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CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON THE CONSTITUTION

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

S. 1393

A BILL TO AUTHORIZE ACTIONS BY THE ATTORNEY GENERAL
PRIVATIONS OF CONSTITUTIONAL AND OTHER
;OTECTED RIGHTS OF INSTITUTIONALIZED
PERSONS

IE 17, 22, 23, 30, AND JULY 1, 1977

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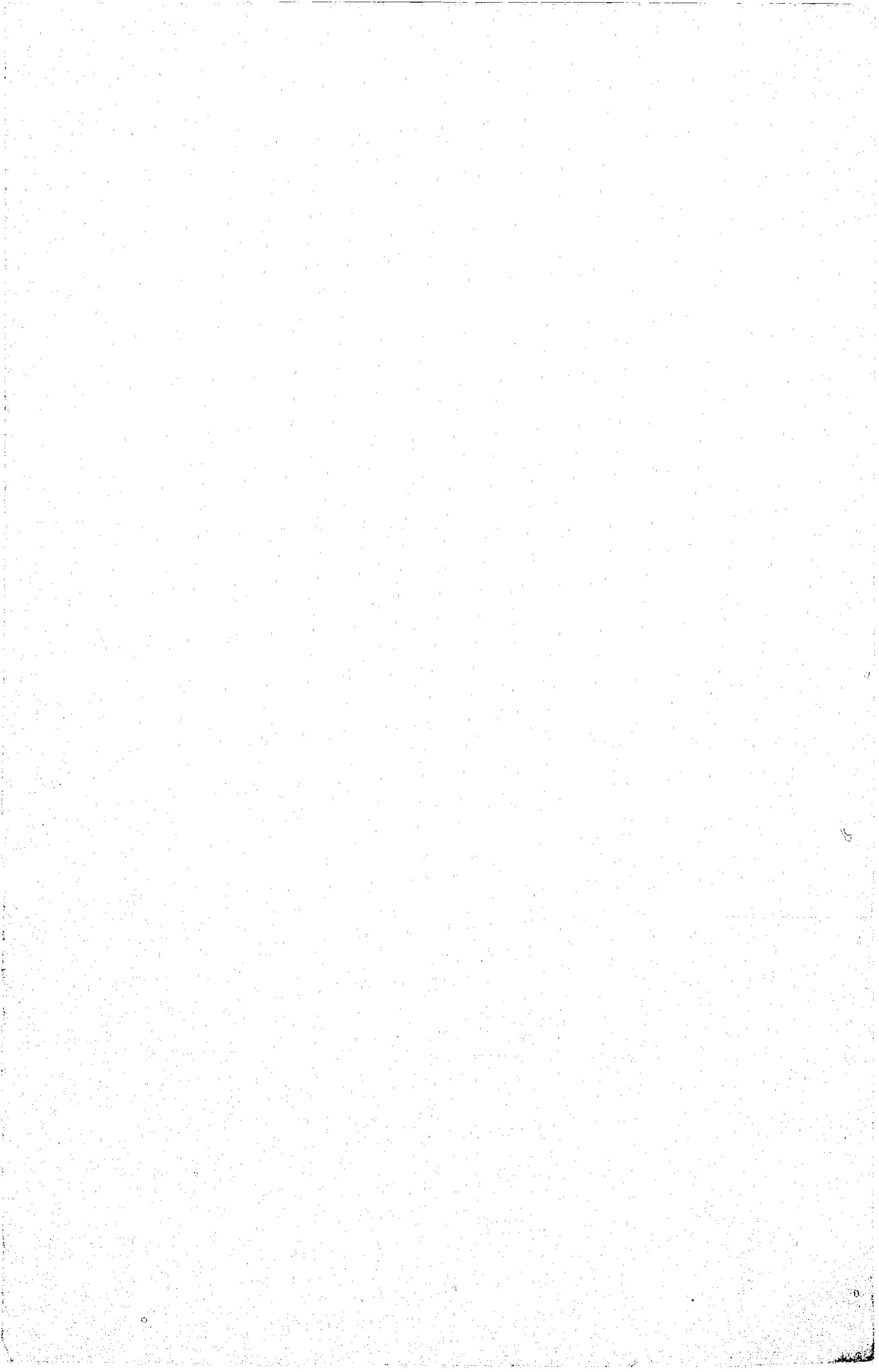

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ACQUISITIONS

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OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

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JUNE 17, 22, 23, 30, AND JULY 1, 1977

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CONTENTS

STATEMENTS AND INTRODUCTIONS BY MEMBERS OF CONGRESS

	Page
Bayh, Hon. Birch, U.S. Senator from the State of Indiana, chairman, Subcommittee on the Constitution	1
Hatch, Hon. Orrin G., U.S. Senator from the State of Utah	553
Kastenmeier, Hon. Robert W., U.S. Representative from the State of Wisconsin	363
Koch, Hon. Edward I., U.S. Representative from the State of New York	938
Mathias, Hon. Charles McC. Jr., U.S. Senator from the State of Maryland	545
Metzenbaum, Hon. Howard M., U.S. Senator from the State of Ohio	123

ALPHABETICAL LIST OF WITNESSES

Berzon, Stephen P., legal director, Children's Defense Fund, Washington, D.C	787
Bodensteiner, Prof. Ivan, professor of law, Valparaiso University, Indiana; director of litigation, Project Justice and Equality, Inc	206
Brelje, Dr. Terry B., superintendent, Chester Mental Health Center, Chester, Ind	215
Brodsky, Dr. Stanley, representative, American Psychological Association; professor of psychology, University of Alabama	443
Bronstein, Alvin J., executive director, National Prison Project, Washington, D.C	632
Burch, Hon. Francis B., attorney general for the State of Maryland, accompanied by George Nielson, deputy attorney general	556
Carabello, Bernard, volunteer, One-to-One (Community Service Center for the Mentally Retarded); former resident, Willowbrook State School, New York	75
Clements, Dr. James, director, Georgia Retardation Center; chairman, Willowbrook Review Panel	372
Days, Hon. Drew S. III., Assistant Attorney General, Civil Rights Division, Department of Justice, accompanied by Frank Allen, Deputy Chief, Appellate Section; Mike Thrasher, Director, Office of Special Litigation; Frank Dunbaugh, Deputy Assistant Attorney General; Jesse Queen, Chief, Public Accommodations and Facilities Section; Marie Klimesz, attorney, Appellate Section	8
Donaldson, Kenneth, author, lecturer; former patient, Florida State Hospital at Chattahoochee	79
Dybwad, Gunnar, Gingold professor of human development, Florence Heller Graduate School for Advanced Studies in Human Development, Brandeis University, Massachusetts	198
Freedom, Karen, member, management board, Mental Health Advocacy Project, Los Angeles, Calif.; former patient, UCLA Neuropsychiatric Institute, Los Angeles, Calif	111
Friedman, Paul R., managing attorney, Mental Health Law Project, Washington, D.C	797
Garcia, David S., staff worker, Mental Health Advocacy Project, Los Angeles, Calif.; former patient, Metropolitan State Hospital, Calif	106
Gordon, Theodore, environmental health consultant, U.S. Department of Justice	228
Gorrecht, Freida E., National Coalition for Nursing Home Reform, Detroit, Mich	824
Halpern, Charles R., director, Council for Public Interest Law; member, American Bar Association, Commission on the Mentally Disabled	178

Page

Hansen, Hon. Robert B., attorney general for the State of Utah 606
Kammerlohr, Hon. Mel, assistant attorney general for the State of Nebraska 572
Kastenmeier, Hon. Robert W., U.S. Representative from the State of Wisconsin 363
King, Edward C., directing attorney, National Senior Citizens Law Center, Washington, D.C 900
Marvin, C. Raymond, general counsel, National Association of Attorneys General 605
McGuire, Dr. Michael D., lieutenant colonel, U.S. Air Force; former superintendent, Farview State Hospital, Pa 125
Moore, Acel, reporter, Philadelphia Inquirer; author, "The Farview Findings" 129
Murdock, Joyce, food service employee, Winston-Salem, N.C.; former patient, Caswell Center for the Mentally Retarded, accompanied by Ted Boushy 94
Nagel, William G., executive vice president, American Foundation, Inc., Institute of Corrections, Philadelphia, Pa 768
Posner, Morton, executive director, Federation of Parents Organizations for the New York State Mental Institutions 457
Rawls, Wendell Jr., Washington correspondent, New York Times; author, "The Farview Findings" 129
Rivera, Geraldo, broadcast journalist, ABC News 37
Roos, Dr. Philip, executive director, National Association for Retarded Citizens; former chief of Clinical Psychology Services, Texas Department of Mental Health and Mental Retardation; former superintendent, Austin State School, Austin, Tex 190
Rubin, Harry J., chairman, litigation panel, Mental Health Association 450
Schoen, Kenneth F., commissioner, Minnesota Department of Corrections 407
Scimeca, Jacqueline, para-legal, Ocean-Monmouth Legal Services, Inc., Red Bank, N.J 816
Segal, Irving R., member, American Bar Association, Commission on Correctional Facilities and Services, accompained by Melvin T. Axilbund, staff director 417
Stone, Dr. Alan, professor of law and psychiatry, faculty of law and faculty of medicine, Harvard University 390
Thomas, William J., lecturer; former patient, Farview State Hospital, Pa 89
Travisono, Anthony P., executive director, American Correctional Association, on behalf of William D. Leeke, commissioner, South Carolina Department of Corrections 411
Walinski, Hon. Nicholas J., U.S. district judge for the northern district of Ohio, accompanied by John Czarnecki, attorney 546
Walker, Dr. Bailus, Jr., environmental health consultant, U.S. Department of Justice 228
Wilkins, Dr. Michael, internist, Wayne Miner Neighborhood Health Center, Kansas City, Mo.; former staff physician, Willowbrook State School, New York 71

CHRONOLOGICAL LIST OF WITNESSES

Friday, June 17, 1977

Days, Hon. Drew S. III, Assistant Attorney General, Civil Rights Division, Department of Justice, accompanied by Frank Allen, Deputy Chief, Appellate Section; Mike Thrasher, Director, Office of Special Litigation; Frank Dunbaugh, Deputy Assistant Attorney General; Jesse Queen, Chief, Public Accommodations and Facilities Section; Marie Klimesz, attorney, Appellate Section 8
Rivera, Geraldo, broadcast journalist, ABC News 37
Wilkins, Dr. Michael, internist, Wayne Miner Neighborhood Health Center, Kansas City, Mo.; former staff physician, Willowbrook State School, New York 71
Carabello, Bernard, volunteer, One-to-One (Community Service Center for the Mentally Retarded); former resident, Willowbrook State School, New York 75

	Page
Donaldson, Kenneth, author, lecturer; former patient, Florida State Hospital at Chattahoochee	79
Thomas, William J., lecturer; former patient, Farview State Hospital, Pa	89
Murdock, Joyce, food service employee, Winston-Salem, N.C.; former patient, Caswell Center for the Mentally Retarded, accompanied by Ted Boushy	94
Garcia, David S., staff worker, Mental Health Advocacy Project, Los Angeles, Calif.; former patient, Metropolitan State Hospital, Calif	106
Freedom, Karen, member management board, Mental Health Advocacy Project, Los Angeles, Calif.; former patient, UCLA Neuropsychiatric Institute, Los Angeles, Calif	111

WEDNESDAY, JUNE 22, 1977

McGuire, Dr. Michael D., lieutenant colonel, U.S. Air Force; former superintendent, Farview State Hospital, Pa	125
Rawls, Wendell Jr., Washington correspondent, New York Times; author, "The Farview Findings"	129
Moore, Acel, reporter, Philadelphia Inquirer; author, "The Farview Findings"	129
Halpern, Charles R., director, Council for Public Interest Law; member, American Bar Association, Commission on the Mentally Disabled	178
Roos, Dr. Philip, executive director, National Association for Retarded Citizens; former chief of Clinical Psychology Services, Texas Department of Mental Health and Mental Retardation; former superintendent, Austin State School, Austin Tex	190
Dybwad, Gunnar, Gingold professor of human development, Florence Heller Graduate School for Advanced Studies in Human Development, Brandeis University, Mass	198
Bodensteiner, Prof. Ivan, professor of law, Valparaiso University, Indiana; director of litigation, Project Justice and Equality, Inc	206
Brelje, Dr. Terry B., superintendent, Chester Mental Health Center, Chester Ind	215
Walker, Dr. Bailus, Jr., environmental health consultant, U.S. Department of Justice	228
Gordon, Theodore, environmental health consultant, U.S. Department of Justice	228

THURSDAY, JUNE 23, 1977

Kastenmeier, Hon. Robert W., U.S. Representative from the State of Wisconsin	363
Clements, Dr. James, director, Georgia Retardation Center, chairman, Willowbrook Review Panel	372
Stone, Dr. Alan, professor of law and psychiatry, faculty of law and faculty of medicine, Harvard University	390
Schoen, Kenneth F., commissioner, Minnesota Department of Corrections	407
Travisono, Anthony P., executive director, American Correctional Association, on behalf of William D. Leeke, commissioner, South Carolina Department of Corrections	411
Segal, Irving R., member, American Bar Association, Commission on Correctional Facilities and Services, accompanied by Melvin T. Axilbund, staff director	417
Brodsky, Dr. Stanley, representative, American Psychological Association; professor of psychology, University of Alabama	443
Rubin, Harry J., chairman, litigation panel, Mental Health Association	450
Posner, Morton, executive director, Federation of Parents Organizations for the New York State Mental Institutions	457

