204
Western Carolina Center		91,111	701,957	1,513,062	1,658,430	1,830,542	2,381,135	3,105,348	4,358,784	5,107,362	6,033,425
	6,435,558	7,352,211	8,635,058	10,393,317	11,907,911	12,830,153	15,166,107	16,709,642	22,014,083	24,686,637	27,435,611
	27%	28%	29%	31%	32%	34%	33%	33%	32%	32%	32%
ALCOHOLIC REHABILITATION CENTERS											
ARC - Black Mountain								162,047	664,652	739,390	843,068
ARC - Butner				143,004	174,008	190,947	205,546	348,855	662,920	705,092	756,194
ARC - Greenville								109,100	668,217	762,019	806,765
				143,004	174,008	190,947	205,546	620,002	1,995,789	2,206,501	2,406,027
				1%	1%	1%	1%	1%	3%	3%	3%
WRIGHT SCHOOL		54,137	127,059	161,504	156,050	177,485	161,652	170,816	232,292	271,077	271,244
		1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
RALEIGH OFFICE											
A. State Aid to Community Based Programs		99,374	580,666	1,085,481	1,200,437	1,233,518	1,903,805	2,777,471	4,111,634	5,157,444	7,465,750 (9%)
B. Statewide research, planning, training, evaluation, and management analysis	121,539	168,935	294,077	421,522	323,474	262,270	434,812	485,391	653,799	834,376	994,362 (1%)
C. State-Wide Administrative Services for Mental Health System	77,893	79,061	188,077	205,444	272,904	398,090	536,161	662,976	974,924	1,124,673	1,117,478 (1%)
D. Other: Scholarships and Mental Health Clinic at Central Prison	2,014	43,847	48,611	45,156	75,383	80,946	206,476	269,448	348,531	385,740	395,985
	201,446	391,217	1,111,431	1,757,603	1,872,198	1,974,824	3,081,254	4,195,286	6,088,888	7,502,233	9,973,575
	1%	1%	3%	4%	3%	3%	5%	7%	8%	9%	11%
TOTAL FOR MENTAL HEALTH SYSTEM	23,638,218	25,895,763	29,758,775	33,546,429	37,799,503	39,374,524	46,050,492	51,379,122	68,616,811	77,313,783	86,113,237
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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The Committee approves of the trend toward community mental health programs, Section III(C) of this report contains more detailed findings and recommendations on this subject.

As the shift from large, isolated institutions to community programs proceeds, the Committee is concerned about maintaining quality in the state institutions which are still the backbone of the mental health system. How are North Carolina's institutions rated in comparison with others in the United States? In discussions with several officials of the National Institute of Mental Health, the Chairman of the Committee was pleased to learn that, in terms of the quality of its professional staff, the North Carolina Department of Mental Health was rated among the ten best departments in the nation. What about the overall quality of mental health care in this state compared with that of other states? It is difficult to find specific, unambiguous information on the relative effectiveness of various mental health systems. Measuring inputs to mental health service--i.e., the amount of resources expended--is the only way the Committee has found to compare North Carolina with other states. Three such measurements are shown in the table below. In these terms, North Carolina is significantly below the national average and does not rank highly among the fifty states and the District of Columbia.

Some acute problems in one of the state institutions were brought to light by the State Bureau of Investigation Report on Cherry Hospital. The report documented a number of instances of alleged neglect and nonprofessional conduct of medical personnel, alleged criminal violations by patients and employees, and poor physical conditions. The Department of Mental Health has dismissed all personnel who were significantly involved in the alleged

Three Measures of Mental Health Service Input in North Carolina and the United States as a Whole

	USA Average	North Carolina	N.C. Rank
1. Physician hours per week per 100 resident patients in public mental hospitals, 1970	75.0	52.8	38/51
2. Professional hours per week per 100 resident patients in public mental hospitals, 1970	304	249	34/51
3. Full-time equivalent personnel per 100 resident patients in public mental hospitals, 1970	66.9	62.7	35/51

[SOURCE: "Eleven Indices," Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Washington, D.C., 1971, at pp. 15, 17, and 19.]

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misconduct. The Committee finds that the steps taken by the Department are a satisfactory response to the situation at Cherry Hospital, but recommends that the Department remain continually watchful to avoid recurrence of such problems. The Committee believes that one way of avoiding a recurrence is to give greater attention, within the Department, to patient care at regional hospitals.

The overall impression of the Committee is that while the citizens of the state can rightly respect the quality of public mental health care, much improvement is necessary to bring the quality in all institutions and programs to a level of which North Carolina can be proud. The remaining sections of this report contain specific findings and recommendations as to how improvement can be made.

III. Findings and Recommendations

The detailed findings and recommendations of the Committee on Mental Health are presented below in six parts: new programs, improvement of present service, community mental health, drug abuse, costs and funding, and statutory change.

A. New Programs

1. The mentally retarded. The Committee's finding is that there is presently much unnecessary and costly institutionalization of the mentally retarded, children as well as adults, and that the retarded are being denied the full opportunity to a free public education. The Committee recommends that the standards applied by the U.S. District Court in Wyatt v. Stickney[1] for the care and education of the mentally retarded be adopted as a long-range goal by North Carolina, not because they are legally binding on this state but because of the professional authority on which they are based. These standards are reproduced in Appendix D of this report.

The Committee especially recommends the following policies and actions for immediate adoption.

a. Persons whose mental retardation is "borderline" or "mild" [defined as in the Wyatt standards, p. 13] should not be institutionalized.

b. All retarded persons should receive suitable educational service, regardless of chronological age or degree of retardation. A full educational program should be provided to all retarded persons of school age by the Department of Public Education, in a regular school facility where possible, or in the home or institution.

c. The Department of Public Education should assume primary responsibility for education of the retarded, including those in institutions. Curricula appropriate for this purpose should be developed cooperatively by the Department of Public Education, the state mental retardation centers, and community mental health programs.

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[1] ____ F.Supp. ____, Civil Action No. 3195-N (M.D. Ala. 1972).

d. Community-based care and education of the retarded of all ages should be the preferred treatment. Community and area mental health programs should be responsible for developing means of care other than state institutions--group homes, day care, and the like--to avoid institutionalization and its costs, which are higher than the costs of community care.

e. Greater care should be taken by the Department of Mental Health to explain fully to parents or guardians of adult mentally retarded patients any plan involving their transfer to a community facility or to their homes.

f. The state should provide financial support for "benefactors" in the community who may wish to provide homes or supervision for retarded persons, adults as well as children.

2. Emotionally disturbed children.[1] The Committee finds that programs for emotionally disturbed children, inpatient as well as outpatient, are grossly inadequate in size and scope. The Department of Mental Health has several excellent programs now in operation which, though small, can serve as models for future expansion: the Wright School, which undertakes education of 72 emotionally disturbed children per year (an average of four months each) in a residential setting and at the same time serves children in the surrounding community who attend the public schools; the Regional Child Mental Health Training Program at Dix Hospital, which trains medical and educational professionals and assists the Raleigh Public Schools in operation of an affiliated school for emotionally disturbed children; the Children's Psychiatric Institute at Umstead Hospital, with a capacity of 24 beds; and the Children's Unit at Cherry Hospital, with a capacity of 30. Also the state is fortunate in having the work of the Study Commission on

[1] "Emotionally disturbed children" as used herein includes autistic children.

North Carolina's Emotionally Disturbed Children[1] as a guide for future action. The Committee is hopeful that the continuing review of local and state programs for children conducted by the Governor's Advocacy Commission on Children and Youth[2] will also be of great benefit in planning expansion of mental health service for children.

The Committee recommends the following:

a. The Department of Mental Health should develop a projection of the number of emotionally disturbed children who will require service over the next ten years, and project the number who will not be serviced by present programs.

b. Depending on the amount and type of need projected, the Department of Mental Health should plan an expansion of inpatient and community-based programs for emotionally disturbed children.

c. Regional hospitals should not only treat children on an inpatient basis in greater numbers, but also increase their role in training professionals for work in the community with emotionally disturbed children.

d. The goal of expanded programs for emotionally disturbed children should be to avoid institutionalization and its potential damage to the child by appropriate community-based service, or if institutionalization is necessary, to make inpatient treatment genuinely therapeutic, with the objective of returning the child to the community and providing adequate follow-up service.

e. In planning expansion of programs for children, the Department should take into consideration the recommendations of the Governor's Advocacy Commission on Children and Youth.

3. Geriatric patients. The Committee finds that 30 to 35% of the patients at regional hospitals are over 65 years of age and require no more than 24-hour custodial care. In the past, there was no other

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[1]See "Who Speaks for Children?", published by the Study Commission on North Carolina's Emotionally Disturbed Children, North Carolina State University Print Shop, Raleigh, 1970.

[2]Established pursuant to G.S. 110-65 et seq. (Supp. 1971).

way of caring for the aged. Now, however, there are a number of alternative possibilities which should be explored fully, including nursing or rest home care, boarding homes, group homes for the aged, and living at home where adequate counseling and medical service is provided locally to the aged person and his or her family. Some of these alternatives may involve considerable cost saving in care of the aged, and will free substantial amounts of time of mental health professionals and attendants to work with patients who are genuinely mentally ill. The role of federal funding such as Medicaid needs to be carefully considered, and also the linkage between the Department of Mental Health and the Department of Social Services, which has developed various programs of community-based service to the aged.

For the few geriatric patients who require more than custodial care, more specific inpatient treatment should be provided. The Committee finds that, whatever the merits of the geographic unit system, it does not seem to work well for geriatric patients.

Specifically, the Committee recommends the following:

a. The Department of Mental Health should study the cost benefits and desirability of transferring geriatric patients who require only custodial care to community-based facilities such as nursing or rest homes, boarding homes, group homes for the aged, or to their own homes with suitable medical service supplied to the aged person living with his family.

b. In this study, the linkage between the Department of Social Services and the Department of Mental Health should be considered. Special emphasis should be given to ways in which community mental health service can be expanded to assist the aged and their families to avoid commitment to regional mental hospitals, and to support new community-based custodial arrangements such as boarding or group homes for the aged.

c. In the study, the possibilities of federal funding of new custodial arrangements should be thoroughly investigated.

d. Geriatric patients who are now in regional mental hospitals and require more than custodial care should receive specific treatment depending on need.

B. Improvement of Present Programs

This subsection is concerned with all present activities of the Department of Mental Health, including regional hospitals, mental retardation centers, alcoholic rehabilitation centers, children's units, and community and area mental health programs.

1. The right to treatment of involuntarily hospitalized patients. The constitutional right to treatment is not a settled area of the law. The Committee has found strong legal arguments for such a right. In the view of Senator Sam Ervin, a noted constitutional scholar, there is a constitutional "right to medical treatment, and not just custodial care or detention."[1] Because of the compelling constitutional arguments and other considerations, some jurisdictions have provided a statutory right to treatment. Among them are the District of Columbia, whose Hospitalization of the Mentally Ill Act of 1964 was sponsored in the U.S. Senate by Senator Ervin, and California, which adopted the Lanterman-Petris-Short Act in 1969.

The Committee finds a need for adoption by North Carolina of explicit minimum standards of mental health treatment. It fully endorses the Policy on Patients' Rights recently adopted by Board of Mental Health (reproduced in Appendix C of this report), but finds that more extensive standards are necessary. At the same time, the Committee recognizes that the standards adopted, if too strict, will impose an unacceptable burden on the taxpayer. Accordingly, the

[1]Hearings on Constitutional Rights of the Mentally Ill before the Subcommittee on Constitutional Rights of the Senate Committee on the Judiciary, 91st Cong., 1st & 2d Sess. 4 (1969, 1970).

Committee recommends the adoption by the Board of Mental Health and the General Assembly of the standards of mental health treatment applied by the U.S. District Court for the Middle District of Alabama in the case of Wyatt v Stickney[1], with the exception of those portions of the Wyatt standards which require a higher staff-to-patient ratio than presently exists in state institutions in North Carolina. [The Standards are reproduced in Appendix E of this report.] The Department of Mental Health has worked out an estimate of the cost of full implementation of the Wyatt standards for state mental hospitals (see table on next page). Clearly, the higher staffing ratio is the most expensive item.[2] When that is subtracted, the total cost of compliance is about four million dollars. Most of that amount (about 2.3 million) is allocated to payment for patients' work, which is already required by the Board's own Policy on Patients' Rights. The Committee further recommends that implementation of the Wyatt standards on staffing ratios be considered a desirable long-term goal for state facilities. The staffing standards are too expensive for immediate implementation, but will probably be attainable in the future as community mental health programs gradually reduce the number of institutionalized patients.

The basis for the Committee's recommendation of partial adoption of the Wyatt standards is not a legal one, since these standards, imposed by a U.S. District Court in Alabama, are not legally binding on this state. The basis of the Committee's recommendation is the professional authority of the authors of the standards, who include representatives of the

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[1] ____F. Supp. ____, Civil Action No. 3195-N (M.D. Ala. 1972).

[2]The Wyatt staffing standard is at pp. 16-17 of Appendix E of this report.

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

Estimated Cost of Compliance with Alabama Court Decision

	Broughton	Cherry	Dorothea Dix	John Umstead	TOTAL
Inpatient Population 1973-75	2,100	1,500	1,800	1,200	6,600
Base Budget Positions 1973-75 (1)	1,268	1,278	1,239	885	4,670
Ratio of Patients to Employees	1.7 : 1	1.2 : 1	1.5 : 1	1.4 : 1	1.4 : 1
Change Budget Positions Required for Compliance with Court Decision	733	268	518	269	1,788
Total Positions	2,001	1,546	1,757	1,154	6,458
Ratio of Patients to Employees	1 : 1	1 : 1	1 : 1	1 : 1	1 : 1
(A) Cost of Change Budget Personnel	9,828,110	3,968,064	7,779,357	4,374,902	25,950,433
(B) Pay for Working Patients	728,000	520,000	624,000	416,000	2,288,000
(C) Communication Privileges for Patients	80,400	46,800	56,160	37,440	220,800
(D) Patient Evaluator	26,844	26,844	26,844	26,844	107,376
(E) Living and Visiting Facilities Conducive to Privacy	70,000	37,750	92,000	---	199,750
(F) Patient Release Fund	100,000	81,250	65,834	50,000	297,084
(G) Individual Storage Lockers for Patients' Personal Belongings	525,000	112,000	---	---	637,000
	$11,358,354	$4,792,708	$8,644,195	$4,905,186	$29,700,443

(1) Positions for Training Programs have been excluded from this figure.