THURSDAY, JUNE 30, 1977

Walinski, Hon. Nicholas J., U.S. district judge for the northern district of Ohio, accompanied by John Czarnecki, attorney	546
Burch, Hon. Francis B., attorney general for the State of Maryland, accompanied by George Nielson, deputy attorney general	556
Kammerlohr, Hon. Mel, assistant attorney general for the State of Nebraska	572

	Page
Marvin, C. Raymond, general counsel, National Association of Attorneys General	605
Hansen, Hon. Robert B., attorney general for the State of Utah	606
Bronstein, Alvin J., executive director, National Prison Project, Washington, D.C	632
Nagel, William G., executive vice president, American Foundation, Inc., Institute of Corrections, Philadelphia, Pa	768

FRIDAY, JULY 1, 1977

Berzon, Stephen P., legal director, Children's Defense Fund, Washington, D.C	787
Friedman, Paul R., managing attorney, Mental Health Law Project, Washington, D.C	797
Scimeca, Jacqueline, para-legal, Ocean-Monmouth Legal Services, Inc., Red Bank, N.J	816
Gorrecht, Freida E., National Coalition for Nursing Home Reform, Detroit, Mich	824
King, Edward C., directing attorney, National Senior Citizens Law Center, Washington, D.C	900

LIST OF EXHIBITS

1. S. 1393, a bill to authorize actions by the Attorney General to redress deprivations of constitutional and other federally protected rights of institutionalized persons	4
2. Photographs of conditions in mental retardation facilities and prisons	[1]
3. Guidelines that may be followed by the Attorney General in litigation programs concerning the constitutional rights of institutionalized persons	35
4. Excerpts from "A Special Kind of Courage: Profiles of Young Americans", by Geraldo Rivera. Simon and Schuster, New York. Copyright 1976 by Geraldo Rivera	40
5. Newspaper article from the Washington Post, Saturday, February 5, 1977, "First Mental Patient to Win Right to Liberty is Awarded $20,000"	88
6. Statement from the Mental Health Advocacy Project in support of S. 1393	116
7. Articles from the Philadelphia Inquirer, June–July, 1976, "The Farview Findings," by Wendell Rawls, Jr., and Acel Moore	148
Part I—"The State Treats Patients with Drugs, Brutality and Death"	148
Part II—"The Pattern of Therapy: Sedation and Brutal Neglect"	156
"The Guards Still Run The Place"	161
Part III—"Hustles, Thefts, and Betting are a Way of Life Inside"	162
"Patients Forced To Fight: 'The Guards Wanted Blood' "	165
Part IV—"Close Farview? 40,000 Citizens Said, 'No.' "	167
"Tapes and Photos Depict Horrors"	171
More Farview Findings—"Excerpts From the Farview Tapes"	173
"Coroner Schedules Inquest"	175
"30-Day Term Lasted 32 Years"	176
8. Manual of Standard Procedures for Aversive Therapy	202
9. Articles from "Impact," Vol. VI, No. 6, Texas Department of Mental Health and Mental Retardation, March–April 1977	204
"What is Behavior Modification?"	204
"Shaping Behavior In a School" by June Bilsborough	204
"Shaping Behavior in a Hospital" by Thelma Ledger	205
10. Standards for health services in correctional institutions, prepared by Jails and Prisons Task Force Program Development Board of the American Public Health Association	238
11. Food protection in jails and prisons	349
12. Photos of examples of substandard living conditions in jails and prisons in the United States	354

[1] Photographs may be found in the files of the Subcommittee on the Constitution, Committee on the Judiciary, U. S. Senate.

		Page
13.	Prepared statement of William D. Leeke, commissioner, South Carolina Department of corrections	414
14.	Grievance procedures in the correctional facilities of New York State instituted under the auspices of the association by the special committee on penology	425
15.	Supplemental statement submitted by Irving R. Segal on behalf of the American Bar Association	437
16.	American Bar Association report to the House of Delegates, Commission on Correctional Facilities and Services and the Commission on the Mentally Disabled; "Grievance Mechanisms for the Mentally Disabled and Prisoners—Recommendations"	439
17.	Newspaper article from the New York Times, "Inquiry Links 'Institutional Indifference' to Deaths of 7 at Bronx Mental Facility," by Ronald Sullivan, June 10, 1977	468
18.	Table of court actions and agreements in *Jackson* v. *Hendrick*, 457 Pa. 405, 321A.2d 603, 607 (1974), case concerning the Philadelphia jails	470
19.	For annual report, 1977, prisoners' rights litigation	471
20.	Newspaper article from the New York Post, "Mental Hospital Terror Bared," by Michael Rosenbaum, May 16, 1977	472
21.	State of New York, Commission of Investigation, Life and Death at the Bronx Psychiatric Center, June 9, 1977	474
22.	Letter from Hon. Nicholas J. Walinski, U.S. district judge, northern district of Ohio, western division to Senator Birch Bayh, June 15, 1977	551
23.	Prepared statement of V. Frank Mendicino, attorney general of the State of Wyoming	554
24.	Prepared statement of the prisoner assistance project of the Baltimore Legal Aid Bureau, Inc	569
25.	Prepared statement of Paul L. Douglas, attorney general of the State of Nebraska	577
26.	Prepared statement from the National Center for Law and the Handicapped, in response to the statement submitted by Paul L. Douglas, attorney general of the State of Nebraska	580
27.	Nebraska State Bar Association, jail survey	586
28.	Overcrowding at the Utah State Prison, report to the State legislature, June 1977	618
29.	Newspaper article from the New York Times, "Thinking About the Federal Judiciary," by Frank M. Johnson, Jr., April 9, 1977	643
30.	The Alabama prison system, an analysis and estimate of the cost and economic considerations resulting from the orders of the U.S. district court in *Pugh* v. *Locke* (Civil action No. 74–57–N) and James V. Wallace (civil action No. 74–203–N) 406 F. Supp. 318 (M.D. Ala. 1976)	646
31.	Eight photographs showing the substandard conditions in the Alabama State prison system	762
32.	"Quest or Question? The Presumption of Innocence and the American Jail," by William G. Nagel	780
33.	Letter from Citizens for Better Care to Dr. Maurice Reizen, director, Michigan Department of Public Health, regarding serious deficiencies at the Conner Manor Nursing Home in Detroit, March 25, 1976	829
34.	Response from Michigan Department of Public Health to Citizens for Better Care, April 1, 1976	833
35.	Letter from Citizens for Better Care to Richard Friedman, regional HEW Director, April 1, 1976	833
36.	Memorandum from Cherie Nan Jansen, R.N., and Delphine Shott, R.N., to Dr. Ziel, in regard to the death of Conner Manor patient, Mamie Butts, dated April 1, 1976	834
37.	Letter from Citizens for Better Care to Harry Luchs, Bureau of Health Facilities, to file a formal complaint against Conner Manor in regard to the death of Mamie Butts	836
38.	Letter from Citizens for Better Care to Dr. Maurice Reizen, supporting Department of Public Health's intent-to-deny licensure letter, April 13, 1976	836
39.	Letter of April 20, 1976, from Citizens for Better Care to William Cahalan, Wayne County prosecutor, requesting investigation into criminal negligence in regard to the death of Mamie Butts	836
40.	Newspaper article from the Detroit News "Rest Home Losing License After a Death: Patient Drowns in Tub," April 21, 1976	837

Page

41. Newspaper article from the Detroit Free Press, "State Probes 2d Tub Death," April 29, 1976 838
42. Newspaper article from the Detroit Free Press, "Closing of Nursing Home Ruled Illegal," January 13, 1977 840
43. Most recent inspection reports of Conner Manor, March 14 and 15, 1977 841
44. Correspondence from Charles Chomet, executive director, Citizens for Better Care, to John Laing, administrator, Friendship Manor Nursing Home, and Dr. Maurice S. Reizen, director, Michigan Department of Public Health, with enclosure on "Background Information About Patient Care at Friendship Manor Nursing Home in Detroit," October 15, 1976 860
45. Response by Dr. Maurice S. Reizen on the improvement of conditions at Friendship Manor, October 26, 1976 869
46. Formal complaint filed by Citizens for Better Care on the problems found at Friendship Manor, November 12, 1976 870
47. Letter from Henry Langberg, attorney, to Dr. Maurice Reizen, December 21, 1976 872
48. Letter from Charles Chomet to Congressman Claude Pepper, dated January 6, 1977 877
49. Letter from Charles Chomet to Richard Friedman, Director, Health, Education, and Welfare, Region V, January 6, 1977 878
50. Letter from Dr. Maurice S. Reizen to John A. Laing in regard to notice of intent to deny licensure and certification 879
51. Last inspection reports issued by Wayne County Department of Public Health, March 23, 1977 880
52. Letter from Dr. Maurice S. Reizen to John A. Laing, in regard to amended notice of intent to deny licensure/certification 900

APPENDIXES

Part 1.—Statements and Correspondence

1. Narrative summary, site visit of Farview State Hospital, by Marshall D. Fitz, M.D.; Mary Rose Martinelli, MSN; and June McLaughlin, R.D., July 20–22, 1976 911
2. Prepared statement of the National Association of Coordinators of State Programs for the Mentally Retarded, Inc 930
3. Prepared statement of the National Center for Law and the Handicapped 934
4. Prepared statement of the National Committee on Patients Rights 935
4a. Prepared statement of William W. Treanor, executive director of the National Alternatives Project 936
5. Prepared statement of Hon. Edward I. Koch, a U.S. Representative in Congress from the State of New York 938
6. Statement of Deficiencies and Plan of Correction, Manhattan Psychiatric Center, Wards, Island, N.Y.:
   - Meyer Building 942
   - Dunlap Building 950
   - Kirby Building 958
7. Letter from Hon. Edward I. Koch, a U.S. Representative in Congress from the State of New York, to Dr. Lawrence Kolb, commissioner, Department of Mental Hygiene, November 8, 1976 962
8. Letter from Alvin M. Mesnikoff, M.D., regional director, N.Y. State Department of Hygiene, to Hon. Edward I. Koch, a U.S. Representative in Congress from the State of New York, November 23, 1976 964
9. Statement from the Manhattan State Citizens Group, an analysis of Dr. Mesnikoff's reply to Congressman Koch's letter to Commissioner Kolb 969
10. Letter from Hon. Edward I. Koch to James D. Isbister, administrator, Mental Health Administration, Department of Health, Education, and Welfare, December 30, 1976 976
11. Letter from Francis N. Waldrop, M.D., Deputy Administrator, Mental Health Service, Department of Health, Education, and Welfare to Hon. Edward I. Koch 977