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American Psychological Association, the American Orthopsychiatric Association, and the American Association on Mental Deficiency.

The Committee wishes especially to recommend to the General Assembly and the Board of Mental Health the following selected portions of the Wyatt standards on treatment of the mentally ill, noting that their effect is somewhat broader than the Board's Policy on Patients' Rights.

a. Mental patients have a right to be free from physical restraint or isolation unless prescribed for good cause by a qualified mental health professional; the only exception should be emergencies where it is likely that the patients could harm themselves or others.

b. Each mental patient should have an inidvidual treatment plan prepared by a qualified mental health professional, to be reviewed at intervals of no more than 90 days, which should include a timetable, criteria for discharge, and a plan for post-hospitalization.

c. Mental patients (or their guardians) have a right to refuse unusual or hazardous treatment procedures, such as lobotomy, electroshock, and aversive conditioning.

d. No medication should be administered without an order by a physician. Each prescription should be reviewed weekly by a physician. No drug should be prescribed for punishment or for the convenience of hospital staff.

e. The 1973 General Assembly should fund the Department of Mental Health's newly introduced unit dose system, which was developed and tested at Western Carolina Center. Until this system is funded and implemented, the Department will not be in full compliance with federal laws concerning drug distribution.[1]

2. Allocation of resources with the Department of Mental Health.

The Committee finds that insufficient attention is being paid by the Department of Mental Health to care of patients in state institutions. There is a need to redirect some of the staff resources in the central office to actual problems of patient care in the field. The Committee has discerned

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[1]The Department of Mental Health requested, but did not receive, funds from the 1971 General Assembly to implement the unit dose system.

inequalities of treatment quality among the four mental health regions, and finds it regrettable that the opportunity for treatment should depend on the region in which a patient happens to reside. Finally, the Committee finds that private professional resources outside the Department are not being used adequately at present.

The Committee recommends the following:

a. The percentage of the time of the Department of Mental Health professionals spent in actual patient care at state institutions should be increased. Professional employees of the Department assigned to the central office in Raleigh should spend at least half their time in the field--either at state institutions or community mental health facilities.

b. Each of the Deputy Commissioners of mental health regions should reside, or have an office, in their region.

c. In order to reduce present differences in quality of treatment and administration among the state institutions, the Department should take steps to ensure that innovations, once tried and proven successful at one institution, be adopted by the other institutions.

d. The Department should create incentives for some of the state institutions to "catch up" with the progress made by others. In particular, medical staff vacancies at Cherry and Broughton Hospitals should be filled. The Department should consider increasing the existing salary differentials favoring these two hospitals.

e. In order to benefit from skills and techniques developed by private professionals and hospitals, the Department should make more extensive use of private psychiatrists and clinical psychologists, especially in community mental health programs.

3. Staff development within the Department of Mental Health.

The quality of public mental health service in North Carolina is essentially the quality of the people who provide it. Nothing is more important than

their level of skill and dedication. The Committee finds that more attention should be given to certain problems of staffing and staff development covered by the specific findings and recommendations below.

a. The Committee finds an insufficient affiliation between state programs for the mentally ill and the mentally retarded (including community-based programs as well as institutions) and the major schools of medicine, psychology, and education in the state. It therefore recommends the joint development by the Department of Mental Health and the universities and other professional schools in the state (public and private) of a complete program of residency training. This program should be operated on an equal basis at all state facilities, not just those near major universities. It should be offered not only to students of medicine and clinical psychology, but also to graduate students in special education, school psychology, nursing, and related fields, including those students whose career plans include work with the mentally ill or mentally retarded in community programs. The Committee believes that such a program will benefit the state facilities by providing additional manpower and by introducing the point of view of students from these various disciplines; and further, that it will benefit the students by giving them clinical experience and stimulating their interest in the field of mental health.

b. Of all the institutional staff, attendants and cottage parents have the most frequent contact with patients and are therefore an important element in the therapeutic environment. Because advancement opportunity for attendants and cottage parents is poor, the Committee recommends the establishment of a career ladder for attendants and cottage parents, including pay incentives for training and education received either on the job or in schools outside the Department. The Department of Mental Health should create a position above the level of attendant for persons who obtain the Mental Health Associate degree now offered by some community colleges. When the career ladder for attendants and cottage parents has been established, the Departments of Personnel and Mental Health should review the job classification and salary level of attendants and cottage life personnel to determine whether upgrading is appropriate.

c. In the forensic units of state mental hospitals, there is a continued loss of trained attendants to the Department of Correction because of salary differentials. The base pay of an attendant is now about $5000 per year while that of a Security Officer I in the state prison system is about $6300. The Committee recommends that a separate job classification for forensic unit attendant be created at the same level as that of prison security officer. The Committee feels this is justified because of the higher risks and security needs in forensic units.

d. Attendants' time should be spent attending to patients' needs, but too much is now spent in housekeeping tasks. More building maintenance staff should be hired to free attendants for work with patients.

e. It is the impression of the Committee that some problems at the state institutions, such as those uncovered by the SBI Report on Cherry Hospital, are due to psychological inaptitude of some staff members, professional as well as nonprofessional. The Department should require more psychological testing and screening of present and prospective employees of the Department, especially those who work directly with patients. Even a small number of psychologically unfit staff can create poor conditions for treatment.

f. The Committee recommends a new arrangement for administration of all state mental hospitals and mental retardation centers. The position of Business Manager of each such institution should be replaced with that of Hospital Administrator. The position of General Business Manager of the Department of Mental Health should be replaced by that of General Hospital Administrator. All Hospital Administrators and the General Hospital Administrator should be required to be graduates of accredited graduate schools of hospital administration. A direct line of authority should be created from the General Hospital Administrator in Raleigh to the Hospital Administrators in each of the mental hospitals and mental retardation centers.

C. Community and Area Mental Health Programs

Present statutes express a statewide policy favoring community and area mental health programs. G.S. 122-35.1 (1964) provides:

> It shall be the policy of the State Department of Mental Health to promote the establishment of mental health clinics in those localities which have shown a readiness to contribute to the financial support of such clinics, assisted by the federal and State grants-in-aid to the extent available.

G.S. 122-35.19 (Supp. 1971) authorizes the Board of Mental Health to establish area mental health programs, and to "develop and test budgeting procedures for combining local and State grants-in-aid funds." G.S. 122-35.20 (Supp. 1971) provides:

> Subject to the supervision, direction, and control of the State Board of Mental Health, the area mental health board shall be responsible for reviewing and evaluating the area needs and programs in mental health, mental impairment, mental retardation, alcoholism, drug dependence, and related fields, and for developing jointly with the State Department of Mental Health an annual plan for the effective development, use and control of State and local facilities and resources in a comprehensive program of mental health services for the residents of the area.

The Committee finds that these are good and workable policies, and that the Board and Department are in fact complying with these statutes and are shifting the emphasis in mental health service to community programs [see statistics discussed in Section II above]. The eventual result, of which the Committee approves, will be a mental health service system in which treatment in large, isolated state institutions is exceptional and where most mental health service is delivered in the community. During the period of transition from institutional programs to community programs, however, caution must be exercised. The problems of state institutions must not be neglected. At the same time, we must remember that before any patient is transferred from a state institution to a local community, appropriate community facilities must be prepared. "Community mental health program" is not a magic slogan. To be effective, such programs must be planned carefully. Without adequate planning, community facilities may be worse than the institutional programs they are meant to replace.[1]

Preceding sections of this report have described problems and inadequacies of present public mental health service which will have to be remedied at the community level. Examples are the problem of over-institutionalization of the retarded [Section III(A)(1)], the inadequacy

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[1]See "Where Have All the Patients Gone?", a report prepared by the California State Employees' Association, Sacramento (1972).

of present programs for emotionally disturbed children [Section III(A)(2)], and the need to transfer many geriatric patients from hospitals to a community setting [Section III(A)(3)]. All of these problems, in a sense, are being "handed back" to the community by the recommendations herein. All will therefore have to be solved by, among other things, increasing the responsibility of community and area programs. Increased responsibility will require increased awareness in local communities of the need for such programs, and increased ability to plan, fund, and operate them.

The Committee's conclusion is that the Department of Mental Health should more assiduously stimulate community and area mental health planning, and the General Assembly should, in the coming years, offer additional incentives to counties for beginning and expanding community programs. Specifically, the Committee recommends:

a. The state should increase its share of community program funding from the present level [two-thirds of the first $30,000 and one-half the remainder; G.S. 122-35.12 (Supp. 1971)] to a level of ninety percent over the next ten years.

b. The Department of Mental Health should provide more public education at the local level about the need for community mental health service, and offer more assistance to communities in planning such services and in obtaining state and federal funds.

D. Drug Abuse

G.S. 122-35.24 (Supp. 1971) authorizes the Department of Mental Health

> . . . to establish as the need arises and as funds permit, in areas to be designated by the Commissioner of Mental Health, community-based programs for the treatment and prevention of drug abuse [emphasis added].

The Committee fully supports this statutory policy, and also recognizes that in all its activity related to drug abuse, the Department of Mental Health must be guided by the North Carolina Drug Authority, whose powers include the authority to

> . . . [c]oordinate all State efforts related to drug abuse prevention, education, control, treatment, and rehabilitation to the end that the effort to control drug abuse shall be efficiently and effectively administered and duplicating and overlapping efforts eliminated. [G.S. 143-473(b)(1) (Supp. 1971)].

The Committee finds that the present level of funding of the North Carolina Drug Authority ($44,000 for the 1971-72 biennium) is inadequate. The Director of the Drug Authority should be a Psychiatrist (M.D.), Ph.D. Clinical Psychologist, or the equivalent, and should have nationally recognized professional competence in prevention and treatment of drug abuse. To obtain a person with such qualifications for this key position, a salary of $35,000 to $38,000 will have to be paid, according to knowledgeable sources consulted by the Committee. An adequate supporting staff for the Drug Authority would require approximately $50,000. Other costs including personnel benefits would bring the total necessary for the Drug Authority to an estimated $100,000 per year, or $200,000 per biennium. The General Assembly must face the fact that this level of funding is necessary if the mission of the Drug Authority as provided by the statute is to be accomplished.

The Committee finds that, as in the case of community mental health programs, greater funding incentives and greater encouragement and assistance by the Department of Mental Health are required to extend and improve community drug abuse programs. Further, the Committee finds that more attention needs to be paid to drug abuse prevention programs--first, by the Department of Mental Health, which has until now been concerned

almost exclusively with treatment, and second, by the Department of Public Education. All evidence considered by the Committee indicates that in the war against drugs, prevention and education are as effective as treatment. Finally, the Committee finds that, although community programs should receive the most emphasis, inpatient programs for long-term treatment should not be neglected. As community programs expand, and the needs of drug abusers become better understood, increased facilities for inpatient drug abuse treatment may be required.

The specific recommendations of the Committee are as follows.

a. To enable the North Carolina Drug Authority to perform fully the function assigned to it by law, the General Assembly should fund its staff at the level indicated in the findings above, and should establish qualification requirements for the position of Director as described in the findings above.

b. The General Assembly should extend the state's share of community drug abuse program funding from the present level of fifty percent [Session Laws 1971, ch. 1123, sec. 5] to ninety percent over a period of ten years.

c. The Department of Mental Health should provide more assistance to communities in planning community drug abuse programs and in obtaining state and federal funds.

d. The Department of Public Education should initiate courses of instruction and other appropriate programs to prevent and counteract drug abuse among children of school age. These programs should begin at the earliest possible age, and should be considered as important as any other aspect of health education for the protection of children.

e. The General Assembly should be prepared to fund, and the Department of Mental Health to operate, facilities for long-term inpatient treatment of drug abusers should such facilities be found necessary for persons referred from community drug abuse programs.

E. Needed Statutory Revision

As explained in Section I(B) of this report, the following recommendations for statutory change are limited to a few changes which the General Assembly is virtually compelled to make by recent legal developments. One additional change, relating to the authority of the superintendents of public mental institutions to order autopsies of deceased patients, is prompted by a need for additional information about the causes of death among mental patients, which will assist in improving diagnosis and treatment and preventing needless deaths.

1. G.S. 122-86 (1964), which deals with discharge from a state mental hospital of persons acquitted of a crime by reason of insanity and then committed, should be rewritten.

According to the first sentence of this statute, a person acquitted of a capital felony by reason of insanity may not be discharged without authorization from the General Assembly. This provision was declared unconstitutional by the North Carolina Supreme Court in 1904, but was rewritten with a proviso preserving the right of a patient committed after an insanity acquittal to petition for habeas corpus. The statute places a qualification on the right to petition for habeas corpus in that the application may not be granted without a certificate from the superintendent of the hospital. This qualification was declared unconstitutional by the North Carolina Supreme Court in March 1972, with respect to persons acquitted by reason of insanity and then committed [In re Tew, 280 N.C. 612, 187 S.E.2d 13 (1972)]. Even after this qualification on the right to habeas corpus is excised, doubt is cast on the validity of the requirement of legislative authorization of discharge where acquittal was for a capital offense and of the governor's authorization where the offense was less than capital.

As Justice Sharp commented in In re Tew, the reenactment of the requirement of legislative authorization after it had been held unconstitutional did not validate it. Furthermore, a verdict of not guilty by reason of insanity amounts to a full acquittal, and subsequent commitment is not a punishment. Since a person committed after an insanity acquittal is not being punished, it is probably unconstitutional for the procedures for his discharge to differ from procedures for the discharge of any person committed involuntarily.