Page

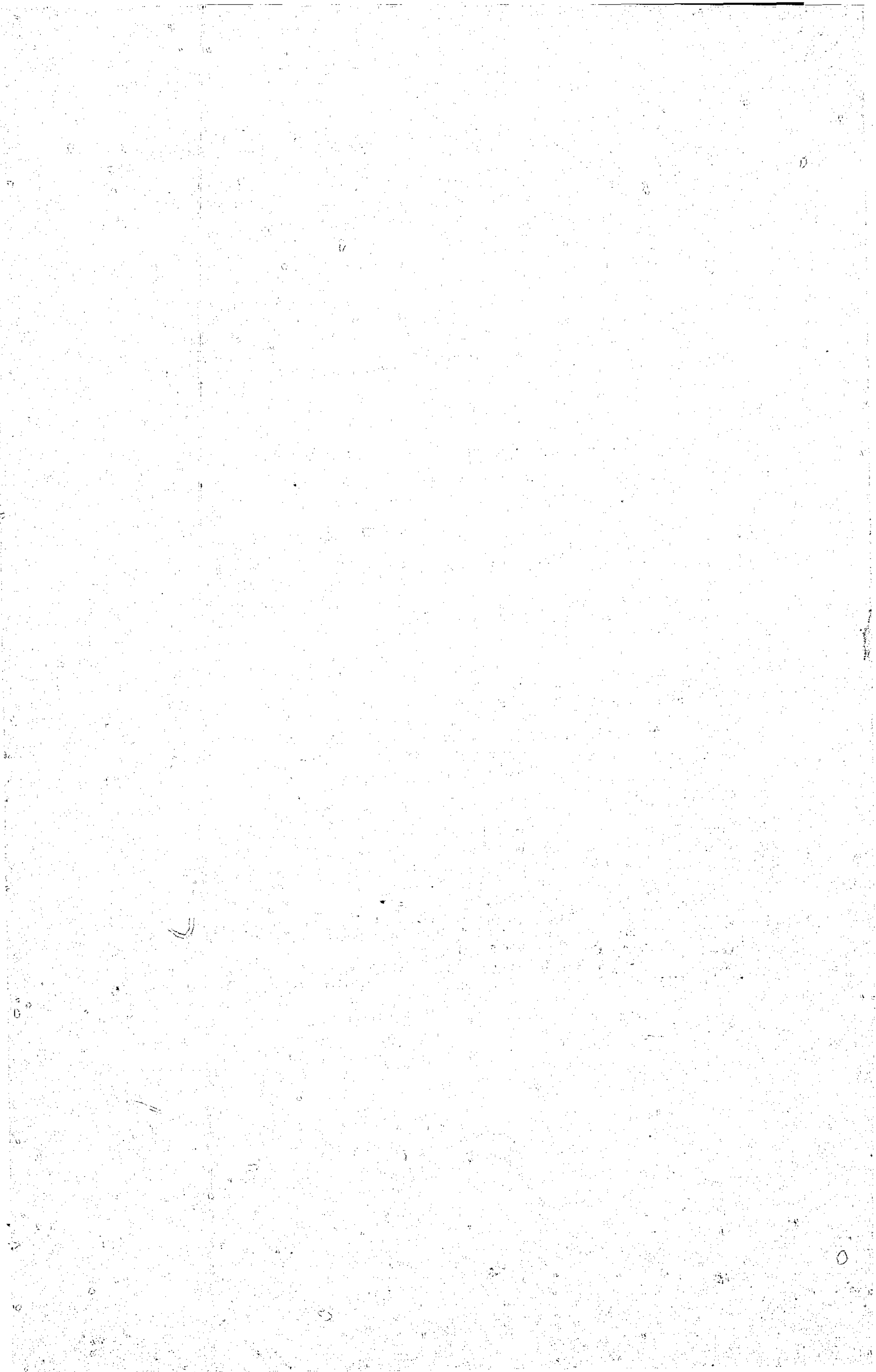
12. Letter from Milton Webber, program officer, Bureau of Health Insurance, Department of Health, Education and Welfare, to Hon. Edward I. Koch ____ 977
13. Letter from Hon. Edward I. Koch to Hon. Drew S. Days, III, Assistant Attorney General, Civil Rights Division, U.S. Department of Justice, June 16, 1977 ____ 978
14. Prepared statement of Stanley C. Van Ness, public advocate-public defender, State of New Jersey before the Committee on the Judiciary, House of Representatives in support of H.R. 2439 and H.R. 5791, May 23, 1977 ____ 979
15. Letter from Evelle J. Younger, attorney general, Department of Justice, State of California to Hon. Birch Bayh, chairperson, Subcommittee on the Constitution, U.S. Senator from the State of Indiana, June 27, 1977 ____ 983
16. Letter from Harry F. Swanger, deputy director, National Juvenile Law Center, St. Louis University School of Law to Hon. Birch Bayh, chairperson, Subcommittee on the Constitution, U.S. Senator from the State of Indiana, July 25, 1977 ____ 988

PART 2.—NEWSPAPER ARTICLES AND REPORTS

17. "Albany Investigates Violent Deaths at Psychiatric Center in the Bronx" by Nathaniel Sheppard Jr., New York Times, December 3, 1976 ____ 991
18. "Terror Bared at Mental Hospital", by Michael Rosenbaum, New York Post, May 16, 1977 ____ 993
19. "More Horror Uncovered at Hospital", by Michael Rosenbaum, New York Post, May 17, 1977 ____ 994
20. "Beatings and Suicides at Bronx State Center", by Michael Rosenbaum, New York Post, May 17, 1977 ____ 995
21. Editorial from the New York Post, May 17, 1977, "Hospital Under Siege" ____ 996
22. "Blame Hospital in Deaths, Beatings", by Marcia Kramer, New York Daily News, June 10, 1977 ____ 997
23. Editorial from the New York Times, June 16, 1977, "Life and Death at Bronx Psychiatric" ____ 998
24. Excerpts from "Wards of the State", a report on the causes, nature, and extent of patient abuse in New York State mental health facilities ____ 998

PART 3.—COURT CASES

25. *Wyatt* v. *Stickney*, 334 F. Supp. 1341 (M.D. Ala. 1971) ____ 1009
26. *Wyatt* v. *Aderholt*, 503 F. 2d 1305 (5 Cir, 1974) ____ 1012
27. *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975) ____ 1024
28. *New York Association for Retarded Children, Inc.* v. *Rockefeller*, 357 F. Supp. 752 (E.D. N.Y. 1973) ____ 1034
29. *Morales* v. *Turman*, 364 F. Supp. 166 (E.D. Tex. 1973) ____ 1049
30. *Newman* v. *State of Alabama*, 349 F. Supp. 278 (M.D. Ala. 1972) ____ 1062
31. *Gates* v. *Collier*, 501 F. 2d 1291 (1974) ____ 1070
32. *Battle* v. *Anderson*, 376 F. Supp. 402 (E.D. Okla. 1974) ____ 1095
33. *United States* v. *Solomon*, 419 F. Supp. 358 (D. Md. 1976) ____ 1126



CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS

FRIDAY, JUNE 17, 1977

U.S. SENATE,
SUBCOMMITTEE ON THE CONSTITUTION
OF THE COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:10 a.m., room 2228, Dirksen Senate Office Building, Hon. Birch Bayh, chairman, presiding.

Present: Senators Bayh, Scott, and Hatch.

Staff present: Nora Manella, counsel; Nels Ackerson, chief counsel and executive director; Mary K. Jolly, staff director; and Linda Rogers-Kingsbury, chief clerk.

OPENING STATEMENT OF HON. BIRCH BAYH, U.S. SENATOR FROM THE STATE OF INDIANA AND CHAIRMAN, SUBCOMMITTEE ON THE CONSTITUTION

Today the Subcommittee on the Constitution initiates 4 days of hearings on S. 1393, a bill designed to secure for thousands of institutionalized persons in this country the full guarantees of the U.S. Constitution and Federal laws that are designed to govern and protect all of us. S. 1393 provides express statutory authority for the U.S. Justice Department to sue and to intervene in suits brought against State institutions which systematically deny their residents fundamental rights guaranteed by the Constitution and laws of the United States.

Few would challenge the assertion that the mentally ill, the retarded, the chronically disabled, prisoners, confined juveniles, and the elderly are among the least represented citizens in American society today. Isolated from normal communities, disenfranchised, and without resources to exert economic or political leverage, the institutionalized are singularly ill equipped to redress deprivations of fundamental rights through conventional legal channels. Few are aware of their rights; even fewer are able to marshall the resources necessary to secure effective legal representation. And virtually none is in a position to see that basic rights, once secured, will continue to be protected.

For several years, the Department of Justice has been active in a litigation program to ensure enforcement of Federal rights for persons confined in State institutions.

I compliment you, Mr. Days, and those who came before you for these efforts.

Since the Department was first ordered by a Federal court to appear as amicus in a 1971 case, it has actively participated in a series of landmark lawsuits that have led to the amelioration of the worst conditions of confinement. Additionally, by challenging the constitutionality of numerous State commitment statutes, the Department has been instrumental in causing several State legislatures to review and subsequently to rewrite their commitment laws. In virtually every case in which the Department has participated, the claims of institutionalized residents have been upheld, and the adjudicating courts have ordered massive relief. There can be no question, therefore, that the efforts of the Department have resulted in vastly improved living conditions for thousands of institutionalized individuals, as well as the deinstitutionalization of many persons unnecessarily confined.

What we're talking about here are conditions that almost defy description. I think to many Americans they are unbelievable. We're talking about institutionalized citizens—children, elderly, disabled, retarded, prisoners—confined through the course of law by some of our States. They are living in institutions where, in one instance, 100 percent of the residents contracted hepatitis, where maggots were found in food, where one toilet was provided for 200 men, where we have documented cases of physical and mental abuse by guards entrusted with the care of such persons. I would rather not discuss it publicly because of the horrors involved.

The purpose for this legislation and the purpose for being here is to see that those people, the young and the old, the sane and the insane, who are institutionalized, are guaranteed the constitutional protection that all citizens of this country are entitled to. These have not been available.

The Department of Justice has accomplished much, but despite these accomplishments, the Department is now faced with the prospect of having to halt its remarkably successful program. Two Federal district courts have held recently that the Department lacks authority to initiate suit against State institutions for deprivations of residents' constitutional rights, absent express statutory authority. Both cases are currently on appeal. Regardless of their outcome, however, it is clear that without expressed authority from Congress, the Department will face procedural roadblocks in every case brought to enforce the rights of institutionalized persons.

Congress has the power to prevent this anomalous result, by enacting a law which creates no new substantive rights. Here I want to make it clear that we're not creating new rights. What we are doing is merely providing an effective enforcement mechanism for those rights already adjudicated under the Constitution and Federal laws. Congress can ensure that the guarantees of the Bill of Rights become reality for thousands of institutionalized individuals throughout the country. Without such law, these guarantees will be little more than lofty rhetoric.

The witnesses testifying at these hearings have been invited with three goals in mind. First, in recognition of the need to establish, by firsthand documentation, the existence of widespread deprivations of institutionalized persons' constitutional rights, we have asked

former institution residents to present their own real-life stories and those of their companions.

Second, in an effort to highlight the unique disabilities faced by institutionalized individuals in seeking to redress even the most obvous grievances, we have requested the testimony of persons intimately familiar with the operation of such institutions, including hospital and prison administrators, staff physicians, experts in the fields of mental health, mental retardation, criminology, and also environmental health consultants.

Finally, in order to demonstrate the proven effectiveness of the Justice Department's past litigation efforts in securing fundamental Federal rights for the institutionalized, we have invited lawyers, judges, and concerned organizations that have participated in suits in which the Department has played an active role. Interested individuals and groups who oppose S. 1393, or portions of it, have also been invited to present their views.

In this—what I think can adequately be called "the last great frontier of civil rights litigation"—it is essential that Congress move swiftly; for although we have made progress in many areas, this is the last frontier where we have large numbers of citizens in this country who are being denied their constitutional rights. Congress has the power to act, and I hope it will do so.

At this time I would like to submit a copy of S. 1393 for the record.

[The bill, S. 1393, was marked "Exhibit No. 1" and is as follows:]

[EXHIBIT NO. 1]

95TH CONGRESS
1ST SESSION

S. 1393

IN THE SENATE OF THE UNITED STATES

APRIL 26 (legislative day, FEBRUARY 21), 1977

MR. BAYH introduced the following bill; which was read twice and referred to the Committee on the Judiciary

A BILL

To authorize actions by the Attorney General to redress deprivations of constitutional and other federally protected rights of institutionalized persons.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 SECTION 1. Whenever the Attorney General has reason-
4 able cause to believe that a State or its agent is subjecting
5 persons confined in an institution, as defined in section 4, to
6 conditions which deprive them of any rights, privileges, or
7 immunities secured by the Constitution or laws of the United
8 States, and that such deprivation is pursuant to a pattern or
9 practice of resistance to the full enjoyment of such rights,
10 privileges, or immunities, the Attorney General is authorized

II

1 to institute a civil action for or in the name of the United
2 States in any appropriate district court of the United States
3 against such party or parties for such relief as he deems nec-
4 essary to insure the full enjoyment of such rights, privileges,
5 or immunities. The district courts shall exercise such jurisdic-
6 tion without regard to whether the aggrieved party or parties
7 shall have exhausted any administrative or other remedies
8 provided by law. Whenever, in a proceeding instituted under
9 this section, any official of a State or subdivision thereof is
10 alleged to have committed any act or practice subjecting per-
11 sons confined in an institution to the deprivation of any rights,
12 privileges, or immunities secured by the Constitution or laws,
13 the act or practice shall also be deemed that of the State and
14 the State may be joined as a party defendant. If, prior to the
15 institution of such proceeding, such official has resigned or
16 has been relieved of his office and no successor has assumed
17 such office, the proceeding may be instituted against the
18 State.

19 SEC. 2. Prior to the institution of a suit under section 1,
20 the Attorney General shall certify that he has notified ap-
21 propriate officials of the institution of the alleged depriva-
22 tions of rights, privileges, or immunities secured by the Con-
23 stitution or laws of the United States, that following such
24 notification he is satisfied that the institution of an action will
25 materially further the vindication of such rights, privileges,

1 or immunities, and that such a suit by the United States is
2 in the public interest.

3 SEC. 3. Whenever an action has been commenced in any
4 court of the United States seeking relief from conditions
5 which deprive persons confined in institutions of any rights,
6 privileges, or immunities secured by the Constitution or laws
7 of the United States, the Attorney General for or in the name
8 of the United States may intervene in such action upon
9 timely application if the Attorney General certifies that the
10 case is of general public importance. In such case, the United
11 States shall be entitled to the same relief as if it had insti-
12 tuted the action.

13 SEC. 4. As used in this Act, "institution" means—

14 (1) any treatment facility for mentally ill, disabled,
15 or retarded persons;

16 (2) any facility for the chronically physically ill
17 or handicapped;

18 (3) any nursing home;

19 (4) any jail, prison or other correctional facility,
20 or any pretrial detention facility; or

21 (5) any facility in which juveniles are held await-
22 ing trial or in which juveniles have been placed for pur-
23 poses of receiving rehabilitative care or treatment or for
24 any other State purpose.