2. G.S. 35-3 (1966), which deals with the appointment of guardians for patients in state hospitals, should be reconsidered.

According to G.S. 122-55 (1964), hospitalization of an allegedly mentally ill person or alleged inebriate or mental retardate shall have no effect on incompetency proceedings. G.S. 35-3 is listed as a specific exception to this general proposition. It provides that a patient in a regional mental hospital, alcoholic rehabilitation center, or mental retardation center may be found incompetent (in order to have a guardian appointed for him) on certification of incompetency from the superintendent of the facility. There is an inconsistency in saying, on the one hand, that hospitalization shall have no effect on competency and, on the other hand, that any hospitalized person may be found incompetent by certification. Also, G.S. 35-3 may be vulnerable to constitutional attack on several grounds, including due process, equal protection, or improper delegation of judicial power.

3. G.S. 122-44 (1964), which requires that all nonindigent patients or those responsible for their support pay the cost of treatment in Department of Mental Health facilities, is now vulnerable to constitutional attack insofar as it concerns payment by involuntarily committed patients. The General Assembly should be prepared to amend it and to provide funds to replace such payment.

This provision may be unconstitutional with respect to involuntarily committed patients. In Department of Mental Hygiene v. Kirchner, 60 Cal.2d 716, 400 P.2d 321 (1965), the California Supreme Court held unconstitutional under both the state and federal equal protection clauses the relatives' support provisions of the state's mental health program. In Kirchner, the child of a person involuntarily committed to a state mental hospital was asked to pay for his parent's care in the hospital. The California Supreme Court held that involuntary commitment served the purposes of the state, and the cost of financing this public purpose could not be arbitrarily charged to a single class of society. Charging one particular class of persons amounted to a form of tax discrimination with no rational basis. This decision is not binding in North Carolina. However, it provides a potential basis for a similar attack on G.S. 122-44, at least in cases of involuntary commitment.

4. G.S. 90-218 (1965), which now permits "post-mortem examination" of deceased inmates of public institutions in the state "for the care of the sick, the feeble-minded or insane," should be amended to permit superintendents of public mental hospitals to authorize complete autopsies on deceased patients for the purpose of accumulating information on usual causes of death of mental patients. The amendment should require that the next of kin be notified and have the right to refuse autopsy within a reasonable period of time.

F. Costs and Funding

In the latter portion of this subsection of the report, cost estimates are given covering the expansion and improvement of mental health service as recommended herein. The Committee requests that the budgetary staffs

of the Department of Mental Health and the Department of Public Education[1] work with it to develop more accurate cost projections. The preliminary figures given below are sufficiently realistic to show the order of magnitude of the funding increases which will be required to bring mental health service up to the level at which the Committee believes it should be.

In considering ways of funding the recommended expansion and improvement of service, the Committee is guided by the following considerations.

1. The voters of the state should be asked for their support of improved mental health service at this time.

2. The cost of the service improvements recommended by the Committee exceeds significantly the current and projected budgets of the Departments of Mental Health and Public Education.

3. Funding schemes which will exceed present and projected sources of revenue, and thereby require increased taxes, should be avoided if possible.

4. Full use should be made of federal funding programs.

The Committee sees several acceptable ways of funding its package of mental health service improvements, and leaves the choice to the wise judgment of the 1973 General Assembly. The funding schemes described below are not mutually exclusive and could be used in combination.

One funding method is simply to provide the necessary funds to the Departments of Mental Health and Public Education as a general fund appropriation. If this method of funding is selected, the views of the voters on improving mental health service should be obtained and considered.

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[1] The Department of Public Education's role, in these recommendations, will be in education of the mentally retarded and in education about drugs and drug abuse.

This should be done by means of an opinion poll conducted by a competent private firm or research institute. Another method of funding is unprecedented in this state but has been used by a number of other states: bonds could be issued to cover the cost of improved services. Although such bonds have never been issued by the General Assembly, there is no constitutional bar against it. The total amount of such a bond issue, once approved by the voters, could be obtained by a series of issues timed to coincide with phased planning and implementation of the recommended mental health service improvements. A third method is in a sense a combination of the first two. The currently planned request for capital improvements in the Department of Mental Health's expense budget for the 1973-75 biennium, which involves a total of approximately $26 million, could be removed from the expense budget and satisfied by means of a bond issue. The expense of the recommended service improvements could then be substituted for all, or some portion of, the removed capital items, in such a way that the cost of the improved service could be met over the next five to ten years. Eventually, the question of continued funding of the higher level of service would again be faced; however, by that time, community mental health programs may well have lowered costs of institutional programs, including capital improvements, which would release funding capacity and allow continuation of service at the higher level.

The Committee wishes to stress the need to exploit fully the potential of federal programs. G.S. 122-35.1 (1964) provides:

> The State Department of Mental Health is hereby designated as the State's mental health authority for purposes of administering federal funds allotted to North Carolina under the provisions of the National Mental Health Act and similar federal legislation pertaining to mental health activities . . . It shall be the policy of the State Department of Mental Health to promote the establishment of mental health clinics in those localities which have shown a readiness to contribute to the

financial support of such clinics, assisted by the federal and State grants-in-aid to the extent available.

The Committee recommends that the Department of Mental Health work more vigorously to assist local communities in obtaining federal funds and to take advantage of federal funding possibilities for mental health at the state level.

Estimate of Costs to State. In the table which follows, the Committee has attempted to provide rough but realistic cost estimates for those of its recommendations which will require significant increases in state spending during the 1973-75 biennium. The cost items are listed in order of occurrence in this report of the recommendations to which they belong. The primary sources of information on which the cost estimates are based are the Department of Mental Health, the Charlotte Drug Education Center, and the North Carolina Association for Retarded Children.

ESTIMATED COSTS TO STATE OF RECOMMENDATIONS, 1973-75 BIENNIUM

	Location in This Report	Biennial Cost 1973-75 NON-RECURRING	1973-75 RECURRING	1973-75 TOTAL
1. Study of internal management and organization of Department of Mental Health.	p. 1	$100,000		$ 100,000
2. Mental Health Code Commission: cost of staff work to prepare proposed statutory revisions for 1975 General Assembly.	p. 2	125,000		125,000
3. Implementation of the standards for inpatient care of the mentally retarded imposed by the U.S. District Court in Wyatt v. Stickney, with the exception of the staffing ratio standards. NOTE: $1,977,000 of this amount is for payment of working patients.	p. 7; App. D		$ 3,708,000	3,708,000
4. Full educational program for all retarded persons of school age, including those now living in the community as well as those in regional mental retardation centers	p. 7			
a. Curriculum development.		500,000		500,000
b. Operation of 6 hour per day educational program for institutionalized mentally retarded persons age 6-21 in state mental retardation centers (2600 children x $1800 per child x 2 years).			9,360,000	9,360,000
c. Operation of 6 hour per day educational program for mentally retarded persons age 6-21 living in the community or in private institutions and not now served by public school programs for the educable and trainable mentally retarded (36,600 children x $1250 per child per year x 2 years).			45,750,000	45,750,000

	Location in This Report	Biennial Cost 1973-75 NON-RECURRING	1973-73 RECURRING	1973-75 TOTAL
5. Community-based programs for the mentally retarded:	pp. 7-8			
a. Mental Retardation Complexes			$2,114,000	$2,114,000
b. Group homes			2,175,000	2,175,000
c. Day and residential care. [Much of this amount is matched 3 to 1 by federal funds under Title IV-A of the Social Security Act.]			583,000	583,000
d. Institution-community liaison for persons transferred to community programs from retional Mental Retardation Centers and their families.			252,000	252,000
e. Community services in Eastern Region operated by Caswell MRC: day care, work activity, emergency care, temporary care to relieve families.			2,492,000	2,492,000
6. Expansion of inpatient and community programs for emotionally disturbed children:	pp. 8-9			
a. Children's programs within community mental health centers.			2,500,000	2,500,000
b. Expansion of present Department of Mental Health training programs for children's mental health.			1,119,000	1,119,000
7. Implementation of the inpatient mental health treatment standards imposed by the U.S. District Court in Wyatt v. Stickney, with the exception of the staffing ratio standards. NOTE: $2,288,000 of this amount is for payment of working patients.	pp. 11-13; App. E		3,750,000	3,750,000
8. Unit dose system of medication in regional hospitals.	p. 13		5,642,000	5,642,000

	Location in This Report	Biennial Cost 1973-75 NON-RECURRING	1973-75 RECURRING	1973-75 TOTAL
9. Cost of salary differential for medical staff positions at Broughton and Cherry Hospitals. NOTE: The Department of Mental Health currently offers a differential for starting salary at these hospitals, which does not affect maximum pay. The present budget of the Department includes funds for merit salary increases which would permit a ten percent differential in maximum pay. Hence the cost of a differential in maximum pay would be zero.	p. 14		0	0
10. Expansion of present residency training programs to include all regional mental hospitals, mental retardation centers and complexes, children's units, and community mental health programs, and to include students of psychology, nursing, and related fields, as well as students of medicine and psychiatry.	p. 15		2,800,000	2,800,000
11. Career ladder for attendants and cottage parents:	p. 15			
a. In service training.			1,718,000	1,718,000
b. Salary incentives for training (either in service or in schools outside the Department of Mental Health). NOTE: This estimate is based on an estimated three step increase in pay grades.			5,025,000	5,025,000
12. Additional pay for Forensic Unit Attendants to make the total salary for the position equal to that of Security Officer I in the Department of Correction.	p. 15		150,000	150,000
13. Additional building maintenance and housekeeping staff to free more of attendants' time for actual work with patients.	p. 16		1,335,000	1,335,000

	Location in This Report	Biennial Cost 1973-75 NON-RECURRING	Biennial Cost 1973-75 RECURRING	Biennial Cost 1973-75 TOTAL
14. Additional funds required in the 1973-75 biennium to increase the current state share of community mental health programs to ninety percent over the next ten years. NOTE: This estimate is based on the assumption that the local share will remain constant at about $4,760,000 per year. It also assumes that the actual state-local ratio, which is currently about 50-50, will increase as follows: 60-40 (1973-75), 70-30 (1975-77), 80-20 (1977-79), 85-15 (1979-81), and 90-10 (1981-83). Under these assumptions, the additional cost in the final biennium (1981-83) will be $74,464,768, and the average additional cost per biennium will be $31,624,766. The current biennial state appropriation for this purpose is about $11,215,000.	pp. 16-18		$3,065,000	$3,065,000
15. Additional funds required to upgrade N.C. Drug Authority staff (current funding is $44,000 per biennium).	pp. 19-20		156,000	156,000
16. Additional funds required in the 1973-75 biennium to increase the state share of community drug abuse programs to ninety percent over the next ten years. NOTE: This estimate assumes that the local share will remain constant at about $275,000 per year. It also assumes that the actual state-local ratio, which is currently 50-50, will increase as follows: 60-40 (1973-75), 70-30 (1975-77), 80-20 (1977-79), 85-15 (1979-81), 90-10 (1981-83). Under these assumptions, the additional cost in the final biennium (1981-83) will be $4,400,000, and the average additional cost per biennium will be $1,924,998. The current biennial state appropriation for this purpose is about $550,000.	pp. 19-20		275,000	275,000

	Location in This Report	Biennial Cost 1973-75 NON-RECURRING	1973-75 RECURRING	1973-75 TOTAL
17. Drug abuse prevention program within Department of Public Education.	pp. 19-20			
a. Nonrecurring cost of adding to drug education film and tape cassette stock of State Library.		$ 25,000		$ 25,000
b. Technical assistance team to develop curriculum and train teachers, principals, and counselors to use curriculum.			$ 154,000	154,000
18. TOTAL		750,000	94,123,000	94,873,000

APPENDICES

CORRECTIONS

TO

REPORT OF THE LEGISLATIVE RESEARCH COMMISSION CONCERNING MENTAL HEALTH SERVICES (1972)

Please insert the corrected cost estimates (pp. 27-30) in place of pp. 27-31 of the original report. The corrected cost figures, totalling $48,052,934 rather than the original $94,873,000, are based on information received subsequent to the preparation of the original report.

ESTIMATED COSTS TO STATE OF RECOMMENDATIONS, 1973-75 BIENNIUM

	Location in This Report	Biennial Cost 1973-75 NON-RECURRING	1973-75 RECURRING	1973-75 TOTAL
1. Study of internal management and organization of Department of Mental Health.	p. 1	$100,000		$ 100,000
2. Mental Health Code Commission: cost of staff work to prepare proposed statutory revisions for 1975 General Assembly.	p. 2	100,000		100,000
3. Implementation of the standards for inpatient care of the mentally retarded imposed by the U.S. District Court in Wyatt v. Stickney, with the exception of the staffing ratio standards. NOTE: $1,977,000 of this amount is for payment of working patients.	p. 7; App. D		$ 3,708,000	3,708,000
4. Full educational program for all retarded persons of school age, including those now living in the community as well as those in regional mental retardation centers	p. 7			
a. Operation of 6 hour per day educational program for institutionalized mentally retarded persons age 6-21 in state mental retardation centers (2600 children x $1800 per child x 2 years).			9,360,000	9,360,000
b. Extension of present public school special education programs for mentally retarded persons age 6-21 living in the community.			10,415,520	10,415, 520

CORRECTED

	Location in This Report	Biennial Cost 1973-75 NON-RECURRING	1973-73 RECURRING	1973-75 TOTAL
5. Community-based programs for the mentally retarded:	pp. 7-8			
a. Mental Retardation Complexes			[$2,114,000]	[$2,114,000]*
b. Group homes			[2,175,000]	[2,175,000]*
c. Day and residential care. [Much of this amount is matched 3 to 1 by federal funds under Title IV-A of the Social Security Act.]			[583,000]	[583,000]*
d. Institution-community liaison for persons transferred to community programs from retional Mental Retardation Centers and their families.			[252,000]	[252,000]*
e. Community services in Eastern Region operated by Caswell MRC: day care, work activity, emergency care, temporary care to relieve families.			[2,492,000]	[2,492,000]*
6. Direct 100% State grants for local programs for emotionally disturbed children:	pp. 8-9		2,500,000	2,500,000
7. Implementation of the inpatient mental health treatment standards imposed by the U.S. District Court in Wyatt v. Stickney, with the exception of the staffing ratio standards. NOTE: $2,288,000 of this amount is for payment of working patients.	pp. 11-13; App. E		3,750,000	3,750,000
8. Unit dose system of medication in regional hospitals.	p. 13		[5,642,000]	[5,642,000]*

*NOTE: The bracketed figures are already in the 1973-75 DMH Change Budget, and are placed here to indicate approval by the Commission of the amounts and programs. These figures are not included in the total.

CORRECTED

	Location in This Report	Biennial Cost 1973-75 NON-RECURRING	1973-75 RECURRING	1973-75 TOTAL
9. Cost of salary differential for medical staff positions at Broughton and Cherry Hospitals. NOTE: The Department of Mental Health currently offers a differential for starting salary at these hospitals, which does not affect maximum pay. The present budget of the Department includes funds for merit salary increases which would permit a ten percent differential in maximum pay. Hence the cost of a differential in maximum pay would be zero.	p. 14		0	0
10. Legislative Research Commission study of expansion of present residency training programs to include all public (state and local) mental health and mental retardation programs, and to include students of psychology, social work, nursing and related fields, as well as students of medicine and psychiatry.	p. 15		0	0
11. Career ladder for attendants and cottage parents:	p. 15			
a. In service training.			1,718,267	1,718,267
b. Salary incentives for training (either in service or in schools outside the Department of Mental Health). NOTE: This estimate is based on an estimated three step increase in pay grades.			5,025,296	5,025,296
12. Additional pay for Forensic Unit Attendants to make the total salary for the position equal to that of Security Officer I in the Department of Correction.	p. 15		150,000	150,000
13. Additional building maintenance and housekeeping staff to free more of attendants' time for actual work with patients.	p. 16		1,334,528	1,334,528

CORRECTED

	Location in This Report	Biennial Cost 1973-75 NON-RECURRING	1973-75 RECURRING	1973-75 TOTAL
14. Additional funds required in the 1973-75 biennum to increase the current state share of community mental health programs to sixty percent. NOTE: This estimate is based on the assumption that the local share will be about $17,012,647 per biennium. The figure of $8,606,323 is in addition to the present DMH Base and Change budget total of $17,012,647 for this purpose in 1973-75.	pp. 16-18		$8,606,323	$8,606,323
15. Additional funds required to upgrade N.C. Drug Authority staff (current funding is $44,000 per biennum).	pp. 19-20		156,000	156,000
16. Additional funds required in the 1973-75 biennum to increase the state share of community drug abuse programs to sixty percent. NOTE: This estimate assumes that the local share will be about $1,333,333 per biennum. The figure of $950,000 is in addition to the present DMH Base and Change budget total of $1,050,000.	pp. 19-20		950,000	950,000
17. Drug abuse prevention program within Department of Public Education.	pp. 19-20			
a. Nonrecurring cost of adding to drug education film and tape cassette stock of State Library.		$ 25,000		$ 25,000
b. Technical assistance team to develop curriculum and train teachers, principals, and counselors to use curriculum.			$ 154,000	154,000
18. TOTAL		225,000	47,827,934	48,052,934

CORRECTED

APPENDIX A

AUTHORIZING RESOLUTION

AND

MEMBERS OF COMMITTEE ON MENTAL HEALTH

GENERAL ASSEMBLY OF NORTH CAROLINA
1971 SESSION

S

I

SENATE RESOLUTION 871

Sponsors: Senators Allsbrook, Baugh, Church and Scott.

Referred to: Rules and Operation of Senate.

June 24

A RESOLUTION AUTHORIZING AND DIRECTING THE LEGISLATIVE RESEARCH COMMISSION TO MAKE A COMPLETE IN-DEPTH STUDY OF THE DEPARTMENT OF MENTAL HEALTH AND RELATED PROGRAMS AND TO MAKE RECOMMENDATIONS TO THE GENERAL ASSEMBLY.

Whereas, North Carolina has for many years realized that it is in the best interest of the State to provide proper care, treatment and research in order to promote the mental health of the citizens; and

Whereas, the Department of Mental Health has made progress in the area of mental health through its various programs and facilities; and

Whereas, the General Assembly does not have available an up-to-date in-depth study of the mental health programs, facilities, and needs of the State; and

Whereas, due to the growing use of drugs, alcohol and the stress of the times, there is an increasing demand for mental health care; and

Whereas, the State cannot render the kind of mental health services and provide for the future needs without an in-depth study of the present services provided on the State, local and private levels;

Now therefore, be it resolved by the Senate:

Section 1. The Legislative Research Commission is hereby authorized and directed to conduct an in-depth investigation and study of the Department of Mental Health and all related programs to determine whether sufficient facilities, treatment, care, supervision, guidance, rehabilitation, and mental health services are being provided for the mentally ill, mentally retarded, alcoholics and drug addicts of the State. The study shall include, but not be limited to, an evaluation of facilities, professional and staff personnel, custodial care, State, local and other related mental health programs, funding, and every aspect of the organization and operation of the Department of Mental Health.

Sec. 2. The Commission is authorized to employ such experts, consultants, professional and technical personnel, as it deems necessary to make a complete in-depth study of the Department of Mental Health and related programs.

Sec. 3. The Commission shall make its report and findings and recommendations to the 1973 General Assembly.

Sec. 4. This resolution shall become effective upon ratification.

STATE OF NORTH CAROLINA

LEGISLATIVE RESEARCH COMMISSION

STATE LEGISLATIVE BUILDING

RALEIGH 27611

CO CHAIRMAN:
GORDON P. ALLEN
PRESIDENT PRO TEMPORE, SENATE

MEMBERS:
SEN LAMAR GUDGER
SEN F. O'NEIL JONES
SEN CHARLES H. LARKINS, JR.
SEN WILLIAM W. STATON
SEN THOMAS E. STRICKLAND

CO-CHAIRMAN:
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SPEAKER, HOUSE OF REPRESENTATIVES

MEMBERS:
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REP. ERNEST B. MESSER
REP. WILLIAM R. ROBERSON, JR.
REP. CARL J. STEWART, JR.
REP. WILLIS P. WHICHARD

COMMITTEE ON MENTAL HEALTH
(SR 871)

Senator Charles H. Larkins, Jr., Chairman
Post Office Box 3029
Kinston, North Carolina

Senator Julian R. Allsbrook
Post Office Drawer 40
Roanoke Rapids, North Carolina

Senator Philip J. Baugh
Baugh Industries
Baugh Building
Charlotte, North Carolina

Representative Jule McMichael
Post Office Box 1140
Reidsville, North Carolina

Representative James T. Mayfield
322 Kendale Court
East Flat Rock, North Carolina

Representative Robie L. Nash
232 Richmond Road
Salisbury, North Carolina

Representative J. Ernest Paschall
113 East Nash Street
Wilson, North Carolina

Senator Marshall A. Rauch
1121 Scotch Drive
Gastonia, North Carolina

Senator Ralph H. Scott
Route 1
Haw River, North Carolina

Senator Thomas E. Strickland
112 North William Street
Goldsboro, North Carolina

APPENDIX B

NAMES OF PERSONS WHO TESTIFIED

AT MEETINGS OF THE COMMITTEE ON MENTAL HEALTH

LEGISLATIVE RESEARCH COMMISSION

Committee on Mental Health

Persons appearing before the Committee--

Dr. Eugene Hargrove, Commissioner, Dept. of Mental Health --
(Background information on the Dept. of Mental Health and an outline of services provided by the Department)

Dr. Lennox Baker, Sec., Depart. of Human Resources --
(His ideas on mental health)

Mr. Jere Annis, State Pres. of the N.C. Association of Retarded Children--
(Explained the purpose of suit filed against the State on behalf of retarded children)

Mr. Carey Pendley, Executive Director, N. C. Association of Retarded Children--
(history of his association and current needs in the field of mental retardation)

Rep. Howard Twiggs, member, Board of Directors of the N. C. Mental Health Association--
(Reviewed findings of the study made by his Association and explained the Alabama decision in the suit against the state regarding its mental health programs)

Mr. Victor Sydnor, Executive Director of the N. C. Mental Mental Health Association--
(Spoke on the history of the Association and its present activities)

Mr. Joe Byrd, Chm., State Board of Mental Health--
(Spoke on the services provided by the Dept. of Mental Health)

Attorney General Robert H. Morgan--
(Spoke primarily on the SBI investigations at Cherry Hospital)

APPENDIX C

POLICY ON PATIENTS' RIGHTS
OF THE
NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

STATE OF NORTH CAROLINA
DEPARTMENT OF MENTAL HEALTH
P. O. BOX 26327
EXECUTIVE OFFICES
441 N. HARRINGTON STREET
RALEIGH, N. C. 27611

EUGENE A. HARGROVE, M.D.
COMMISSIONER

BEN W. AIKEN
GENERAL BUSINESS MANAGER

DEC 1970
N. C. DEPT. OF MENTAL HEALTH

November 24, 1970

M E M O R A N D U M

TO: Superintendents and Community Program Directors

FROM: Eugene A. Hargrove, M. D.
Commissioner

The North Carolina Board of Mental Health, on November 19, 1970, unanimously adopted the attached policy statement. The Department is directed to implement the provisions of this policy as rapidly as its current resources permit.

All Superintendents and Program Directors of the Department are hereby apprized of the action of the Board. Plans for implementation of the policy should be submitted to the Regional Commissioner no later than January 15, 1971. Periodic reports of progress will be expected, beginning at a date to be announced.

EAH:bs
Attachment

cc: Regional Commissioners

Policy on Patients' Rights

It is the policy of the State Board of Mental Health that every person receiving the services of the Department of Mental Health be accorded, insofar as is within the reasonable capability of the Department and is consistent with therapeutic treatment, such care, treatment and privileges as enhance one's dignity, promote his welfare and protect his rights as a free man.

I. As a means of implementing this policy, the Department of Mental Health is hereby authorized to assure that all persons receiving services, subject to such limitations as may be reasonably necessary and which are entered in his treatment record, shall be allowed to:

1. wear his own clothes;
2. keep and use his own personal possessions, including toilet articles;
3. have access to individual storage space for his personal articles;
4. keep and to spend a reasonable sum of his own money;
5. receive remuneration for work done of value to facility;
6. receive visitors on any day;
7. have reasonable access to telephone, both to make and receive confidential calls;
8. mail and receive unopened correspondence and access to a reasonable amount of letter writing material and postage;
9. to consult legal counsel.

II. The Department of Mental Health is hereby authorized to formulate procedures which assure:

1. A written therapeutic plan of treatment for each inpatient;

2. A record made of all such treatment and of a periodic review of the patient's treatment;

3. A comprehensive review of the patient's physical and mental condition at least annually and a finding stated in his record as to whether or not he should be retained in the facility or discharged, and any recommendations for other appropriate treatment or disposition;

4. That physical restraint, including individual confinement, of a patient is to be utilized only to prevent danger of abuse or injury to himself or others, or as a measure of therapeutic treatment, and all instances of such physical restraint or individual confinement shall be recorded in the patient's treatment record;

5. That a patient may refuse electroshock therapy unless determined by a medical doctor, to be incompetent to make that decision and such finding be recorded in his treatment record;

6. That no unauthorized publication or use of a patient's treatment records shall be permitted. A patient's treatment records are deemed confidential and may be disclosed only on the following conditions and circumstances or as otherwise provided by law:

   (a) as necessary between professional persons and/or agencies in the provision of services to the patient; or

   (b) to those whom the patient or his legal representative designate; or

   (c) to the extent necessary to make claims on behalf of a patient for legal or financial aid, insurance, or medical assistance to which he may be entitled; or

(d) to those engaged in research, pursuant to rules of the facility or the Department, provided that researchers maintain now identification and confidentiality; or

(e) upon the order of a court of competent jurisdiction, or

(f) to the extent necessary to explain to a patient or his legal representative the reasons for and nature of a denial or limitation of his rights.

7. That upon discharge a patient receives, if needed, suitable clothing for and means of transportation to his residence;

8. A patient shall not be arbitrarily transferred;

9. All patients shall upon request be informed of their rights under the mental health laws of the state and the related policies and procedures of the Department and the facility. Printed copies thereof shall be furnished and/or posted in appropriate places;

10. That all employees of the Department are effectively informed of the rights of patients and the Department's policies and procedures for the care, treatment and promotion of patient welfare;

11. When any right of a patient or any policy or procedure of the Department is limited or denied, the nature, extent and reason for such limitation or denial shall be entered in the patient's records. Any continuing denial or limitation shall be reviewed every thirty (30) days and shall be recorded in his treatment record.

12. At such time as a person is initially admitted as an inpatient, unless he specifically objects, he shall inform the facility of the name and address of not more than two adults or corporate entities that he desires be advised of his admission, his rights, and the policies and procedures of the Department. The name and address of such persons shall be recorded in the patient's record, and the person notified. The facility shall make diligent effort to secure the name and address of the patient's legal representative, spouse, child, parent, a relative, attorney or friend. If the facility is unable to locate one of the above, that fact shall be entered in the patient's record and the Commissioner of Mental Health shall be notified. A patient may designate other persons upon a subsequent admission.

13. A patient, or a person designated in 12 above, who believes his rights have been or are being violated may give written notice to the facility which in turn shall promptly investigate the same and make written reply of its findings and disposition. A copy of both the notice and the reply shall be included in the patient's record. If the patient, or designated person, disagrees with the findings and/or disposition, he may make written request to the Commissioner of Mental Health for review. The Commissioner may cause such additional investigation as he deems necessary and shall make written reply with copy to the facility for inclusion in the patient's record. The Commissioner may make such recommendations or direct such actions as he deems appropriate. The Commissioner from time to time shall make report to the State Board of Mental Health of complaints received and dispositions made.