Senator BAYH. The success or failure of the program will depend upon the cooperation of the Department of Justice. In order to understand the activities of the Justice Department as it has proceeded in the past, and to learn how the Department perceives the problems of the institutionalized, we have with us this morning the distinguished Assistant Attorney General of Civil Rights at the Justice Department, Mr. Drew Days.

Perhaps I should ask our distinguished colleague if he has any comments.

Senator HATCH. I want to welcome the witnesses. I hope you will consider both sides in this seemingly crucial matter. I am concerned about the civil rights of people throughout our society as well as with States rights and the Federal encroachments into the rights of the State. I think we have far too much of that today. From that standpoint I will be listening very carefully to see if we can reach noble and commendable objectives without the diminution of the rights of the individual States and the people therein. I hope we can do that because, after all, that's what the bulk of this legislation should be. I'll be interested in testimony you give. It's good to see you again, Mr. Days.

Without further comment, I will be listening carefully today and I hope to ask a few questions.

Chairman BAYH. Thank you, Senator Hatch.

Mr. Assistant Attorney General, you might introduce your distinguished colleagues for us.

I would say that we want to hear both sides of the question, as Senator Hatch said. We want a minimum amount of Federal interference in order to get the job done. I don't know about the rest of you, but if the job were being done I would not be here. The Justice Department has enough jobs to do and they would not be looking into this if it were not needed.

Senator HATCH. Mr. Chairman, I have great respect for you and I would like to make this additional comment.

The more the Federal Government gets involved in almost any problem, the more litigation we have and the more congestion in our courts. Sometimes that's good but sometimes it's a bad thing.

I have found lately that there are many, many bad aspects to litigation and in many ways I think we are fostering and fomenting the retirement program for lawyers with everything we do in the Federal Government. I would hope that this legislation would not run along those lines. I doubt that it will. I am certainly going to keep an open mind, and I want to help you in every way I can to help people who are oppressed or who are having difficulty or whose civil rights are being illegitimately interfered with. My concerns really amount to how far the Federal Government should go in any given area.

Some people have the theory that it should go into every area of our lives. I think most citizens think that it already is in every area of our lives. My attitude is that there are legitimate concerns of the Federal Government. We must ascertain those and try to fulfill those needs.

But there are some illegitimate concerns also, and I think this is an area where we will have to be very careful, not necessarily in this

94-420 O - 77 - 2

area we're discussing today but in the area of the illegitimate involvement of government in all aspects of our lives. We must all be concerned about that.

Senator BAYH. Let me say that this committee will try to avoid illegitimacy. [Laughter.]

Senator HATCH. I would be much more pleased if I had seen it at all times in the past, but I agree with you and I'm sure we will all try to avoid illegitimacy.

Senator BAYH. Knowing my distinguished colleague as I do, I'd be surprised if he were not equally appalled with some of the evidence that we're going to hear presented. I'm sure that in the spirit of cooperation and concern for the citizen's of this country we will be able to move forward and reach an acceptable resolution.

Senator HATCH. I think so. I might add that I have had experience with some of the atrocities and inadequacies of some institutions in our society. I'm equally concerned about how we solve those difficulties and those problems. But I'm equally concerned that we not blame all institutions that are run by States for all illegitimate or inadequate or even atrocious situations which have occurred in some institutions.

I'm sure we're going to hear some very interesting testimony. This is an area which is extremely interesting to me.

Senator BAYH. Mr. Days?

TESTIMONY OF DREW S. DAYS III, ASSISTANT ATTORNEY GENERAL, CIVIL RIGHTS DIVISION, DEPARTMENT OF JUSTICE, ACCOMPANIED BY FRANK ALLEN, DEPUTY CHIEF, APPELLATE SECTION; MIKE THRASHER, DIRECTOR, OFFICE OF SPECIAL LITIGATION; FRANK DUNBAUGH, DEPUTY ASSISTANT ATTORNEY GENERAL; JESSE QUEEN, CHIEF, PUBLIC ACCOMMODATIONS AND FACILITIES SECTION, AND MARIE KLIMESZ, ATTORNEY, APPELLATE SECTION

Mr. DAYS. I would like to express my appreciation for the opportunity to testify on S. 1393. As you suggested, Senator Bayh, let me introduce the people who are with me here today.

I have Frank Dunbaugh, who is the Deputy Assistant Attorney General to my immediate left. Mr. Jesse Queen is the Chief of the Public Accommodations and Facilities Section which handles litigation involving prison conditions. Michael Thrasher is the Director of the Office of Special Litigation which deals with essentially civil situations.

With me also are Frank Allen and Marie Klimesz who are with the Appellate Section of the Civil Rights Division. In addition to helping prepare my testimony their responsibility is to deal with the appellate level cases. They are quite familiar with many of the things I am going to be discussing today.

I have prepared a lengthy statement detailing the position of the Department of Justice on S. 1393 and on related issues. I would like to submit that statement for the record and summarize the essential points of it for you.

Senator BAYH. Without objection, your prepared statement will be inserted in the record after your testimony.

Mr. DAYS. The Department of Justice supports the provisions of S. 1393 which grant the Attorney General authority to institute civil actions in Federal courts to address deprivations of constitutional rights and to intervene in litigation where it has been alleged that institutionalized persons are being deprived of such rights.

Since 1971 the United States has been involved as intervenor or litigating amicus curiae in a large number of cases concerning the constitutional rights of confined persons. Our experience in those cases has demonstrated the existence of widespread practices in the operations of institutions in which persons are confined which deprive such persons of their constitutional rights.

The Department of Justice has reported on these litigation activities to the Congress and has sought and obtained moneys for the purpose of conducting litigation concerning rights of institutionalized persons. The Congress has also given its attention to the rights of such persons through previous hearings and legislation including providing funds for improvement of prison facilities and recognition of the right to care and treatment of developmentally disabled persons.

Legislation such as this would provide some statutory support and direction for the Department's litigation program and would advance the interests which the Congress and the Executive have expressed in this field.

There are at least two reasons the Department supports this legislation. The first is that our experience has shown that the basic constitutional and Federal statutory rights of institutionalized persons are being violated on such a systematic and widespread basis to warrant the attention of the Federal Government. Over the past 20 years when such widespread deprivations of rights have been shown to be occurring Congress has responded by the passage of civil rights legislation giving the Attorney General "pattern or practice" authority to institute civil actions to redress such deprivation.

I believe the conditions in the kinds of institutions covered by this bill warrant authorizing suits by the Attorney General to protect the rights of confined persons. Before I discuss specifically some of the situations which the United States has encountered in litigation, which I believe would meet the "pattern or practice" standard of the bill, I would first like to relate our second reason for supporting this bill.

Because of a lack of a statute authorizing the United States to institute suits such as contemplated by this bill, most of our litigation has been the result of requests by the courts to appear in existing cases either by intervention or as amicus curiae. That situation has at least two drawbacks. First, the ability of the Department to allocate and marshal its limited resources has been hampered by the lack of freedom to select cases to litigate. Second, where private parties are unable to gather the extensive resources necessary to initiate litigation of this kind, serious deprivations of rights may go unredressed.

Mr. Chairman, as you correctly indicated the Department has recently attempted to institute suits against officials in charge of the

operation of two State institutions where our investigations revealed widespread deprivations of the constitutional rights of retarded persons confined therein and where no private suits had been instituted, to challenge the practices resulting in those conditions.

Our theory in those suits is that the Attorney General has inherent authority to protect the interests of the United States as represented, for example, by the expenditure of large amounts of Federal funds in those institutions.

The courts in both cases dismissed our complaints on the basis of lack of authority in the executive branch to bring such suits without express statutory authority, although appeals in both cases are currently pending. Regardless of the outcome of those appeals, the question whether the United States alleges an interest sufficient to provide standing to sue should be settled so it need not be answered on a case-by-case basis.

The resources of the Department would be better spent in litigating the important substantive issues in this area than in defending the authority of the United States to bring such suits.

The enactment of S. 1393 would clarify that authority and would serve as congressional direction about where our litigative resources should be used.

We have prepared for the record a summary of the cases in which the United States has participated which involve the rights of institutionalized persons. Let me briefly summarize here some of the prevalent conditions in institutions enumerated in section 4 of the bill which we have discovered.

In the prison area the United States has participated in many cases in several States concerning conditions of confinement. This is partly as an outgrowth of litigation by the Attorney General under title III of the Civil Rights Act of 1964 to desegregate prison facilities.

The reported decisions in those cases which are cited in my written statement reveal severe overcrowding, lack of adequate medical care, shortage of staff which resulted in a failure to protect inmates from violence at the hands of other inmates, facilities unfit for human habitation which created health hazards, and the infliction of cruel and unusual punishment on the inmates by custodial staff.

In several cases these conditions resulted in the deaths or serious injuries of inmates.

For example, in a suit involving the Louisiana State Penitentiary at Angola, the court found that one of the most serious and deplorable conditions that existed at Angola is the lack of adequate security provided to inmates from physical attacks and abuses by other inmates. The results of the condition were over 270 stabbings and 20 deaths by stabbings in less than a 3-year period and numerable forcible rapes.

We have found that where there are severely overcrowded facilities and lack of sufficient staff to detect and confiscate contraband weapons and control inmate violence these types of acts occur. Often the condition is exacerbated by the use of inmates as guards with custodial authority over other inmates.

Court orders in these cases recognize that prison officials have the duty to protect the inmates in their custody from harm and require

the State to eliminate overcrowding and correct serious deficiencies in medical care and housing.

Another important area concerns the rights of mentally ill and mentally retarded persons who are confined in institutions. Conditions in many of these institutions have been found by the courts to be shocking. In addition to the conditions which these institutions share in common with those in prisons, such as understaffing and the resultant lack of security for the physical safety of patients, and unsanitary conditions, the courts have recognized an important constitutional deprivation suffered by mentally ill and mentally retarded persons.

Let me give you an example of conditions we have identified in this area.

Conditions at the Alabama State facilities for mentally ill and mentally retarded persons were found to fall far short of meeting those standards articulated by the courts as constitutional in several respects. In addition to the basic lack of programs for the treatment of individual patients, the conditions under which residents were obliged to live were dangerous and debilitating. Four mentally retarded residents were found by the court to have died as a result of understaffing, lack of supervision, and brutality.

Quoting from the court's opinion:

> One of the four died after a garden hose had been inserted into his rectum for 5 minutes by a working patient who was cleaning him. One died when a fellow patient hosed him with scalding water. Another patient died when soapy water was forced into his mouth. The fourth died from a self-administered overdose of drugs which had been inadequately secured.

Senator BAYH. We're talking about mental institutions?

Mr. DAYS. That's right.

Senator BAYH. Would you repeat that? Those are four specific examples which I am familiar with, but we're talking about the most unbelievable kind of abuse directed at citizens in this country. Those people were confined in mental institutions who allegedly committed no crime against the State. For our record, would you emphasize that and repeat what the court found?

Mr. DAYS. The court found in an institution dealing with mentally ill and mentally retarded persons that four people had died as the result of understaffing, lack of supervision, and brutality. One of the four died after a garden hose had been inserted into his rectum for 5 minutes by a working patient who was cleaning him. One died when a fellow patient hosed him with scalding water. Another died when soapy water was forced into his mouth. A fourth died from a self-administered overdose of drugs which had been inadequately secured.

The court also found that restraint of residents without doctor's orders was found to be commonplace. One resident was regularly confined in a straitjacket for more than 9 years. Others suffered malnutrition. Patients in all facilities had virtually no privacy. Unsanitary conditions such as insect infestation in the kitchen and dining areas and urine and feces on the floor in the living areas were found to exist in one facility. In contrast to the recommendations of the expert witnesses that there should be one psychiatrist, one graduate level psychologist, and some other requirements, what the court

found was that these institutions were woefully understaffed. One of the expert witnesses referred to the overall condition at the facility for the mentally retarded as simply "storage" of persons not even rising to the level of custodial care.

When such persons are civilly committed for constitutionally permissible purposes such as care, treatment, or habilitation, the courts have found that due process requires that the purpose of confinement be given effect. If such care or treatment or habilitation is not provided the confinement may become punishment for an indefinite period although such persons, as you indicated, Mr. Chairman, have been convicted of no criminal conduct—a denial of liberty without due process of law. Several courts have found that there is a constitutional right to the treatment or care which would give such persons an opportunity to improve their condition and perhaps to return to society. I understand that other witnesses will testify firsthand about conditions at some of these institutions beyond the comments that I make.

But we can, if the subcommittee so desires, prepare for the committee's benefit a graphic presentation of some of these conditions which have been found in some of these institutions at the subcommittee's convenience.

Senator BAYH. Without objection, I would appreciate very much if you would prepare such a description.

I appreciate your chronicling those four instances that occurred in one particular institution.

Mr. DAYS. By graphic I mean photographs [1] and video tapes and we could provide those to the subcommittee its purposes.