The Commissioner may designate one or more persons to receive such requests for review, to make investigations, and reply on his behalf.

APPENDIX D

OPINION OF COURT AND STANDARDS OF TREATMENT OF THE MENTALLY RETARDED: Wyatt v. Stickney

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE

DISTRICT OF ALABAMA, NORTHERN DIVISION

FILED

APR 13 1972

JANE P. GORDON, CLERK

BY _____ DEPUTY CLERK

RICKY WYATT, by and through his aunt and legal guardian, Mrs. W. C. Rawlins, Jr., ET AL., for themselves jointly and severally and for all others similarly situated,

Plaintiffs,

vs.

DR. STONEWALL B. STICKNEY, as Commissioner of Mental Health and the State of Alabama Mental Health Officer; JOHN V. HOTTEL, as Deputy Commissioner of Mental Health of Alabama and as Interim Superintendent of Partlow State School and Hospital at Tuscaloosa; DR. JAMES C. FOLSOM, individually and as Deputy Commissioner for Hospitals of the Alabama State Board of Mental Health; DR. JAIME E. CONDOM, individually and as Superintendent of Searcy Hospital at Mount Vernon, Alabama; CARL M. BOLEY, DR. CLAUDE L. BROWN, JR., DR. PAUL W. BURLESON, ED T. HYDE, DR. J. PAUL JONES, DR. JOHN A. MARTIN, FRANK M. MOODY, DR. ROBERT PARKER, WILLARD SMITH, DR. EVERET STRANDELL, DR. J. GARBER GALBRAITH and JACK NOLEN, as Trustees of the Mental Health Board of Alabama; THE ALABAMA MENTAL HEALTH BOARD, a public corporation; GEORGE C. WALLACE, as Governor of Alabama; and PERRY O. HOOPER, as Judge of Probate of Montgomery County, Alabama, and all other Judges of Probate of Alabama, jointly and severally, who are similarly situated; and all of their successors in each office,

Defendants,

UNITED STATES OF AMERICA, the AMERICAN PSYCHOLOGICAL ASSOCIATION; the AMERICAN ORTHOPSYCHIATRIC ASSOCIATION; the AMERICAN CIVIL LIBERTIES UNION, and the AMERICAN ASSOCIATION ON MENTAL DEFICIENCY,

Amici Curiae.

CIVIL ACTION NO. 3195-N

(Partlow State School and Hospital)

ORDER AND DECREE

This litigation originally pertained only to Alabama's mentally ill,[1/]

1/ On March 12, 1971, in a formal opinion and decree, this Court held that patients involuntarily committed to Bryce Hospital because of mental illness were

(Contd.)

but, by motion to amend granted August 12, 1971, plaintiffs have expanded their class to include residents of Partlow State School and Hospital, a public institution located in Tuscaloosa, Alabama, designed to habilitate the mentally retarded.[2/] In their amended complaint, plaintiffs have alleged that Partlow is being operated in a constitutionally impermissible fashion and that, as a result, its residents are denied the right to adequate habilitation. Relying on these allegations, plaintiffs have asked that the Court promulgate and order the implementation at Partlow of minimum medical and constitutional standards appropriate for the functioning of such an institution. Plaintiffs have asked also that the Court appoint a master and a professional advisory committee to oversee the implementation of judicially ordered guidelines and appoint a human rights committee to safeguard the personal rights and dignity of the residents. Finally plaintiffs have requested the Court to grant various forms of relief intended to ameliorate the financial difficulties certain to arise in connection with the upgrading of Alabama's public

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1/ Contd.
being deprived of the constitutional right, which they unquestionably possess, "to receive such individual treatment as [would] give each of them a realistic opportunity to be cured or to improve his or her mental condition." Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971). On August 12, 1971, the Court granted plaintiffs' motion to add to the lawsuit patients confined at Searcy Hospital, Mount Vernon, Alabama, another institution which, although designed to treat the mentally ill, failed to do so in accordance with constitutional standards. The Court, having unavailingly afforded defendants an opportunity to promulgate and effectuate minimum standards for adequate treatment of the mentally ill, determined on December 10, 1971, that such standards had to be judicially formulated and ordered implemented. Wyatt v. Stickney, 334 F. Supp. 1341 (M.D. Ala. 1971). To that end, the Court conducted a hearing on February 3-4, 1972, at which the parties and amici submitted proposed standards for constitutionally adequate treatment, and presented expert testimony in support of the proposals. The aspect of the case relating to the Bryce-Searcy facilities will be considered by the Court in a decree separate from the present one.

2/ As expressed by amici in their briefs and substantiated by the evidence in this case, mental retardation refers generally to subaverage intellectual functioning which is associated with impairment in adaptive behavior. This definitional approach to mental retardation is based upon dual criteria: reduced intellectual functioning and impairment in adaptation to the requirements of social living. The evidence presented reflects scientific advances in understanding the developmental processes of the mental retardate. The historic view of mental retardation as an immutable defect of intellegence has been supplanted by the recognition that a person may be mentally retarded at one age level and not at another; that he may change status as a result of changes in the level of his intellectual functioning; or that he may move from retarded to nonretarded as a result of a training program which has increased his level of adaptive behavior to a point where his behavior is no longer of concern to society. See United States President's Panel on Mental Retardation, Report of the Task Force on Law, 1963. (Judge David L. Bazelon, Chairman.)

mental health institutions.[3]

On February 28-29, 1972, the Court conducted a hearing on the issues formulated by the pleadings in this case. Evidence was taken on the adequacy of conditions currently existing at Partlow as well as on the standards requisite for a constitutionally acceptable minimum habilitation program. The parties and amici[4] stipulated to a broad array of these standards and proposed additional ones for the Court's evaluation. The case now is submitted upon the pleadings, the evidence, the stipulations, and the proposed standards and briefs of the parties.

Initially, this Court has considered plaintiffs' position, not actively contested by defendants, that people involuntarily committed[5] through noncriminal procedures to institutions for the mentally retarded have a constitutional right to receive such individual habilitation as will give each of them a realistic opportunity to lead a more useful and meaningful life and to return to society. That this position is in accord with the applicable legal principles is clear beyond cavil. In an analogous situation involving the mentally ill at Bryce Hospital, this Court said:

> "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.' Rogsdale v. Overholser, 281 F.2d 943, 950 (D.C. Cir. 1960). The

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3/ More specifically, in a motion filed September 1, 1971, and renewed March 15, 1972, plaintiffs have asked that they be permitted to join various state officials as defendants in this case. Plaintiffs maintain that these officials, including, among others, the members of the State Legislature and the treasurer and the comptroller of Alabama, are necessary parties for the attainment of complete relief. Among the relief plaintiffs seek in connection with the state officials is an injunction against the expenditure of state funds for non-essential functions of the state until enough money is available to provide adequately for the financial needs of the Alabama Mental Health Board. In addition, plaintiffs have asked the Court to order the sale of a portion of defendant Mental Health Board's land holdings and other assets and to enjoin the Board from the construction of any physical facilities, including any planned for regional centers.

4/ The amici in this case, including the United States of America, the American Orthopsychiatric Association, the American Psychological Association, the American Civil Liberties Union, and the American Association on Mental Deficiency, have performed invaluable service for which this Court is indeed appreciative.

5/ The Court will deal in this decree only with residents involuntarily committed to Partlow because no evidence has been adduced tending to demonstrate that any resident is voluntarily confined in that institution. The Court will presume, therefore, that every resident of Partlow is entitled to constitutionally minimal habilitation. The burden falls squarely upon the institution to prove that a particular resident has not been involuntarily committed, and only if defendants satisfy this difficult burden of proof will the Court be confronted with whether the voluntarily committed resident has a right to habilitation.

purpose of involuntary hospitalization for treatment purposes is treatment and not mere custodial care or punishment. This is the only justification, from a constitutional standpoint, that allows civil commitments to mental institutions such as Bryce." Wyatt v. Stickney, 325 F. Supp. at 784.

In the context of the right to appropriate care for people civilly confined to public mental institutions, no viable distinction can be made between the mentally ill and the mentally retarded. Because the only constitutional justification for civilly committing a mental retardate, therefore, is habilitation, it follows ineluctably that once committed such a person is possessed of an inviolable constitutional right to habilitation. 6/

Having recognized the existence of this right, the Court now must determine whether prevailing conditions at Partlow conform to minimum standards constitutionally required for a mental retardation institution. The Court's conclusion, compelled by the evidence, is unmistakably clear. Put simply, conditions at Partlow are grossly substandard. Testimony presented by plaintiffs and amici has depicted hazardous and deplorable inadequacies in the institution's operation. 7/

6/ It is interesting to note that the Court's decision with regard to the right of the mentally retarded to habilitation is supported not only by applicable legal authority, but also by a resolution adopted on December 27, 1971, by the General Assembly of the United Nations. That resolution, entitled "Declaration on the Rights of the Mentally Retarded", reads in pertinent part:

> ". . . The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential."

7/ The most comprehensive testimony on the conditions currently prevailing at Partlow was elicited from Dr. Philip Roos, the Executive Director for the National Association for Retarded Children. Dr. Roos inspected Partlow over a two-day period and testified as to his subjective evaluation of the institution. In concluding his testimony, Dr. Roos summarized as follows:

> ". . . I feel that the institution and its programs as now conceived are incapable of providing habilitation of the residents. Incarceration, certainly for most of the residents, would I feel have adverse consequences; would tend to develop behaviors which would interfere with successful community functioning. I would anticipate to find stagnation or deterioration in physical, intellectual, and social spheres. The conditions at Partlow today are generally dehumanizing, fostering deviancy, generating self-fulfilling prophecy of parasitism and helplessness. The conditions I would say are hazardous to psychological integrity, to health, and in some cases even to life. The administration, the physical plants, the programs, and the institution's articulation with the community and with the consumers reflect destructive models of mental retardation. They hark back to decades ago when the retarded were misperceived as being sick, as being threats to society, or as being subhuman organisms. The new concepts

(Contd.)

Commendably, defendants have offered no rebuttal.[8] At the close of the testimony, the Court, having been impressed by the urgency of the situation, issued an interim emergency order "to protect the lives and well-being of the residents of Partlow." In that order, the Court found that:

> "The evidence . . . has vividly and undisputedly portrayed Partlow State School and Hospital as a warehousing institution which, because of its atmosphere of psychological and physical deprivation, is wholly incapable of furnishing [habilitation] to the mentally retarded and is conducive only to the deterioration and the debilitation of the residents. The evidence has reflected further that safety and sanitary conditions at Partlow are substandard to the point of endangering the health and lives of those residing there, that the wards are grossly understaffed, rendering even simple custodial care impossible, and that overcrowding remains a dangerous problem often leading to serious accidents, some of which have resulted in deaths of residents." Wyatt v. Stickney, March 2, 1972. (Unreported Interim Emergency Order.)

Based upon these findings, the Court has concluded that plaintiffs have been denied their right to habilitation and that, pursuant to plaintiffs' request, minimum standards for constitutional care and training must be effectuated at Partlow. Consequently, having determined from a careful study of the evidence that the standards set out in Appendix A to this decree are medical and constitutional minimums, this Court will order their implementation.[9] In so ordering, the Court emphasizes that these standards are, indeed, minimums only peripherally approaching the ideal to which defendants should aspire.

7/ Contd.

> in the field of mental retardation are unfortunately not reflected in Partlow as we see it today--concepts such as normalization, developmental model in orientation toward mental retardation, the thrust of consumer involvement, the trend toward community orientation and decentralization of services; none of these are clearly in evidence in the facility today."

8/ Indeed, on February 22, 1972, defendants filed with the Court a statement of position providing in relevant part that:

> "Assuming that such a federal constitutional obligation exists . . ., defendants will not contest the factual accuracy of an ultimate finding . . . that defendants have not met the constitutional obligation to provide adequate care at [Partlow], . . ."

At the hearing, defendants adopted the testimony of Dr. Roos in its entirety.

9/ In addition to the standards detailed in this order, it is appropriate that defendants comply also with the conditions, applicable to mental health institutions, necessary to qualify Partlow for participation in the various programs, such as Medicare and Medicaid, funded by the United States Government. Because many of these conditions of participation have not yet been finally drafted and published, however, this Court will not at this time order that specific Government standards be implemented.

It is hoped that the revelations of this case will furnish impetus to defendants to provide physical facilities and habilitation programs at Partlow substantially exceeding medical and constitutional minimums.

For the present, however, defendants must realize that the prompt institution of minimum standards to ensure the provision of essential care and training for Alabama's mental retardates is mandatory and that no default can be justified by a want of operating funds. In this regard, the principles applicable to the mentally ill apply with equal force to the mentally retarded. See Wyatt v. Stickney, 325 F. Supp. at 784-85.

In addition to requesting that minimum standards be implemented, plaintiffs have asked that defendants be directed to establish a standing human rights committee to guarantee that residents are afforded constitutional and humane habilitation. The evidence reflects that such a committee is needed at Partlow, and this Court will order its initiation. This committee shall have review of all research proposals and all habilitation programs to ensure that the dignity and human rights of residents are preserved. The committee also shall advise and assist residents who allege that their legal rights have been infringed or that the Mental Health Board has failed to comply with judicially ordered guidelines. At reasonable times the committee may inspect the records of the institution and interview residents and staff. At its discretion the committee may consult appropriate, independent specialists who shall be compensated by the defendant Board.[10/] The Court will appoint seven members to comprise Partlow's human rights committee, the names and addresses of whom are set forth in Appendix B to this decree. Those who serve on the committee shall be paid on a per diem basis and be reimbursed for travel expenses at the same rate as members of the Alabama Board of Mental Health.

Plaintiffs, as well as amici, also have advocated the appointment of a federal master and a professional advisory committee to oversee the implementation of minimum constitutional standards. These parties maintain that conditions at Partlow largely are the product of shameful neglect by the state officials charged with responsibility for that institution. Consequently,

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10/ The recitation of the licenses of this committee, and similarly, of the committees to be inaugurated at the Bryce and Searcy facilities, is not intended to be inclusive. The human rights committee of each mental health institution shall be authorized, within the limits of reasonableness, to pursue whatever action is necessary to accomplish its function.

plaintiffs and amici insist, these state officials have proved themselves incapable of instituting a constitutional habilitation program. Although this Court acknowledges the intolerable conditions at Partlow and recognizes defendants' past nonfeasances, it, nevertheless, reserves ruling on the appointment of a master and a professional advisory committee.[11/] Federal courts are reluctant to assume control of any organization, but especially one operated by a state. This Court, always having shared that reluctance, has adhered to a policy of allowing state officials one final opportunity to perform the duties imposed upon them by law. See e.g., Sims v. Amos, 336 F. Supp. 924 (M.D. Ala. 1972); Nixon v. Wallace, C.A. No. 3479-N, M.D. Ala., January 22, 1972. Additionally, since the entry of the interim emergency order of March 2, 1972, defendants have worked diligently to upgrade conditions at Partlow in conformity with court-established deadlines. These factors, combined with defendants' expressed intent that the present order will be implemented forthwith and in good faith, cause the Court to withhold its decision on the appointments. Nevertheless, this Court notes, and the evidence demonstrates convincingly, that the operation of Partlow suffers from a virtual absence of administrative and managerial organization. This long-enduring organizational deficiency has been intensified by the lack of dynamic, permanent leadership. Regrettably, the problem has remained unresolved over the span of this litigation and, indeed, has been compounded by the appointment of acting and interim superintendents. The massive program of reform and reorganization to be launched at Partlow requires the guidance of a professionally qualified and experienced administrator. Consequently, this Court will order that defendants employ such an individual on a permanent basis. Should defendants fail to do so, or otherwise fail to comply timely with the provisions of this decree, the Court will be obligated to appoint a master.

The Court also reserves ruling upon plaintiffs' motion that defendant

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11/ The Court's decision to reserve ruling on the appointment of a master causes it to reserve ruling also on the appointment of a professional advisory committee to aid the master. Nevertheless, the Court notes that the professional mental health community in the United States has responded with enthusiasm to the proposed initiation of such a committee to assist in the upgrading of Alabama's mental retardation services. Consequently, this Court strongly recommends to defendants that they develop a professional advisory committee comprised of amenable professionals from throughout the country who are able to provide the expertise the evidence reflects is important to the successful implementation of this order.

Mental Health Board be directed to sell or encumber portions of its extensive land holdings. Similarly, this Court reserves ruling on plaintiffs' motion seeking an injunction against the expenditure of state funds for nonessential functions of the state, and on other aspects of plaintiffs' requested relief designed to ameliorate the financial problems incident to the effectuation of minimum medical and constitutional standards. The Court reserves these rulings despite the fact that the primitive conditions, as well as the atmosphere of futility and despair which envelops both staff and residents at Partlow, can be attributed largely to dire shortages of operating funds. By withholding its decisions, the Court continues to observe its long-standing policy of deferring to state organizations and officials charged by law with specified responsibilities. The responsibility for appropriate funding ultimately must fall, of course, upon the State Legislature and, only to a lesser degree, upon the defendant Mental Health Board. Unfortunately, never, since the founding of Partlow in 1923, has the Legislature adequately provided for that institution.[12/] The result of almost fifty years of legislative neglect has been catastrophic; atrocities occur daily.[13/] Although, in fairness, the present State Legislature can be faulted relatively little for the crisis situation at Partlow, only that body can rectify the gross omissions of past Legislatures. To shrink from its constitutional obligation at this critical juncture would be to sanction the inhumane conditions which plague the mentally retarded of Alabama. The gravity and immediacy of the situation cannot be overemphasized. At stake is the very preservation of human life and dignity. Consequently, a prompt response from the State Legislature, as well as from the Mental Health Board and other responsible state officials, is imperative.

In the event, though, that the Legislature fails to satisfy its

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12/ By defendants' admission, Partlow State School and Hospital always has been a "step-child" of the state--never having received the public support it so desperately required. Not until the short term in office of Governor Lurleen Wallace was any emphasis placed upon securing adequate care for Alabama's mentally retarded. Beginning with Mrs. Wallace's tenure in 1966, the budget for mental health has increased but remains woefully short of the minimum required for constitutional care.

13/ A few of the atrocious incidents cited at the hearing in this case include the following: (a) a resident was scalded to death by hydrant water; (b) a resident was restrained in a strait jacket for nine years in order to prevent hand and finger sucking; (c) a resident was inappropriately confined in seclusion for a period of years, and (d) a resident died from the insertion by another resident of a running water hose into his rectum. Each of these incidents could have been avoided had adequate staff and facilities been available.

well-defined constitutional obligation and the Mental Health Board, because of lack of funding or any other legally insufficient reason, fails to implement fully the standards herein ordered, it will be necessary for the Court to take affirmative steps, including appointing a master, to ensure that proper funding is realized[14/] and that adequate habilitation is available for the mentally retarded of Alabama.

Finally, the Court has determined that this case requires the awarding of a reasonable attorneys' fee to plaintiffs' counsel. The basis for the award and the amount thereof will be considered and treated in a separate order. The fee will be charged against the defendants as a part of the court costs in this case.

To assist the Court in its determination of how to proceed henceforth, defendants will be directed to prepare and file a report within six months from the date of this decree detailing the implementation of each standard herein ordered. This report shall be comprehensive and shall include a statement of the progress made on each standard not yet completely implemented, specifying the reasons for incomplete performance. The report shall include also a statement of the financing secured since the issuance of this decree and of defendants' plans for procuring whatever additional financing might be required. Upon the basis of this report and other information available, the Court will evaluate defendants' work and, in due course, determine the appropriateness of appointing a master and of granting other requested relief.

Accordingly, it is the ORDER, JUDGMENT and DECREE of this Court:

1. That defendants be and they are hereby enjoined from failing to implement fully and with dispatch each of the standards set forth in Appendix A attached hereto and incorporated as a part of this decree;

2. That a human rights committee for Partlow State School and Hospital be and is hereby designated and appointed. The members thereof are listed in Appendix B attached hereto and incorporated herein. This committee shall have the purposes, functions, and spheres of operation previously set forth in this

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14/ The Court realizes that the Legislature is not due back in regular session until May, 1973. Nevertheless, special sessions of the Legislature are frequent occurrences in Alabama, and there has never been a time when such a session was more urgently required. If the Legislature does not act promptly to appropriate the necessary funding for mental health, the Court will be compelled to grant plaintiffs' motion to add various state officials and agencies as additional parties to this litigation and to utilize other avenues of fund raising.

order. The members of the committee shall be paid on a per diem basis and be reimbursed for travel expenses at the same rate as members of the Alabama Board of Mental Health;

3. That defendants, within 60 days from this date, employ a professionally qualified and experienced administrator to serve Partlow State School and Hospital on a permanent basis;

4. That defendants, within six months from this date, prepare and file with this Court a report reflecting in detail the progress on the implementation of this order. This report shall be comprehensive and precise and shall explain the reasons for incomplete performance in the event the defendants have not met a standard in its entirety. The report also shall include a financial statement and an up-to-date timetable for full compliance;

5. That the court costs incurred in this proceeding, including a reasonable attorneys' fee for plaintiffs' lawyers be and they are hereby taxed against the defendants;

6. That jurisdiction of this cause be and the same is hereby specifically retained.

It is further ORDERED that a ruling on plaintiffs' motion for further relief, including the appointment of a master, filed March 15, 1972, be and the same is hereby reserved.

Done, this the 13th day of April, 1972.

UNITED STATES DISTRICT JUDGE

APPENDIX A

MINIMUM CONSTITUTIONAL STANDARDS FOR
ADEQUATE HABILITATION OF THE MENTALLY RETARDED

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[1/] 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

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1/ See Standard 7, infra.

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.

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:

		Mild[2/]	Moderate	Severe/Profound
(1)	Class Size	12	9	6
(2)	Length of school year (in months)	9-10	9-10	11-12
(3)	Minimum length of school day (in hours)	6	6	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.

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.

III. 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 mental retardation with his medical treatment.

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

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;

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.

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.

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 psychoactive 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. § 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. § 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'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; and

(c) Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S. C. § 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.

34. 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.

35. 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.

c. 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 toe nails 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. The toilets 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 be immediately 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°F nor fall below 68°F.

(3) Thermostatically controlled hot water shall be provided in adequate quantities and maintained at the required temperature for resident use (110°F at the fixture) and for mechanical dishwashing and laundry use (180°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 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 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/] 60	Moderate 60	Severe/Profound 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

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4/ See n. 2, supra.

institution:

Physicians	1:200
Physical Therapists	1:100
Speech & Hearing Therapists	1:100
Dentists[5/]	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[6/]	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 physiatrist 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.

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.

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.

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 B

PARTLOW HUMAN RIGHTS COMMITTEE

1. Ms. Harriet S. Tillman - Chairman - 3544 Brookwood Road, Birmingham, Alabama
2. Dr. J. W. Benton - 3008 Brook Hollow Lane, Birmingham, Alabama
3. Mr. Paul R. Davis - Tuscaloosa News, Tuscaloosa, Alabama 35401
4. Reverend Robert Keever - University Presbyterian Church, Tuscaloosa, Alabama 35401
5. Ms. Nancy Poole - 1836 Dorchester, Birmingham, Alabama
6. Mr. Eugene Ward - c/o Partlow State School and Hospital, Tuscaloosa, Alabama 35401
7. Ms. Estelle Witherspoon - Alberta, Alabama 36720

FILED

APR 21 1972

JANE P. GORDON, CLERK
BY _____
DEPUTY CLERK

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE

DISTRICT OF ALABAMA, NORTHERN DIVISION

RICKY WYATT, by and through his aunt and legal guardian, Mrs. W. C. Rawlins, Jr., ET AL.

Plaintiffs,

vs.

CIVIL ACTION NO. 3195-N

DR. STONEWALL B. STICKNEY, etc., ET AL.,

Defendants,

UNITED STATES OF AMERICA, ET AL.,

Amici Curiae.

O R D E R

It is ORDERED that the orders entered herein April 13, 1972, for Bryce and Searcy Hospitals and for Partlow State School and Hospital be and each is hereby amended as follows:

1. Standard 8 for Bryce and Searcy Hospitals be and the same is hereby stricken and the following is substituted therefor:

> 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 for research involving human subjects published by the American Psychiatric and Psychological Associations and with those required by the United States Department of Health, Education and Welfare for projects supported by that agency.

2. Standard 20 for Bryce and Searcy Hospitals be and the same is hereby stricken and the following is substituted therefor:

> 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 Moderate 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 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 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.

It is further ORDERED that all references to the Fair Labor Standards Act in the standards promulgated by this Court for Bryce and Searcy Hospitals and for Partlow State School and Hospital be changed to read as follows: "Fair Labor Standards Act, 29 U.S.C. § 206 et. seq. as amended, 1966."

Done, this the 21st day of April, 1972.

UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE

DISTRICT OF ALABAMA, NORTHERN DIVISION

FILED

AUG 7 1972

JANE P. GORDON, CLERK
BY_____
DEPUTY CLERK

RICKY WYATT, by and through his aunt and legal guardian MRS. W. C. RAWLINS, JR., ET AL.,

Plaintiffs,

vs.

DR. STONEWALL B. STICKNEY, as Commissioner of Mental Health and the State of Alabama Mental Health Officer, ET AL.,

Defendants,

UNITED STATES OF AMERICA, ET AL.,

Amici Curiae.

CIVIL ACTION NO. 3195-N

O R D E R

Upon consideration of the defendants' motion for an order of modification filed July 19, 1972, the motion of the defendants seeking dismissal of their motion for an order of modification filed August 4, 1972, and the plaintiffs' and the defendants' joint motion for an order of modification filed August 4, 1972, it is ORDERED that the order of this Court made and entered herein April 13, 1972, relating to the Partlow State School and Hospital, be and the same is hereby amended and modified as follows:

(1) By substituting for Standard 46, as set out in Appendix A to this Court's April 13, 1972, order, the following:

> 46. On or before February 7, 1973, 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 procedure. Each resident's guardian, next of kin of 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. The defendants shall fully implement, in conjunction with this Standard, the provision of Standards 9-13 relating to th

individualized habilitation plan. If by October 30, 1972, two-thirds (2/3) of such evaluations and plans have not been completed, additional staff or contract personnel shall be hired in order to insure that on or before February 7, 1973, all such evaluations and plans will be completed.

(2) By adding to Standard 49, as set out in Appendix A to this Court's order of April 13, 1972, the following:

49. The above standards heretofore enumerated applicable to Partlow as a residential facility may be modified and adjusted when professionally and scientifically appropriate upon the placement of residents in less restrictive community based alternatives consistent with the approved principles of Normalization as expressed in the professional literature.

Done, this the 7th day of August, 1972.

UNITED STATES DISTRICT JUDGE

APPENDIX E

OPINION OF THE COURT AND STANDARDS OF TREATMENT OF MENTAL PATIENTS: Wyatt v. Stickney

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE

DISTRICT OF ALABAMA, NORTHERN DIVISION

FILED

APR 13 1972

JANE P. GORDON, CLERK

BY _____

DEPUTY CLERK

RICKY WYATT, by and through his aunt and legal guardian, Mrs. W. C. Rawlins, Jr., ET AL., for themselves jointly and severally and for all others similarly situated,

Plaintiffs,

vs.