Senator BAYH. Let those who waiver as far as the need for this legislation view those first hand. I don't think I need that particular documentation but some others might. We will make that available.

Mr. DAYS. Another area of concern for the United States has been litigation involving constitutionality of State commitment statutes. In each of the States in which we have been involved in challenging such statutes the State has passed new legislation substantially improving the procedural standards under which its citizens are involuntarily committed. Let me say that one of the most recent examples of that is a case presented to the Supreme Court this term, *Kremens v. Bartley*, out of Pennsylvania which found that the conditions had changed in terms of the standard for civil commitment of juveniles and that there was not a proper case for it to address some of the issues that had been initially raised. I think it fair to say that those changed rules and regulations were a direct result of the litigation brought in that State challenging the existing practices.

The United States has also participated in cases involving the constitutional rights of delinquent and dependent children placed by the States in institutions. This litigation revealing brutality against children and lack of treatment to accomplish the stated objective for their confinement has resulted in court orders requiring improvement in treatment and care.

The Department of Justice is committed to continuing to do what our resources permit in this area of the law. This is not to say that

[1] These photographs were labeled "Exhibit 2" and can be found in the subcommittee's files.

litigation will solve all the problems in institutions, as I'm sure the Congress is well aware. We see the proposed grant of authority in this bill as an opportunity to use the expertise and resources of the United States to institute suits where they are most needed to protect the constitutional rights of persons throughout the country who are confined in institutions.

I believe that a systematic and selective litigation program by the United States would also have a positive effect on the caseload of the courts by providing a vehicle for dealing with individual complaints by confined persons in a comprehensive manner.

Before I close I would like to address briefly some of the specific language of the bill and make some suggestions for amendment.

Section 1 of the bill which authorizes suits by the Attorney General also provides that the district court shall exercise jurisdiction without regard to whether the aggrieved party or parties shall have exhausted any administrative remedies provided by law.

We agree that since the Attorney General represents the United States in such cases, rather than any individual, that he should not be required to exhaust State administrative remedies nor should he be required to wait on exhaustion by other persons. To the extent, however, that this sentence implies that the Attorney General will be acting on behalf of individuals, it may raise questions of interpretation. It should, therefore, be made clear in the report on the bill that the Attorney General represents the legal interest of the United States.

Because the exhaustion issue in another respect is before the House of Representatives and because a distinguished court of appeals judge testified in favor of such a requirement for prisoners, I believe I should say something about such a proposal.

I wrote a letter to the House Subcommittee on Exhaustion which —I'm sorry, I don't think there is a House Committee on Exhaustion yet but I made a bad punctuation. [Laughter.]

This has been made available to the subcommittee staff. But briefly I do not favor an exhaustion requirement for institutionalized juveniles and mentally incompetent persons. There is some merit to a requirement for prisoners but I believe more needs to be known about how it would work as I described in my letter to the House subcommittee.

I think it is particularly important that if there is to be an exhaustion requirement for prisoners that it be made clear that it would not apply if the administrative remedy is not adequate to address the problem complained of and that there must be exhaustion only of plain, speedy, and efficient remedies, not those which serve only to delay the resolution of grievances.

The Attorney General is empowered under sections 1, 2, and 3 of the bill to make certain determinations in deciding whether to institute or intervene in litigation.

Such preconditions to suit are similar to those in prior civil rights legislation providing "pattern or practice" authority to the Attorney General. Court decisions under those provisions have concluded that such determinations are a matter for the Attorney General's judgment, considering the specific facts of each case, and are not a proper subject for judicial inquiry.

I believe it is important that the subcommittee make clear in its report on this bill that the determination of the Attorney General with regard to potential institutions' suits are intended to be similarly unreviewable.

I would interpret this to mean that Congress does intend the Attorney General to engage in realistic presuit negotiations before filing suit. In that connection and in recognition of the important issues inherent in litigation by the Federal Government against the State or its officials, I would like to suggest that language be added to section 2 that would assure that notification of alleged violations would be given to the appropriate Governor and State attorneys general as well as to the appropriate officials of the institutions and that language be added to section 1 indicating that a complaint pursuant to the authority of the bill would be signed by the Attorney General or in his absence by the Acting Attorney General.

That completes my prepared remarks. I would be pleased to answer any questions which you may have.

Senator BAYH. Mr. Days, I think you have done an excellent job as our leadoff witness here in zeroing in on the major purposes behind our hearings. Some of us have pointed out that this type of power, as exercised under severe restraints, has been effective in providing relief for large numbers of people. Moreover, as you have pointed out, this is not a new and novel right to be given to the Attorney General; he already has been given the authority to redress patterns or practices of unconstitutional conduct by States in other contexts.

Let me try to direct my attention to a few of the areas that I think are the most important. Then I might ask you to respond to other questions in writing. We're operating under a time restraint this morning. The full committee is going to have to take over our hearing room this afternoon. We would like to be through by then.

We have the *Solomon* and *Mattson* decisions in which the Justice Department unsuccessfully attempted to initiate suit without express statutory authority. Those are on appeal.

Suppose the court sustains the Justice Department. Will that make the need for this legislation moot?

Mr. DAYS. If it were made clear that the Government could intervene in ongoing suits? Is that what you're asking?

Senator BAYH. Or could initiate.

Mr. DAYS. You mean if there were judicial resolution?

Senator BAYH. Yes; if the district courts in *Solomon* and *Mattson* are reversed, the legal process is still a long, drawn out one.

Mr. DAYS. Indeed, and after all I think other circuits will not necessarily be bound by those decisions. I think we could expect to face similar challenges throughout the country and that issue could be around for a number of years. We would spend enormous resources of the Government litigating procedural matters while people continued to suffer similar deprivations that I have described.

Senator BAYH. One of the reasons that I felt compelled to sponsor this kind of legislation and introduce it is this. I share with the Senator from Utah a concern over the intervention of the Federal Government into areas of responsibility entrusted primarily to the States. Whether our concerns are similar in degree we will know only when we get into the legislation and begin to discuss our differences

at the committee level. Like him, however, I would like for the Justice Department to intervene as little as possible to get the maximum results. It would seem to me that one of the benefits to be derived by legislation would be to permit the Justice Department a wider discretion to pick and choose and to direct its attention to the areas of greatest abuse.

In the past, the cases in which you have been involved—with the exception of *Solomon* and *Mattson*—have been those brought by other parties, and the Department's posture has been that of litigating amicus or of plaintiff-intervenor. I would think, however, that those cases might not necessarily involve the worst abuses; that, in fact, some of the most deplorable conditions might exist in institutions where no one had yet been able to bring suit. If the Attorney General were given the authority in this bill to bring suit against those institutions where you felt the greatest abuses existed, where the greatest relief could be secured for the largest numbr of people, wouldn't that permit you to use your resources more efficiently? And wouldn't that also minimize confrontation with States by limiting Department involvement to suits against institutions which really were the worst in the Nation?

Mr. DAYS. That's exactly right. We are at the mercy in some respects of private litigants and courts in order to conduct our litigation program. We are not able in an intelligent fashion and a systematic fashion to determine how we can use our resources most effectively. We are concerned about these issues and feel we have a role to play. So we essentially have to use whatever vehicles presently exist in order to get at these problems.

But if we have statutory authority, I think certainly we could be much more controlled and much more directed in terms of how we litigated these issues.

In addition, in terms of protecting principles of federalism, I think it is important for the States to understand that the Attorney General's authority is clear. While his authority is in some sense ambiguous, we have difficulty communicating to States that we will go forward and challenge some of these problems unless they are willing to sit down and talk about this. But we would be interested in deferring to the States as much as possible and perhaps just the fact that Congress has made clear its support of the Attorney General's authority would provide incentive to the States to get on with this business of dealing with some of these problems.

Senator BAYH. In other words, you think giving the Attorney General the authority will persuade States to do things voluntarily which now they have to be dragged into court to get accomplished; is that right?

Mr. DAYS. Yes.

Senator BAYH. The ultimate confrontation might decrease instead of increase so you would have voluntary and cooperative compliance.

Mr. DAYS. One of the important things about maintaining the proper balance between State and Federal governments is that the lines of authority be clear. It seems to me that once States understood that the Congress and not merely the executive branch had determined that this was an important issue and had to be addressed, then there would be a reduction of a lot of the charges of usurpation of State

authority or interloping in situations that are really only of the States' concern. I think a lot of the air would be cleared on this score but would not result in wholesale litigation on the part of the Department of Justice against States and local governments on these issues.

Senator BAYH. Let me ask you to direct your attention to the major problem area as I see it, which is this. As you have pointed out and as we all know, there has been a possible conflict between States' rights and Federal rights.

We have invited the States' attorneys general to testify. We understand that, at least in the House, they took a dim view of this legislation.

If my recollection is correct, in my home State, just this week I think it was, the Attorney General addressed the National Conference of the States' Attorneys General and emphasized that suits would not be initiated against any State until all efforts at voluntary compliance had failed.

Could you give us your view as to what responsibility you would have and the Attorney General would have in exercising authority under this bill and how that responsibility could be made compatible with States' rights? How would you handle this so as to avoid involvement where the State was making serious efforts to solve the problem or where there was no significant abuse?

Mr. DAYS. If I understand correctly, the litigation programs that we are presently following was developed under the past administration. There were guidelines established as to what types of suits should be brought. Certainly in the guidelines and all of our litigation since that time have addressed the question of impact. Where are the worst situations? Where does there appear to be systematic abuse as opposed to individual complaints of constitutional deprivation?

I think we have stressed the need to communicate with State officials in order to give them some sense of our concerns and in order to get some indication as to whether the State is willing to move forward with these problems or not.

But I think that in our litigations thus far we have compiled records which are very impressive prior to considering litigation. We have said to the States and their institutions, "This is what we have found. What do you propose to do about it?"

I think it's fair to say that suits were brought only when it was apparent that very little movement was taking place to address these problems. Of course, when you're talking about some of the conditions that I described, there is not a great deal of time for negotiation. There must be a reasonable time for discussion and the ending of some of the most grievous violations of people's constitutional rights. I think the litigation program upon this point has reflected, contrary to statements made from some quarters, a very reasoned, controlled, and respectful process. We have not gone into litigation except where we found two situations—broad violations of constitutional rights almost to the level of shocking the conscience of the court and sometimes beyond that and also where we felt that there was no indication of movement on the part of the State to address these problems.

As I said in my summary of my prepared testimony, we feel it very important that Governors and State attorneys general be brought into the process, not merely the directors of these institutions, so that they can exercise whatever authority they have within the State to deal with some of these problems.

Let me give you an example of how I think the process might work. About a week ago I went to Oklahoma City to meet with the Governor there to talk about the prison conditions in that State in an ongoing litigation situation. While we did not resolve every problem that the State prison system had, it was my feeling that my going out there and sitting down with the Governor and the attorney general and talking about our objectives as to what the court was going to require and how best to achieve those ends, was a very constructive process. I think the Attorney General has instructed me and I have instructed the attorneys in my division that this process must be carried on. But it seems to me that legislation could reinforce that process. That's what I have been suggesting that the whole process be respectful of the sovereignty, the dual sovereignty of the State and Federal Government and that there be a meaningful effort to work out some of these situations. But where that effort fails, I think it would be appropriate for the Attorney General of the United States to decide that a lawsuit is necessary. This would be a decision made by the Attorney General. It would not be something relegated to a line attorney in the Civil Rights Division or anywhere else. I think those sets of safeguards would give the States a feeling that the Federal Government was not coming in in an intrusive and disrespectful fashion but that these suits reflected the greatest respect and highest considerations at the Attorney General level.

Senator BAYH. I have one more question and then I will yield to my colleagues.

In another subcommittee which I had the good fortune to chair, the Juvenile Delinquency Subcommittee, it was brought to our attention that in many institutions while populations of "inmates" which we talked about were mentally retarded children. Massive amounts of sedation were applied there. The sedation was not therapeutically applied but was administered as a way to put mental handcuffs on inmates so that they would not have to be supervised. That way you don't have to worry about the normal energy of children, retarded or not. You sedate them sufficiently and they become nothing but breathing vegetation. They just lie there.

Have there been any suits brought, to your knowledge, in this area?

Mr. DAYS. In all of our cases we have several where we have been able to document this type of medication. I think I mentioned the restraints of certain institutionalized persons for 9 years. But we have seen it commonly used to restrain people for 24 hours at a time—straitjacketed or restrained in bed for 24 hours a day.

Senator BAYH. You mentioned someone who had been in a straitjacket for 9 years; is that right?

Mr. DAYS. That's right. The person involved in that situation was found to have atrophied limbs because of the conditions under which she had to exist for 9 years.

Senator BAYH. Senator Scott?

Senator SCOTT. Just on that one point let me say that. Let me develop that one point and ask for further information.

Mr. Days, tell us about this case of 9 years. You mean that somebody was in a straitjacket 24 hours a day for 9 years; is that right? It does not seem possible to me. Where did this happen? Was it really 24 hours a day or was it periodically over a period of 9 years?