DR. STONEWALL B. STICKNEY, as Commissioner of Mental Health and the State of Alabama Mental Health Officer; JOHN V. HOTTEL, as Deputy Commissioner of Mental Health of Alabama and as Interim Superintendent of Partlow State School and Hospital at Tuscaloosa; DR. JAMES C. FOLSOM, individually and as Deputy Commissioner for Hospitals of the Alabama State Board of Mental Health; DR. JAIME E. CONDOM, individually and as Superintendent of Searcy Hospital at Mount Vernon, Alabama; CARL M. BOLEY, DR. CLAUDE L. BROWN, JR., DR. PAUL W. BURLESON, ED T. HYDE, DR. J. PAUL JONES, DR. JOHN A. MARTIN, FRANK M. MOODY, DR. ROBERT PARKER, WILLARD SMITH, DR. EVERET STRANDELL, DR. J. GARBER GALBRAITH and JACK NOLEN, as Trustees of the Mental Health Board of Alabama; THE ALABAMA MENTAL HEALTH BOARD, a public corporation; GEORGE C. WALLACE, as Governor of Alabama; and PERRY O. HOOPER, as Judge of Probate of Montgomery County, Alabama, and all other Judges of Probate of Alabama, jointly and severally, who are similarly situated; and all of their successors in each office,

Defendants,

UNITED STATES OF AMERICA, the AMERICAN PSYCHOLOGICAL ASSOCIATION; the AMERICAN ORTHOPSYCHIATRIC ASSOCIATION; the AMERICAN CIVIL LIBERTIES UNION, and the AMERICAN ASSOCIATION ON MENTAL DEFICIENCY,

Amici Curiae.

CIVIL ACTION NO. 3195-N

(Bryce Hospital and Searcy Hospital)

ORDER AND DECREE

This class action originally was filed on October 23, 1970, in behalf of patients involuntarily confined for mental treatment purposes at Bryce Hospital, Tuscaloosa, Alabama. On March 12, 1971, in a formal opinion and decree, this

Court held that these involuntarily committed patients "unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition." The Court further held that patients at Bryce were being denied their right to treatment and that defendants, per their request, would be allowed six months in which to raise the level of care at Bryce to the constitutionally required minimum. Wyatt v. Stickney, 325 F.Supp. 781 (M.D. Ala. 1971). In this decree, the Court ordered defendants to file reports defining the mission and functions of Bryce Hospital, specifying the objective and subjective standards required to furnish adequate care to the treatable mentally ill and detailing the hospital's progress toward the implementation of minimum constitutional standards. Subsequent to this order, plaintiffs, by motion to amend granted August 12, 1971, enlarged their class to include patients involuntarily confined for mental treatment at Searcy Hospital[1/] and at Partlow State School and Hospital for the mentally retarded.[2/]

On September 23, 1971, defendants filed their final report, from which this Court concluded on December 10, 1971, that defendants had failed to promulgate and implement a treatment program satisfying minimum medical and constitutional requisites. Generally, the Court found that defendants' treatment program was deficient in three fundamental areas. It failed to provide: (1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment and (3) individualized treatment plans. More specifically, the Court found that many conditions, such as nontherapeutic, uncompensated work assignments, and the absence of any

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1/ Searcy Hospital, located in Mount Vernon, Alabama, is also a State institution designed to treat the mentally ill. On September 2, 1971, defendants answered plaintiffs' amended complaint, as it related to Searcy, with the following language:

> "Defendants agree to be bound by the objective and subjective standards ultimately ordered by this Honorable Court in this cause at both Bryce and Searcy."

This answer obviated the necessity for this Court's holding a formal hearing on the conditions currently existing at Searcy. Nevertheless, the evidence in the record relative to Searcy reflects that the conditions at that institution are no better than those at Bryce.

2/ The aspect of the case relating to Partlow State School and Hospital for the mentally retarded will be considered by the Court in a decree separate from the present one.

semblance of privacy, constituted dehumanizing factors contributing to the degeneration of the patients' self-esteem. The physical facilities at Bryce were overcrowded and plagued by fire and other emergency hazards. The Court found also that most staff members were poorly trained and that staffing ratios were so inadequate as to render the administration of effective treatment impossible. The Court concluded, therefore, that whatever treatment was provided at Bryce was grossly deficient and failed to satisfy minimum medical and constitutional standards. Based upon this conclusion, the Court ordered that a formal hearing be held at which the parties and amici 3/ would have the opportunity to submit proposed standards for constitutionally adequate treatment and to present expert testimony in support of their proposals.

Pursuant to this order, a hearing was held at which the foremost authorities on mental health in the United States appeared and testified as to the minimum medical and constitutional requisites for public institutions, such as Bryce and Searcy, designed to treat the mentally ill. At this hearing, the parties and amici submitted their proposed standards, and now have filed briefs in support of them. 4/ Moreover, the parties and amici have stipulated

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3/ The amici in this case, including the United States of America, the American Orthopsychiatric Association, the American Psychological Association, the American Civil Liberties Union, and the American Association on Mental Deficiency, have performed exemplary service for which this Court is indeed grateful.

4/ On March 15, 1972, after the hearing in this case, plaintiffs filed a motion for further relief. This motion served, among other things, to renew an earlier motion, filed by plaintiffs on September 1, 1971, and subsequently denied by the Court, to add additional parties. That earlier motion asked that the Court add:

> "Agnes Baggett, as Treasurer of the State of Alabama; Roy W. Sanders, as Comptroller of the State of Alabama; Ruben King, as Commissioner of the Alabama Department of Pensions and Security, George C. Wallace as Chairman of the Alabama State Board of Pensions and Security, and James J. Bailey as a member of the Alabama State Board of Pensions and Security and as representative of all other members of the Alabama State Board of Pensions and Security; J. Stanley Frazer, as Director of the Alabama State Personnel Board and Ralph W. Adams, as a member of the Alabama State Personnel Board and as representative of all other members of the Alabama State Personnel Board."

The motion of September 1, 1971, also sought an injunction against the treasurer and the comptroller of the State paying out State funds for "non-essential functions" of the State until enough funds were available to provide adequately for the financial needs of the Alabama State Mental Health Board.

In their motion of March 15, 1972, plaintiffs asked that, in addition to the above-named State officials and agencies, the Court add as parties to this litigation Dr. LeRoy Brown, State Superintendent of Education and Lt. Governor Jere Beasley, State Senator Pierre Pelham and State Representative Sage Lyons, as representatives of the Alabama Legislature. The motion of March 15, 1972,

(Contd.)

to a broad spectrum of conditions they feel are mandatory for a constitutionally acceptable minimum treatment program. This Court, having considered the evidence in the case, as well as the briefs, proposed standards and stipulations of the parties, has concluded that the standards set out in Appendix A to this decree are medical and constitutional minimums. Consequently, the Court will order their implementation.[5/] In so ordering, however, the Court emphasizes that these standards are, indeed, both medical and constitutional minimums and should be viewed as such. The Court urges that once this 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.

In addition to asking that their proposed standards be effectuated, plaintiffs and amici have requested other relief designed to guarantee the provision of constitutional and humane treatment. Pursuant to one such request for relief, this Court has determined that it is appropriate to order the initiation of human rights committees to function as standing committees of the Bryce and Searcy facilities. The Court will appoint the members of these committees who shall have review of all research proposals and all rehabilitation programs, to ensure that the dignity and the human rights of patients are preserved. The committees also shall advise and assist patients who allege that their legal rights have been infringed or that the Mental Health Board has failed to comply with judicially ordered guidelines. At its discretion, the committees may consult appropriate, independent specialists who shall be compensated by the defendant Board. Seven members shall comprise the human rights committee for each institution, the names and addresses of whom are

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4/ Contd.
also requested the Court to appoint a master, to appoint a human rights committee and a professional advisory committee, to order the sale of defendant Mental Health Board's land holdings and other assets to raise funds for the operation of Alabama's mental health institutions, to enjoin the construction of any physical facilities by the Mental Health Board and to enjoin the commitment of any more patients to Bryce and Searcy until such time as adequate treatment is supplied in those hospitals.

5/ In addition to the standards detailed in this order, it is appropriate that defendants comply also with the conditions, applicable to mental health institutions, necessary to qualify Alabama's facilities for participation in the various programs, such as Medicare and Medicaid, funded by the United States Government. Because many of these conditions of participation have not yet been finally drafted and published, however, this Court will not at this time order that specific Government standards be implemented.

set forth in Appendix B to this decree. Those who serve on the committees shall be paid on a per diem basis and be reimbursed for travel expenses at the same rate as members of the Alabama Board of Mental Health.

This Court will reserve ruling upon other forms of relief advocated by plaintiffs and amici, including their prayer for the appointment of a master and a professional advisory committee to oversee the implementation of the court-ordered minimum constitutional standards.[6/] Federal courts are reluctant to assume control of any organization, but especially one operated by a state. This reluctance, combined with defendants' expressed intent that this order will be implemented forthwith and in good faith, causes the Court to withhold its decision on these appointments. Nevertheless, defendants, as well as the other parties and amici in this case, are placed on notice that unless defendants do comply satisfactorily with this order, the Court will be obligated to appoint a master.

Because the availability of financing may bear upon the implementation of this order, the Court is constrained to emphasize at this juncture that a failure by defendants to comply with this decree cannot be justified by a lack of operating funds. As previously established by this Court:

> "There can be no legal (or moral) justification for the State of Alabama's failing 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." Wyatt v. Stickney, 325 F.Supp. at 785.

From the above, it follows consistently, of course, that 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.

Despite the possibility that defendants will encounter financial difficulties in the implementation of this order, this Court has decided to

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6/ The Court's decision to reserve its ruling on the appointment of a master necessitates the reservation also of the Court's appointing a professional advisory committee to aid the master. Nevertheless, the Court notes that the professional mental health community in the United States has responded with enthusiasm to the proposed initiation of such a committee to assist in the upgrading of Alabama's mental health facilities. Consequently, this Court strongly recommends to defendants that they develop a professional advisory committee comprised of amenable professionals from throughout the country who are able to provide the expertise the evidence reflects is important to the successful implementation of this order.

reserve ruling also upon plaintiffs' motion that defendant Mental Health Board be directed to sell or encumber portions of its land holdings in order to raise funds.[7/] Similarly, this Court will reserve ruling on plaintiffs' motion seeking an injunction against the treasurer and the comptroller of the State authorizing expenditures for nonessential State functions, and on other aspects of plaintiffs' requested relief designed to ameliorate the financial problems incident to the implementation of this order. The Court stresses, however, the extreme importance and the grave immediacy of the need for proper funding of the State's public mental health facilities. 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. 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.

In the event, though, that the Legislature fails to satisfy its well-defined constitutional obligation, and the Mental Health Board, because of lack of funding or any other legally insufficient reason, fails to implement fully the standards herein ordered, it will be necessary for the Court to take affirmative steps, including appointing a master, to ensure that proper funding is realized[8/] and that adequate treatment is available for the mentally ill

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7/ See n. 4, supra. The evidence presented in this case reflects that the land holdings and other assets of the defendant Board are extensive.

8/ The Court understands and appreciates that the Legislature is not due back in regular session until May, 1973. Nevertheless, special sessions of the Legislature are frequent occurrences in Alabama, and there has never been a time when such a session was more urgently required. If the Legislature does not act promptly to appropriate the necessary funding for mental health, the Court will be compelled to grant plaintiffs' motion to add various State officials and agencies as additional parties to this litigation, and to utilize other avenues of fund raising.

of Alabama.

This Court now must consider that aspect of plaintiffs' motion of March 15, 1972, seeking an injunction against further commitments to Bryce and Searcy until such time as adequate treatment is supplied in those hospitals. Indisputably, the evidence in this case reflects that no treatment program at the Bryce-Searcy facilities approaches constitutional standards. Nevertheless, because of the alternatives to commitment commonly utilized in Alabama, as well as in other states, the Court is fearful that granting plaintiffs' request at the present time would serve only to punish and further deprive Alabama's mentally ill.

Finally, the Court has determined that this case requires the awarding of a reasonable attorneys' fee to plaintiffs' counsel. The basis for the award and the amount thereof will be considered and treated in a separate order. The fee will be charged against the defendants as a part of the court costs in this case.

To assist the Court in its determination of how to proceed henceforth, defendants will be directed to prepare and file a report within six months from the date of this decree detailing the implementation of each standard herein ordered. This report shall be comprehensive and shall include a statement of the progress made on each standard not yet completely implemented, specifying the reasons for incomplete performance. The report shall include also a statement of the financing secured since the issuance of this decree and of defendants' plans for procuring whatever additional financing might be required. Upon the basis of this report and other available information, the Court will evaluate defendants' work and, in due course, determine the appropriateness of appointing a master and of granting other requested relief.

Accordingly, it is the ORDER, JUDGMENT and DECREE of this Court:

1. That defendants be and they are hereby enjoined from failing to implement fully and with dispatch each of the standards set forth in Appendix A attached hereto and incorporated as a part of this decree;

2. That human rights committees be and are hereby designated and appointed. The members thereof are listed in Appendix B attached hereto and incorporated herein. These committees shall have the purposes, functions, and spheres of operation previously set forth in this order. The members of the

committees shall be paid on a per diem basis and be reimbursed for travel expenses at the same rate as members of the Alabama Board of Mental Health;

3. That defendants, within six months from this date, prepare and file with this Court a report reflecting in detail the progress on the implementation of this order. This report shall be comprehensive and precise, and shall explain the reasons for incomplete performance in the event the defendants have not met a standard in its entirety. The report also shall include a financial statement and an up-to-date timetable for full compliance.

4. That the court costs incurred in this proceeding, including a reasonable attorneys' fee for plaintiffs' lawyers, be and they are hereby taxed against the defendants;

5. That jurisdiction of this cause be and the same is hereby specifically retained.

It is further ORDERED that ruling on plaintiffs' motion for further relief, including the appointment of a master, filed March 15, 1972, be and the same is hereby reserved.

Done, this the 13th day of April, 1972.

UNITED STATES DISTRICT JUDGE

APPENDIX A

MINIMUM CONSTITUTIONAL STANDARDS FOR ADEQUATE TREATMENT OF THE MENTALLY ILL

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.

II. Humane 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. § 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. § 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 nonambulatory patients to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit non-ambulatory 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.