Mr. DAYS. This was in an institution in Tuscaloosa, Alabama. In fact, the record reflects that she was kept in a straitjacket for that period of time.

Senator SCOTT. Twenty-four hours a day for nine years?

Mr. DAYS. Yes.

I think that example, of course, is a very shocking one, but it points up the extent to which the general public is unaware of what is going on in these institutions. That has been one of the most impressive consequences of some of this litigation. The conditions under which institutionalized persons are forced to live have been brought to the attention of the general public.

Senator SCOTT. Is this a case that results in a suit involving your Department of Justice?

Mr. DAYS. Yes; it's one of the leading cases in this area in which the Justice Department was asked to participate.

Senator SCOTT. Being familiar with the adage that "Hard cases make bad law," is this an isolated case in your judgment?

Mr. DAYS. It was not. It was a situation of an institutionalized person in the context of all kinds of other deprivations. As I think I indicated unsanitary conditions, lack of adequate staff, excessive medication, lack of treatment, in other words, people were being warehoused in that situation.

Senator BAYH. If the Senator would yield, I would be glad to make available information of the type Mr. Days is outlining. I think the hearings I just spoke of were held before the gentleman came to the Senate; in any event, the gentleman was certainly not on the subcommittee at the time. But the conditions we learned about during the course of those hearings absolutely appalled me.

Of course we can make distinctions between various kinds of institutions. No doubt the public, in general, sees significant distinctions between criminal institutions, where the inmates have been convicted of a crime, and other types of institutions for the mentally and physically handicapped. Even these distinctions, however, must be handled carefully where rights of individuals are at stake.

But as far as public acceptance of institutional conditions is concerned, part of what we are talking about here is conditions in juvenile institutions where you have large numbers of children who have been confined not because of their criminal conduct, but because of mental abnormalities of one kind or another. You see dozens of them in ward after ward subjected to so-called "handcuffing drugs." We get all up tight if we find out an institution is handcuffing or tying children in bed, but here they are being handcuffed and tied to those beds by drugs. We do have a clear record of that kind of thing in institutions where those children have not committed any crime at all against society. Excuse me, Senator, but that really gets me when I think about that.

Senator SCOTT. If this is a general thing then obviously I believe all members of the committee or a concerned person or any reasonable person would have that concern.

Mr. Chairman, I think at a later time we need to have this happen. You mentioned States attorneys general. Perhaps the bar association or some superintendents of some of these penal and mental institutions could come in. I'm looking over the witness list. It does not seem to be a balanced list.

Senator BAYH. We're going to have 4 days of hearings. We are going to have all those categories covered by our colleague. If our colleague has specific witnesses whom he feels can bring specific expertise then we would be glad to talk to them and let them talk to us.

Senator SCOTT. I will review that. Thank you.

Senator HATCH. Mr. Days, as I have reviewed the legislation, I think we all have to agree that the examples you have given are gross examples. Nobody can be pleased with this type of treatment for anybody whether it is in a prison facility or a mental institution.

My question is this. How does this proposed legislation help solve the problem? Justice obtains the right to bring the suit, but what does that do to resolve the issues?

Mr. DAYS. As I have indicated, I think that what the Federal Government needs to do is to have explicit authority to address some of these issues. We have become already involved in some of these cases. I think the courts have indicated——

Senator HATCH. But you have indicated that it is important from the standpoint that the Justice Department would have the authority to enter these cases directly rather than as amicus curiae or as an intervenor. This would lend more credibility to the extent that a lot of State institutions which are not complying with reasonable standards would start to clean up the messes that they have. We're assuming that there are a number of them.

In your brief you mention three or four of them.

I think you have covered the various cases very well and in a scholarly manner.

My point is this. Let us assume the statute gives you the right and let's assume it's constitutionally sound that you have the right to bring this litigation on behalf of the U.S. Government against the head of the institution or the State.

What remedies can the court give according to this bill?

Is injunction the only remedy or what remedies do you have?

Mr. DAYS. I think we would be interested in corrective measures with respect to these conditions.

Senator HATCH. How does this bill provide that? I do not see any particular corrective remedial approaches from this bill. I see a right to sue. Maybe I'm misreading it.

Mr. DAYS. Are you asking whether this bill says specifically what types of relief the Attorney General can give?

Senator HATCH. Yes. What types of relief would the Attorney General be entitled to seek as a person with standing under this bill?

Mr. DAYS. I think that one would have to look to the general equity powers of the Federal courts to address unconstitutional conditions.

Senator HATCH. The bill provides that the Attorney General can "bring suit in an appropriate district court of the United States against such party or parties for such relief as he deems necessary to insure the full enjoyment of such rights, privileges, or immunities." You're talking about equitable relief—the whole gambit; is that right?

Mr. DAYS. Yes.

Senator HATCH. Who is going to set up the standards for the State? Let's start with the distinguishing standards between the care and treatment of mentally ill people and the care and treatment of inmates in the correctional institutions. Who does that? We have a bill here but who is going to determine what the standards are? Will it be a case by case basis or will there be some agency in the Federal Government which, as a result of this bill, will have to do that?

Mr. DAYS. It would be a case-by-case basis.

Senator HATCH. And you feel, if I understand you correctly, that the very fact that you have the right to litigate and to bring these people into Federal court, and in the language of the bill "seek such relief as the Attorney General deems necessary to insure the full enjoyment of such rights, privileges, or immunities" will help to clean up the gross injustices that exist in some cases in our country and in various States, municipalities, and counties?

Mr. DAYS. I think that is right because of the fact that many of these cases require resources that are not available to the private bar. I think the Federal Government cannot only handle these suits but it can bring to the court adequate information about what standards have been established elsewhere. It has the research capacity and the familiarity with the development of this area of the law in order to really assist the court. That has been our experience in our cases up to this point. Courts have looked to the U.S. Government for the type of resources and balanced presentation as to what the standards should be or what the relief should be. I think that is the role we will continue to serve.

Senator HATCH. I think we can all agree that the examples cited are bad and that we would like to stop those, no matter what the approach is.

Mr. DAYS. Yes.

Senator HATCH. I think it gets a lot more difficult in this area. What methods will be used in the Justice Department formulation of which matters should be litigated and which should not?

For instance, I think we must admit that there are a wide group of disparities in the mental health field between what certain psychiatrists say and what other psychiatrists, psychologists, clinical psychologists, social workers, or sociologists say. There are lots of differing views. What type of methodology are you going to consider before such suits will be brought?

Mr. DAYS. There have been developed minimal standards with respect to the conditions of the institutionalized. Those are the standards that we would be using in evaluating conditions in institutions around the country.

Senator HATCH. Could you tell us what sources and what standards you would be relying upon as minimum standards?

I do not want to have suits brought because some inmate was denied a toothbrush or something. I do not want him to be denied a toothbrush, but on the other hand I think we don't want to clog up the Federal courts with every little complaint that comes down the pike. We must have substantive approaches here, assuming that the bill passes.

Mr. DAYS. Senator Hatch, I think that trying to determine what constitutes a pattern or practice of constitutional deprivation, sufficient to warrant the involvement of the Federal Government, is an exercise that the Federal Government has been going through for many years. It is hard in an abstract sense to identify what an adequate case looks like. But I think we have a lot of expertise in this area and in other areas.

For example, how does one determine that there is a basis for a pattern or practice housing suit or a pattern or practice suit with respect to employment discrimination? These are judgments that I think in past legislation the Congress has given over to the judgment of the Attorney General and his staff.

All we are asking is that the same confidence be shown in the Attorney General and the Federal Government in this comparable area of civil rights and constitutional deprivation.

Senator HATCH. One of the things I'm worried about in this bill, among others, is that I think it's written in such a way that it may be unconstitutional because it gives the Attorney General, really, basically unprecedented powers to seek any kind of relief he deems necessary, without any guidelines and without any determination as to what is fair or what is not fair in an area where we have such a wide disparity of opinions. I'm talking about mental health and even the area of correctional abuse. We have a wide disparity of differences there. Some people feel you must be tough with these people and others feel that every person in a criminal institution is an emotionally disturbed person and should be treated as such. Others feel that there should be no jails at all.

Senator BAYH. If the Senator will yield, let me say this. I think the Senator is raising a point that is a legitimate one.

Would it be helpful if we would ask Mr. Days to give some thought to this question and to submit to the committee the suggested guidelines and perhaps some of these guidelines could be incorporated in the bill? Certainly inasmuch as the Justice Department clearly has exercised this right before and the Federal court, particularly in the case of intervening, has not ruled that this is unconstitutional, it would be nice to know what guidelines the Justice Department is already applying—not only the kinds that you would see as being applicable in this particular situation if this bill passes, but what do you do now; would that be helpful?

Senator HATCH. Yes; I think it would be helpful. I do not expect you to have definitive answers to these questions yet but I want to point out the problem. This is a new area, an area that is pregnant with all kinds of problems. I want to create a solid piece of law and cause some thinking in this area rather than have what only looks like a wonderful bill because it deals with people who are oppressed. I agree they are oppressed. I think we ought to do something about

it. I think we ought to do it in the right way, however, rather than do it just because it's a humane thing to do.

In addition to being a humane thing to do, let's do it in a legal manner so that our States are not completely oppressed by the Federal Government. A lot of people are concerned every time we give this type of authority even to the Justice Department which I find to be a commendable organization in our Government in almost every way. But a lot of people are concerned that such a granting of authority is the beginning of the end in many ways because the States are going to be tied up in Federal court all day long every day, on matters that may not even be important.

You are saying that they will be important matters or they would not be brought. I think we ought to have some thought given to the guidelines and some thought given to how we are going to delineate between the problems we are confronted with in regard to institution situations or the emotional and disturbance standpoint and those in the correctional institutions talking about rehabilitation. What is the scope and how are we going to apply the law in this particular case?

Senator SCOTT. If the gentleman will yield, I'd like to ask Mr. Days what other agency of the Government do you depend on? Do you depend on HEW or some other Government agency to develop these standards or help you develop these standards? I was trying to follow up Senator Hatch's question there.

Mr. DAYS. We have on occasion looked to the Bureau of Prisons because they have——

Senator SCOTT. Not as to mental patients?

Mr. DAYS. But in the environmental area in terms of what are adequate conditions. We have used public health service staff in some of these respects. We have actually used State experts. In many of the cases we have been involved in——

Senator SCOTT. If you could include that in your written response that would be helpful.

Senator HATCH. In addition to that I would like to point out a couple other things that I consider to be problems in the bill. I realize we are pressured for time today so I don't want to keep you very long. I want to compliment you for your statement here and for the degree of effort that has gone into it. I think it is an excellent statement, as usual, from having seen you work in the past and the work of those around you.

But I would like to say this about the bill which provides that—

> If, prior to the institution of such proceeding, such official has resigned or has been relieved of his office and no successor has assumed such office, the proceeding may be instituted against the State.

Now I suggest that you may want to be able to institute the proceeding, assuming that this is constitutional and assuming all the other precedents have been complied with, you may want to have that proceeding be against the State, municipality, county, or government entity. The State may have absolutely nothing to do with the county institution and vice versa. We may have to correct that.

I have one other thing. Along with Senator Bayh I raise the question about just how much certification and prenotification and just how much work will be performed by the Attorney General with

the local and State officials to see if there is compliance and whether or not we're going to have massive paperwork to obtain compliance. One thing we are inundated with in our lives right now is massive paper work which does not really do anybody any good. I wonder if there is going to be some sort of a team in the Justice Department which goes out and works with these people so it can be done on the spot and the corrections can be made and agreed upon. If there are disagreements we at least know what the disagreements are before we go to court.

I would like to see better and more cooperative efforts rather than just a flood of papers which don't accomplish anything going back and forth between the two. It delays things and increases the injustice not only to the individuals being oppressed but to the State and the Federal Government.

I would like to see this. In the urgent instances, such as you have pointed out here today, there is no question that we must act immediately. If we're going to have this bill at all, that right ought to be provided.

But in the vast majority of cases which will be "questionable cases," that is cases to determine and delineate just what are the rights of the inmates of the respective institution, I think we ought to have some sort of procedures perhaps outlined in the bill or certainly outlined by the Attorney General concerning just exactly what the States will be subjected to in this and whether it will be reasonable or is it going to be another legal quagmire that really accomplishes nothing, but costs the States and local government a fortune.

Also, another thing I would like for you to give some thought to and maybe help us on the committee with is this. How can we prevent the Federal Government from oppressing a municipality, county, city? They may not have a lot of money to defend themselves in this situation. How do we prevent that so there is not just a default. Those local governments often agree with the Federal Government but have legitimate aims to be served and legitimate differences that may be better than what the Federal Government is demanding. I doubt if that will be the case but I'm thinking into the future, and I realize how these things became massive litigation with massive problems and massive expense to society. In the end the inmates end up being treated not much better anyway.

Those are areas that concern me and rather than ask questions on them I have given you my ideas and hopefully with the great expertise you have personally, and the people around you on your staff and other people in the Government that you might call upon, maybe we can have some help from you at this point rather than leave it up in the air with a beautiful, high-sounding moral and ethical bill that really does not mean very much.