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

Classification (Contd.)	Number of Employees (Contd.)
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;

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

(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 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 in 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

BRYCE HUMAN RIGHTS COMMITTEE

1. Mr. Bert Bank - Chairman - P. O. Box 2149, Tuscaloosa, Alabama 35401
2. Ms. Ruth Cummings Bolden - 1414 9th Street, Tuscaloosa, Alabama 35401
3. Ms. Babs Klein Heilpern - 2526 Jasmine Road, Montgomery, Alabama 36111
4. Mr. Joseph Mallisham - 3028 20th Street, Tuscaloosa, Alabama 35401
5. Ms. Alberta Murphy - 13 Hillcrest, Tuscaloosa, Alabama 35401
6. Mr. Junior Richardson - 17 CW, Bryce Hospital, Tuscaloosa, Alabama 35401
7. Mr. John T. Wagnon, Jr. - 822 Felder Avenue, Montgomery, Alabama 36106

SEARCY HUMAN RIGHTS COMMITTEE

1. Dr. E. L. McCafferty, Jr. - Chairman - 1653 Spring Hill Avenue, Mobile, Alabama 36604
2. Hon. James U. Blacksher - 304 South Monterey, Mobile, Alabama
3. Hon. Thomas E. Gilmore - P. O. Box 109, Eutaw, Alabama 35462
4. Ms. Consuello J. Harper - 3114 Caffey Drive, Montgomery, Alabama 36108
5. Hon. Horace McCloud - Mount Vernon, Alabama
6. Sister Eileen McLoughlin - 404 Government Street, Mobile, Alabama 36601
7. Ms. Joyce Nickels - c/o Searcy Hospital, Mount Vernon, Alabama

1973 REPORT

LEGISLATIVE RESEARCH COMMISSION

A STUDY OF THE "GEOGRAPHIC UNIT" CONCEPT WITHIN NORTH CAROLINA STATE MENTAL HOSPITALS

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I. Resolution Directing the Study.

II. Article 2C of G.S. Chapter 122, Establishment of Area Mental Health Programs.

INTRODUCTION

On May 14, 1971, the North Carolina General Assembly ratified House Joint Resolution 715 as Resolution 66 of the 1971 Session. This Resolution directed the Legislative Research Commission to "study the 'geographical unit' concept within the state mental hospitals to evaluate the practicality, the effectiveness and the economy of this type of operation." (A copy of HJR 715 is contained in Appendix I.)

Pursuant to the direction of HJR 715 the Co-Chairmen of the Legislative Research Commission appointed Representative Carl J. Stewart Chairman of a Committee which was to undertake the study and to report its findings back to the full Commission. Representative Stewart is a member of the Legislative Research Commission; other members of the Committee on the Geographic Unit within State Mental Hospitals were drawn from the General Assembly at large. The Committee members are: Representative Robert Q. Beard, Representative James T. Beatty, Senator Luther J. Britt, Jr., Representative Nancy B. Chase, Senator David T. Flaherty, and Representative Joseph B. Raynor, Jr.

The Committee had a number of meetings and public hearings, made individual visits to state mental institutions, and received for its consideration a summary of a recent State Bureau of Investigation report on North Carolina mental hospitals. Dr. Eugene A. Hargrove, Commissioner of the N. C. Department of Mental Health, and Dr. Eugene Malony, a practicing psychiatrist

with experience in the State Hospital system, participated in Committee meetings. Staff assistance was provided by Mr. David Warren, Assistant Director of the Institute of Government, and Mr. William H. Potter, Jr., Research Director for the Legislative Services Office.

BACKGROUND

The Committee initially found the directive of HJR 715 ambiguous. The resolution was captioned "A Joint Resolution Authorizing and Directing the Legislative Research Commission to Study the Area Unit Concept of Treatment of the Mentally Ill ..." (emphasis added) yet the commissioning Section 1 of the resolution limits the scope of the directive to an evaluation of the geographic unit concept.

THE AREA PROGRAM

The confusion in the resolution is easily understood. The Area Program is a concept clearly articulated in G.S. 122-35.18 through G.S. 122-35.22. These sections of the General Statutes, Article 2C. Establishment of Area Mental Health Programs, were enacted by Chapter 470 of the 1971 North Carolina Session Laws. (Article 2C of G.S. Chapter 122 is contained in Appendix II.) Under G.S. 122-35.19(1), the North Carolina Board of Mental Health is given authority to establish area mental health

programs "to consist of a combining and interrelationship of resources, personnel, and facilities of the Department of Mental Health, and of the community mental health program to serve the population of the area designated pursuant to this Article." Other sections of Article 2C provide for Area Mental Health Boards, with equitable area-wide representation consisting of county commissioners, physicians, attorneys and other citizens at large.

In 1965 the North Carolina Department of Mental Health had already been reorganized under four mental health regions, each with its own commissioner. Each region contains a mental hospital, a mental retardation center, and an alcoholism program. The 1971 legislation made possible further decentralization. The decentralization under the area program has had the effect of shifting authority for mental health programs from elected county commissioners to area policy boards appointed by them. To date, the area concept has not been fully implemented, nor has its ultimate function been fully developed or clarified.

The Committee quickly concluded that the sponsor of HJR 715 had no real quarrel with the Area Programs per se but that they were largely concerned with another program called the "Geographic Unit" concept.

THE GEOGRAPHIC UNIT

In 1848 North Carolina began a program of institutional care for the mentally ill. Hospitals competed for funds under this program until the creation of the Hospital Board of Control in 1945. The Department of Mental Health was established as a state agency in 1964 and a few years later took over some local mental hygiene clinics from the Department of Public Health. At this point, North Carolina was providing very limited out-patient care to a few people. At the same time, the State was providing some acute care and a large amount of custodial care at centralized institutions. There was little linkage between community programs and institutions, and there was no comprehensive system for the delivery of mental health services.

Three hospitals were serving white patients and one institution was serving black patients. In 1965 all four hospitals were racially integrated, and the state was divided into four regions -- each with a mental hospital for adult patients. This change generated much anxiety for hospital staffs within the system as well as for families of the patients involved -- especially at Cherry, the formerly all black institution.

Shortly following integration, the geographic unit system was introduced. It had been widely applauded in professional psychiatric and administrative journals throughout the United States. Its application involves the decentralization of large institutions (North Carolina's four) into what amounts to several small hospitals, called units, each with its own provision for continuity of care. Patients are grouped according

to the community or geographic catchment area in which they reside. Men and women patients are mixed, and no attempt is made to segregate them by symptoms of illness. Admission is directly to the unit rather than to a central admissions service.

It was hoped that the unit system would achieve these goals:

1. Provide comprehensive and continuous care for psychiatric patients by improving hospital community linkage.
2. Decentralize large state hospitals to provide management decisions close to the local situation.
3. Minimize the concept of "chronic" patients and to provide active treatment for all patients.

Though lofty in concept, in practice and in application the geographic unit program has created strain on the mental health system bordering on turmoil. It has also caused staffing duplication.

Back ward patients (long term, chronic, regressed) have been thrust together with admission ward patients (less seriously disturbed). This does help the back ward patient, but in some cases has severely disturbed the admission ward patient (and his family!). If they are split into several programs the quality of certain specialized services, such as an adolescents' program or an alcoholism program, inevitably suffers; the necessary specialized skills have simply been spread too thin.

CONCLUSIONS AND RECOMMENDATIONS

Perhaps as a result of HJR 715 itself, the state regional hospitals are retreating markedly from the geographic unit

emphasis. For example, more than fifty percent of the Dorothea Dix population is now back in special units /Admission, Geriatric (elderly), Nursing Care, Infirmary, Forensic (criminal), Medical Surgical, Research, Resocialization and Alcoholic/ rather than geographic units. The Department is now exploring revising the geographic unit system in two areas (Southeastern and Sandhills) and going entirely to special programs.

Thus we find that the tension and frustration which gave rise to House Joint Resolution 715 is already beginning to subside. The investigation by your committee has already served a great purpose. Our hope is that the analysis of this report might hasten the modification of the geographic unit program now under way within the system at large.

In carrying out this modification the Committee feels that the following specific recommendations will be useful:

1. Newly admitted elderly patients should be treated in a single geriatric admission and evaluation unit no matter what community they come from.
2. Moderately disturbed or depressed patients should not be evaluated or treated in the same ward area as are the more chronic or seriously disturbed patients.
3. As patient census decreases, more specialized programs should remain intact.

Appendix I

Resolution Directing the Study.

GENERAL ASSEMBLY OF NORTH CAROLINA
1971 SESSION
RATIFIED BILL

RESOLUTION 66

HOUSE JOINT RESOLUTION 715

A JOINT RESOLUTION AUTHORIZING AND DIRECTING THE LEGISLATIVE RESEARCH COMMISSION TO STUDY THE AREA UNIT CONCEPT OF TREATMENT OF THE MENTALLY ILL IN THE STATE MENTAL HOSPITALS.

Whereas, the North Carolina Department of Mental Health has implemented a "geographical unit" concept for treatment of the mentally ill; and

Whereas, the State's four mental hospital facilities have been divided into units serving patients only from a specific county or counties; and

Whereas, each such unit may require fixed staffing and supporting services despite the variation in the number of patients cared for within each unit; and

Whereas, there exists under such operations the possibility of unequal distribution of patients and staff among units;

Now, therefore, be it resolved by the House of Representatives, the Senate concurring:

Section 1. The Legislative Research Commission with advice, direction and assistance of the Advisory Budget Commission is hereby authorized and directed to study the "geographical unit" concept within the state mental hospitals to evaluate the practicality, the effectiveness and the economy of this type of operation.

Sec. 2. The Legislative Research Commission shall report its findings and recommendations to the 1973 General Assembly.

Sec. 3. This resolution shall become effective upon ratification.

In the General Assembly read three times and ratified, this the 14th day of May, 1971.

H. P. TAYLOR, JR.

H. P. Taylor, Jr.
President of the Senate

PHILIP P. GODWIN

Philip P. Godwin
Speaker of the House of Representatives

Appendix II

Article 2C.

Establishment of Area Mental Health Programs.

Article 2C.

Establishment of Area Mental Health Programs.

§ **122-35.18. Definitions.**—For purposes of this Article, the following definitions shall apply:

(1) "Area" means a geographic entity consisting of one or more counties, or portions of one or more counties, designated by the Board of Mental Health as a basic unit for the development of mental health programs to serve the population of that geographic entity.

(2) "Mental health program" means any services or activities, or combination thereof, for the diagnosis, treatment, care, or rehabilitation of mentally impaired persons or for the promotion of mental health, which is offered by or on behalf of the geographic entity established pursuant to this Article. (1971, c. 470, s. 1.)

Editor's Note.—Section 2, c. 470, Session Laws 1971, makes the Article effective July 1, 1971.

§ **122-35.19. Area mental health programs.**—The North Carolina Board of Mental Health is authorized to establish area mental health programs. These shall be joint undertakings of the counties or portions thereof, included in the designated area, and the Department of Mental Health for the following purposes:

(1) To develop area mental health programs, to consist of a combining and interrelationship of resources, personnel, and facilities of the Department of Mental Health, and of the community mental health program to serve the population of the area designated pursuant to this Article. The area mental health program shall include, but not be limited to, programs for general mental health, mental disorder, mental retardation, alcoholism, drug dependence, and mental health education.

(2) With the approval of the Department of Administration, to develop and test budgeting procedures for combining local and State grants-in-aid funds with a proportional share of funds appropriated for the operation of departmental facilities serving the population of the area. Provided that "local funds" and "State grants-in-aid" shall be defined and determined in accordance with the provisions of G.S. 122-35.11 and G.S. 122-35.12, and shall be unaffected by the addition of funds appropriated for the operation of State facilities.

(3) To evaluate the effectiveness and efficiency of area mental health programs. (1971, c. 470, s. 1.)

§ 122-35.20. **Area mental health boards.** — (a) In areas where area mental health programs are established in accordance with this Article, an area mental health board shall be appointed for each designated area. The area mental health board shall consist of 15 members and shall meet at least six times per year.

(b) In areas consisting of only one county, the board of county commissioners shall appoint all of the members of the area mental health board. In areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area mental health board. These members shall appoint the other members of the area mental health board in such a manner as to provide equitable area-wide representation.

(c) The area mental health board shall include:

(1) At least one commissioner from each county;
(2) At least two persons duly licensed to practice medicine in North Carolina;
(3) At least one representative from the professional fields of psychology, or social work, or nursing, or religion;
(4) At least three representatives from local citizen organizations active in mental health, or in mental retardation, or in alcoholism, or in drug dependence;
(5) At least one representative from local hospitals or area planning organizations;
(6) At least one attorney practicing in North Carolina.

(d) Any member of an area mental health board who is a public official shall be deemed to be serving on the board in an ex officio capacity to his public office. The ex officio members shall serve to the end of their respective terms as public officials. The other members shall serve four-year terms, except that upon initial formation of an area mental health board, three members shall be appointed for one year, two members for two years, three members for three years, and all remaining members for four years.

(e) Subject to the supervision, direction, and control of the State Board of Mental Health, the area mental health board shall be responsible for reviewing and evaluating the area needs and programs in mental health, mental impairment, mental retardation, alcoholism, drug dependence, and related fields, and for developing jointly with the State Department of Mental Health an annual plan for the effective development, use and control of State and local facilities and resources in a comprehensive program of mental health services for the residents of the area. (1971, c. 470, s. 1.)

§ 122-35.21. **Appointment of area mental health director.**—The area mental health board of each area established pursuant to this Article shall appoint, with the approval of the Commissioner of Mental Health and the State Board of Mental Health, an area mental health director. The area mental health director shall be the employee of the area mental health program, responsible to the area mental health board for carrying out the policies and programs of the area mental health board, and of the State Board of Mental Health. (1971, c. 470, s. 1.)

§ 122-35.22. **Clinical services.**—All clinical services under an area mental health program shall be under the supervision of a person duly licensed to practice medicine in North Carolina. (1971, c. 470, s. 1.)