Mr. DAYS. I have a brief comment with respect to your last statement. The Attorney General recognizes, I think, as do all of us that litigation is not the only answer. The Federal Government has to have a coordinated program with regard to these problems. If funds are not made available and technical guidance is not made available to States and localities to deal with some of these problems then litigation is going to be an oppressive tool, to use your term. There

needs to be a combination. Litigation can't exist in a vacuum, I agree with that.

Senator HATCH. What I'm saying, Mr. Days, is this. I want to be fair with you here. I believe that as you get into this and you start talking to the so-called experts—and I've had enough litigation experience and I've interrogated enough psychiatrists and doctors and socialogists and psychologists to know there are very few of them who agree with each other on any particular issue. You just about get whatever testimony you want within the legitimate gambit of the field. You might find it is a lot bigger quagmire to try to set these guidelines as you try to help us out. I want to be fair and warn you about that. But you already know that because you have worked in the field of civil rights so long. You know there is a large disparity of disagreement and agreement there also.

But I do think that we do need some help from you before we pass this high-sounding and wonderful looking legislation that may cause all kinds of chaos and disruption through our society if, for instance, we don't have reasonable people in the Justice Department or in the State or in the local municipalities, whichever is the case.

I would like to see, if we're going to have legislation, I'd like to see it so that it's fair and not just another Federal Government oppression. I am anxious that it not be an escape clause for certain local officials to litigate for years nor that it be oppressive to the local people from a taxation or litigation standpoint or an expense standpoint.

I hope some of these thoughts are well-received and I hope some of them will be helpful to you.

Senator BAYH. Without objection, a copy of your proposed guidelines will be inserted in the record after your prepared statement.

Thank you very much, gentlemen and ladies. We look forward to having that material and I would like you to expedite it as quickly as you can because we'd like to look at it.

Senator Scott?

Senator SCOTT. Mr. Days, I notice that you do have a rather lengthy statement. I will review it when I get back to the office. I would commend you on the portion that I did here.

There are a number of things that concern me about this. One is that I do not notice in the bill any distinction being made between penal institutions and mental institutions. I wonder whether the people in these institutions are as helpless as it might appear on the surface.

An inmate in a mental institution may well have relatives and friends who are visiting and are attempting to look after the needs. The inmates at the penal institution have made considerable additional work for our courts in recent years due to habeas corpus proceedings and so on. I understand that they have libraries. We hear the jailhouse lawyer phrase being used.

What distinction, if any, would you make as to the need for this law in the way that it finally is acted upon? What distinctions, if any, would you make between penal institutions and mental institutions?

Mr. DAYS. Well, I think that there are probably more similarities than differences, Senator, quite frankly, when we're talking about

conditions of confinement. We are talking about people who, as a group, have very little political power and very little ability to control their environments.

Certainly there is a distinction between mentally competent prisoners and some of the other groups that we're talking about who are presumed, for reasons of mental condition or age, to be incompetent. Clearly, they have less ability in perhaps articulating what their problems are and identifying what changes might be effected in their conditions.

But the important similarity is that they have little ability to control their environments and to effect change in their conditions of life. A prisoner is better able to protect himself perhaps from some type of physical abuse but the records reflect that nevertheless prisoners are systematically in some institutions subjected to abuse.

This type of litigation is designed to make certain that those conditions are corrected.

Senator SCOTT. We have someone in a mental institution and he might be guilty of no wrongdoing at all and the person in the penal institution is there for a wrongdoing—for a violation of a law. Would that have any bearing?

Mr. DAYS. I don't think so. I think our laws dictate that punishment is imposed upon a prisoner by court or through some due process proceeding. What we're talking about is cruel and unusual punishment imposed in complete ignorance of constitutional standards and respect for standards that exist under our laws.

Senator BAYH. Let me mention one example which was brought to our attention. I think I said this before the Senator got here. At least from the public perception point of view there is a distinction. Mr. Days is talking about the legality of it.

One particular example that I think graphically illustrates what we're talking about here is that it is one thing to confine someone to a prison for abusing society, something we all understand is necessary. But it is another thing to say that within that institution, a policy exists whereby an inmate who does not do certain things is put in a cellblock inhabited by homosexuals. That is a form of punishment not contemplated by the court that sentenced him.

Senator SCOTT. I have not heard of any regulations such as that.

Senator BAYH. I think it has a specific case history.

Mr. DAYS. Let me raise one other point. The prisoners have no constitutional right to treatment. The State is not saying insofar as prisoners are concerned "We are putting you in prison because we are so concerned about improving your ability to function." There is a penal principle that is not completely tied up with rehabilitation, although I would assume that that is part of the penal process.

But when we are talking about the mentally ill and juveniles, there is an articulated State determination to provide treatment and not merely warehouse people or to provide them with settings so that they will not be dangerous to themselves or other people and can improve to the best of their abilities.

It seems to me that there is a distinction there. Therefore, if we were looking at a pattern or practice suit insofar as a prison was concerned, the right to treatment, unless we're talking about medical treatment, would not be a basis for that determination. But if we are looking at mental institutions, then clearly that would be a concern.

Senator SCOTT. I do not believe it would serve any useful purpose for us to get into our philosophies with regard to the treatment of mental patients. I am sure that we would agree that we would not want to see them mistreated.

As far as the inmates in institutions are concerned—and I have had very little background in the criminal law field—but I have talked with some of our judges, some of our Federal and State judges as well and they tell me that the inmates in the penal institutions are actually bringing great numbers of suits and taking a considerable portion of the courts' time. Many of these are entirely without merit in the judgment of the court.

But let me pass on, if I may, to this. Does this bill actually make the Attorney General the judge or the supervisor of the institutional practices in each of our 50 States? I am concerned about police power—the dual sovereignty concept. Just how far can the Attorney General go? Can he issue regulations in the event we pass this bill which would govern the State penal institutions?

Mr. DAYS. He cannot. That is not the authority that this bill would give to the Attorney General.

Senator SCOTT. The States would still be in charge of the penal institutions and regulations of the penal and mental institutions and this would merely give the Attorney General standing to bring suits for violation of civil rights guaranteed by the Constitution; is that right?

Mr. DAYS. That is correct.

Senator SCOTT. Would this give the Attorney General access to go into the penal institutions, the city jails, the State and county institutions to inspect them and to see that they were meeting the standards that he would feel they should meet?

Mr. DAYS. Not as a normal course, Senator. I think that, as is true of all of our litigation presently, if we receive complaints or indications that there may be systematic violations of people's constitutional rights, then we investigate. Generally we rely upon the FBI to conduct those investigations. But the investigations are not done on a roving commission type basis. They are predicated by some reasonable expectation that there are problems in some of these institutions.

Senator SCOTT. We have been doing that on a selective basis for 50 years or more; isn't that right?

Mr. DAYS. That is correct.

Senator SCOTT. Mr. Chairman, I know Mr. Days has been here for some time. I do have concerns about this matter, but I'm anxious to hear the thoughts of others also. Let me add my word of welcome and thank you for being with us.

Mr. DAYS. Thank you, Senator.

Senator BAYH. We thank you very much, gentlemen.

[The prepared statement of Drew S. Days follows:]

PREPARED STATEMENT OF DREW S. DAYS III, ASSISTANT ATTORNEY GENERAL, CIVIL RIGHTS DIVISION, DEPARTMENT OF JUSTICE

I am pleased to appear before the Subcommittee to testify on S. 1393 which would clarify the authority of the Attorney General to intervene in or initiate actions involving institutionalized persons.

The Department of Justice supports the provisions of S. 1393 which grant the Attorney General authority to institute civil actions in federal courts to redress deprivations of constitutional rights, and to intervene in litigation where it has been alleged that institutionalized persons are being deprived of such rights.

Since 1971, the United States has been involved, as intervenor or litigating amicus curiae, in a large number of cases concerning the constitutional rights of confined persons. Indeed, the Department of Justice was directed do "strengthen the assurance of full legal rights for the retarded . . . ."[1] The experience of the Department in such litigation has demonstrated the existence of widespread practices in the operation of institutions in which persons are confined which deprive such persons of constitutional or statutory rights. We are committed to continuing to do what our resources permit in this area of law.

The Congress has given its attention to the care and treatment of institutionalized persons through previous hearings and legislation. In Public Law 94-103, Oct. 4, 1975, 89 Stat. 502, Congress recognized the existence of legal rights to care and treatment for the developmentally disabled, and has provided federal funds for a variety of programs to aid mentally retarded and mentally ill persons.[2]

Similarly, Congress has provided funds through the Omnibus Crime and Safe Streets Act, 42 U.S.C. 3701, for, inter alia, improvement of prison facilities.

The Department of Justice has, in recent years, reported on its litigation activities with regard to the rights of institutionalized persons, and has sought and obtained moneys for this purpose.[3] The Attorney General's Annual Reports for 1974, pp. 73-74, and 1975, pp. 85-86 describes the Department's activities in this field. An attorney from the Department testified before the Senate Special Committee on Aging on our litigation efforts relative to that committee's field of interest (Hearings of September 29, 1975, on Mental Health and the Elderly, pp. 48-52) and mentioned the absence of any statutory authority like that contained in H.R. 2439. The Department also reported on its activities in connection with the use of drugs in institutions to the Senate Committee on the Judiciary (Hearings on Drugs in Insitutions, July 31 and August 18, 1975, pp. 4-15). The Senate Subcommittee on Constitutional Rights held hearings in November 1969 and August 1970 on the Constitutional Rights of the Mentally Ill. I believe it is appropriate to consider legislation such as S. 1393 which would provide some statutory support and direction for the litigation program which the Department has already undertaken, in significant part because of the great past interest which the Congress and the Executive have had in this field. The Department of Justice needs this legislation to embark upon a coordinated program of litigation in this important area.

There are, at least, two reasons the Department supports this legislation. First the conditions in the kinds of institutions which are enumerated in Section Four of this bill have produced a growing body of litigation in the federal courts concerning the rights of confined persons. The experience of the Department of Justice through its involvement in this litigation has shown that the basic constitutional and federal statutory rights of institutionalized persons are being violated on such a systematic and widespread basis to warrant the attention of the federal government. The Supreme Court has recognized in the context of correctional institutions that while "[t]raditionally, federal courts have adopted a broad hands-off attitude toward probles of prison administration[,] . . . a policy of judicial restraint cannot encompass any failure to take cognizance of valid constitutional claims whether arising in a federal or state institution. . . ." *Procunier v. Martinez*, 416 U.S. 396, 404-405 (1974). Thus, while the states have broad discretion in the operation of these institutions, where it is found that they are depriving persons confined of constitutional rights, the federal government has an interest and a duty to protect those rights. The bill under consideration would

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[1] President's Statement on Mental Retardation, November 16, 1971, 7 Weekly Compilation of Pres. Doc. 1530.

[2] See 7 U.S.C. 1431 (surplus food); 42 U.S.C. 1761 (school lunch); 20 U.S.C. 1401 (education of the handicapped) 42 U.S.C. 1395d, 1396d (Medicare and Medicaid).

[3] See, e.g., Senate Report, State, Justice, Commerce, the Judiciary and Related Agencies, Appropriations for Fiscal Year 1977, Senate Hearings, Part I—Justifications, Department of Justice, p. 595-596.

aid in fulfilling this duty by allowing the Attorney General to institute civil actions in the federal courts where he has "reasonable cause" to conclude that there are deprivations "pursuant to a pattern or practice of resistance to the full enjoyment" by confined persons of their federal rights, privileges, or immunities.

Similar "pattern or practice" authority has been entrusted to the Attorney General under other civil rights statutes. The courts, have interpreted the term "pattern or practice" to mean that the denial of rights consists of something more than an isolated or sporadic incident, but is of a repeated, routine, or generalized[4] nature. I believe that the evidence of deprivation of the rights of involuntarily confined persons is of such a systematic nature as to demonstrate the need for the "pattern or practice" authority of this bill as well as satisfy the terms of this bill. The bill implicitly recognizes, of course, that the operation of the institutions in question is a matter primarily for the states, and, therefore, would require that before suit is filed, the Attorney General must find that there is a "pattern or practice" of deprivation, that appropriate officials have been notified and pre-suit opportunities for negotiated correction have taken place. In fact, this has been the practice of the Civil Rights Division in using the authority which has been granted under other statutes. We first gather sufficient facts to make a sound judgment about whether the law has been violated. We then attempt to achieve voluntary correction, before we file suit. And I believe such suits under those circumstances are entirely appropriate.

This is not to say that litigation will solve all of the problems in institutions, as I am sure the Congress is well aware, and I am sure the Congress will be considering other approaches to institutional problems in other legislation.

Later in my testimony, I want to discusse situations which I believe would meet the pattern or practice standard of the bill, and address what I believe to be the state of the law with regard to those conditions. But first, let me discuss our second reason for supporting this bill.

Because of the lack of a statute specifically authorizing the United States to institute suit to redress deprivations of the rights of institutionalized persons, most of our litigation has been the result of requests by the courts to appear as amicus curiae and through intervention in existing litigation. Thus, the ability of the United States to respond to the serious situations existing in many of these state-operated institutions has beeen dependent upon the selection of litigation by private parties.

While private suits play an important part in the development of the law and the reforms of institutionalized wrongs, resources sufficient to address the complex problems cannot always be mustered by private organizations. However, the ability of the Department of Justice to allocate its resources is hampered by a limitation on freedom to select cases. Resources could be marshalled to serve more effectively the public interest if the Attorney General had the discretion to choose the cases in which the United States would become involved.

The need for such discretion is amply demonstrated by the Department's recent experiences in suits brought on behalf of the United States alleging, based upon our investigations, widespread deprivations of the constitutional rights of retarded citizens housed in two state institutions. No private suits had been instituted to challenge such practices.

The Department brought suit against the state officials charged with operating these institutions on the theory that, where the United States has an interest to protect, there is authority inherent in the Attorney General to protect that interest and to represent the United Stated in the courts. *United States v. Solomon*, 419 F. Supp. 358 (D. Md. 1976) (Rosewood State Hospital), appeal pending, No. 76–2184 (4th Cir.); *United States v. Mattson*, (Boulder Rivre Hospital), appeal pending, No. 76–3568 (9th Cir.).

In both cases, the district courts have granted the defendants' motions to dismiss our complaints on the basis that the executive branch of the federal government lacks the power to bring such a suit absent an authorizing statute. We have appealed both cases. They have been briefed and the *Solomon* case has been argued. I am submitting a copy of the *Solomon* appendix which

[4] *United States v. Ironworkers Local 86*, 443 F.2d 544 (9th Cir.), *cert. denied*, 404 U.S. 984 (1971) (employment); *United States v. Hunter*, 459 F.2d 205 (4th Cir.), *cert. denied*, 409 U.S. 934 (1972) (housing).

contains the district court opinion and our brief to the Fourth Circuit Court of Appeals for inclusion in the Record.

The United States has also recently brought suit against officials in charge of the operation of the Cook County, Illinois, jail alleging that it is being operated in an unconstitutional manner. The defendants' motion to dismiss the complaint, also asserting the absence of authority to sue is presently pending in the district court, *United States* v. *Elrod*, C.A. No. 76C4768 (N.D. Ill.). Although this motion has been briefed and argued, the district judge has indicated that there probably will be no ruling on the motion until the Fourth Circuit decides the *Solomon* case.

The Attorney General has general authority, by virtue of the statutes which created the office, and which describe the general duties of the office, particularly 28 U.S.C. Sections 516–519, to file suit on behalf of the United States to protect the "interests" of the United States are sufficient to provide standing to sue must be answered on a case-by-case basis. So standing, then, would depend upon an analysis in each case of facts with regard to direct federal interests—particularly whether federal funds are involved, and whether statutes or constitutional provisions affecting the institutions involved express governmental interest in the subject of the litigation. Consequently, where we could assert no interest sufficient to give the government standing to sue based upon these considerations, some institutions among those covered by the bill could continue to deprive persons of constitutional rights, absent any privately-initiated litigation.

The right of the United States to intervene in existing litigation has also been challenged, in two cases alleging widespread constitutional violations in institutions—one involves the correctional facilities of the Texas Department of Corrections, *Ruiz, et al.* v. *Estelle*, C.A. No. 5523 (E.D. Tex.) and other, *Halderman and United States* v. *Pennhurst*, C.A. No. 74–1345 (E.D. Pa.), involves a facility for mentally retarded persons in Pennsylvania.[5] The district courts had granted the United States leave to intervene, and courts of appeals denied petitions for writs of mandamus to require the district courts to dismiss the United States from the cases. The Supreme Court of the United States denied certiorari, in both cases (*In Re Estelle*, 426 U.S. 925 (1976) *Beal* v. *Broderick*, No. 76–1316, decided May 24, 1977), but three of the Justices of Supreme Court in the Estelle case expressed doubts about the authority of the United States to assert a claim, by way of intervention, against the state correctional officials where there was no allegation that the state was denying the equal protection of the laws to inmates "on account of race, color, religion, sex, or national origin . . .", 42 U.S.C. 200h–2 (426 U.S. at 928, Rehnquist, J., with whom The Chief Justice, and Mr. Justice Powell joined, dissenting). The enactment of S. 1393 would serve to alleviate such doubts and to clarify the authority of the United States both to institute suit and to intervene in litigation the concerning the constitutional and federal statutory rights of institutionalized persons. It would also serve as congressional direction about where litigative resources should be used.

A discussion of some of the prevalent conditions we have discovered in institutions covered by this bill over the last several years in connection with our limited litigation program, may be helpful to the subcommittee in considering the need for this legislation. We have also prepared for the Record a summary of cases in which the United States has participated which involved the rights of institutionalized persons.

RIGHTS OF PRISONERS

The Civil Rights Division has been delegated the Attorney General's responsibility under Title III of the Civil Rights Act of 1964, 42 U.S.C. 2000b, to initiate litigation to desegregate public facilities which are operated by the States and their subdivisions and may institute suits, under appropriate circumstances, after receipt of a written complaint that an individual is being denied the equal protection of the laws on account of race, color, religion or national origin. In addition, Title IX of the Civil Rights Act of 1964, U.S.C.

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[5] Motions to dismiss the United States as plaintiff-intervenor have also been made and denied in *Horacek and United States* v. *Exon*, C.A. No. 72–L299 (D. Neb. 1976); *Alexander and United States* v. *Hall*, C.A. No. 72–209 (D. S.C. 1976); and in *Rone and United States* v. *Fireman*, C.A. No. 75–35A (N.D. Ohio) a motion is pending decision.

2000h–2, authorizes the Attorney General to intervene in pending litigation seeking relief from the denial of equal protection on account of race, color, religion, sex, or national origin. Under the authority of those statutes, the United States has initiated and participated in fourteen suits to desegregate facilities of state correctional institutions and of jails. In five of those fourteen actions, however, the United States has also alleged that the inmates who are confined in those institutions are being subjected to unconstitutional conditions of confinement. In addition, one suit raises issues concerning only alleged conditions which violate the constitutional prohibition on cruel and unusual punishments in a county jail. In those suits, the United States is relying on the authority theory which I have mentioned previously, and in two cases, that authority has been challenged by the defendants.

The involvement of the United States in litigation concerning the conditions of confinement of prisoners and the deprivation of their constitutional rights in regard to those conditions began in 1971 when the district court granted our motion to intervene under Title IX in the case of *Gates* v. *Collier*, which was brought by inmates of the Mississippi State Penitentiary at Parchman. Our complaint in intervention alleged that in addition to racial segregation of prison facilities, the defendant state officials failed to provide inmates with adequate housing, medical care, and protection from harm; that the water and sewage systems created immediate health hazards; and that prison officials permitted the custodial staff to inflict cruel and unusual punishments upon inmates. The court concluded, 349 F. Supp. 881, 893 (N.D. Miss. 1972), that the Eighth Amendment's prohibition against cruel and unusual punishment "is not limited to specific acts directed at selected individuals but is equally applicable to general conditions of confinement that may prevail at a prison. While confinement, even at hard labor and without compensation, is not necessarily cruel and unusual punishment, it may be so when the conditions and practices become "so bad as to be shocking to the conscience of reasonably civilized people even though a particular inmate may never personally be subject to any disciplinary action." (Citations omitted)

Barracks were unfit for human habitation and in conditions that threatened the physical health and safety of the inmates and solitary confinement practices required inmates to be placed in "dark hole" cells naked and without hygienic materials, bedding, and adequate heat and food. The court also held that penitentiary officials have an obligation "to insure that inmates are not subjected to any punishment beyond that which is necessary for the orderly administration of the prison," 349 F. Supp. at 894, and that the trusty system which allowed incompetent and untrained inmates to "exercise unchecked authority over other inmates" violated that obligation.

The defendants were specifically forbidden by the court's order from continuing to use such excessive means of punishment as beating, shooting, administering milk of magnesia, turning fans on inmates while they are naked and wet, using a cattle prod on the inmates, and shooting at or around them to keep them moving or standing.

The court also ordered the defendants to meet minimal health care requirements, and entered detailed provisions concerning mail censorship, holding that "an inmate's right to send and receive correspondence to courts, public officials and his attorney of record may be impeded only to the limited extent of inspecting incoming mail from these sources. . . . No justificable reason exists curtail inmates' First and Sixth Amendment rights . . ."

In a suit involving the Louisiana State Penitentiary at Angola, in which we participated as amicus at the request of the court, the court found that conditions existed which "should not only shock the conscience of any right thinking person, but which also flagrantly violate basic constitutional requirements as well as applicable state laws, . . ." The unreported order of the court and the findings of fact and conclusions of law of a special master which were adopted by the court will be submitted for inclusion in the Record, *Williams* v. *Edwards*, C.A. No. 71–98 (M.D. La.)[6]

The court found that "one of the most serious and deplorable conditions that exist at Angola is the lack of adequate security provided to inmates from physical attacks and abuses by other inmates."

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[6] The district court's order has been affirmed by the court of appeals. *Williams* v. *Edwards*, 547 F.2d 1206 (5th Cir. 1977).

The results of that condition were over 270 stabbings and 20 deaths by stabbings in less than a three year period and numerous forcible rapes. We have found that where there are severely overcrowded facilities, and a lack of sufficient staff members to detect and confiscate contraband weapons and to control inmate violence these types of acts occur. Often the condition is exacerbated by the use of inmates as guards, with custodial authority over other inmates. The courts have thus found that prison officials have a duty to protect the inmates in their custody from harm at the hands of other inmates and have entered orders requiring the state officials to eliminate overcrowding, to hire additional staff and assure that a sufficient number are present in the facility at all times to maintain security, to classify inmates so that prisoners with overt and aggressive homosexual tendencies are not given access to young male inmates and that inmates who have a record of assault and violence on other inmates are isolated.

The lack of adequate medical care in state and local correctional institutions is another serious condition which we have found through our involvement in these cases. Untrained inmates often are allowed to provide medical treatment to the other inmates, and rarely are professional medical, dental, or psychiatric services available on a regular basis. Inmates in need of medical care are often required to wait for inordinately long periods before receiving diagnosis and treatment, and modern, sanitary hospital facilities are not generally available. The United States was ordered by the court in *Newman* v. *Alabama* to appear as amicus curiae with full rights of a party in a suit brought by inmates of the Alabama Prison System alleging deprivation of constitutionally adequate medical treatment. The district court in an opinion reported at 349 F. Supp. 278 (M.D. Ala. 1972) described the facts which led it to find "a degree of neglect of basic medical needs of prisoners that could justly be called "barbarous" and "shocking to the conscience." [Citation omitted]

In affirming the district court's order granting extensive injunctive relief, the court of appeals stated that (503 F.2d 1320, 1329 (5th Cir. 1974) "[w]hile limited mobility, for example, may be endemic to confinement, forcing inmates to endure severe infirmities without treatment for the duration of confinement is not. . . . incarceration disables an inmate from procuring aid and creates total dependency upon the state for treatment . . . ."

4. CONSTITUTIONAL RIGHTS OF THE MENTALLY ILL AND MENTALLY RETARDED IN INSTITUTIONS

Perhaps the best exposition of the constitutional rights of involuntarily confined mentally ill and mentally retarded persons is found in the opinion in a class action brought on behalf of the residents of three Alabama mental health institutions, in which the United States participated. In these opinions, the first reported ones concerning the rights of institutionalized persons to care and treatment, the court in *Wyatt* v. *Stickney*[7] declared that mentally ill patients "have a constitutional right to receive such individual treatment as will give each of them a reasonable opportunity to be cured or to improve his or her mental condition[,]" and that mentally retarded persons have a constitutional right to "such individual habilitation as will give them a realistic opportunity to lead a more useful and meaningful life and to return to society."

As defined by the court of appeals,[8] the right to treatment includes, first, care by mental health professionals and others that is adequate and appropriate to the needs of the mentally impaired individual in a humane physical and psychological environment. Secondly, it encompasses habilitative treatment which is appropriate to the condition of a mentally retarded person.

Where mentally ill or mentally retarded persons are civilly and involuntarily committed for a particular constitutionally permitted purpose, such as care, or treatment and habilitation, then "due process" requires that the purpose of the confinement must be given effect. If the care, treatment, etc., is not provided, then the confinement is nothing more than punishment which may last indefinitely, although such persons have been convicted of no criminal conduct. That open ended confinement is a denial of liberty without due process of law.

[7] 325 F. Supp. 781, 784 (M.D. Ala. 1971) (mentally ill); 344 F. Supp. 387, 390 (M.D. Ala. 1972) (mentally retarded).
[8] *Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

In addition to the constitutional right to care, treatment or habilitation, the *Wyatt* court recognized, among other things, a right of mentally ill and mentally retarded persons to have such treatment in the least restrictive conditions necessary for that purpose,[9] the right to dignity and privacy, and the right to be free from unnecessary or excessive medication and restraint.

The district court found that there are three fundamental conditions necessary for adequate and effective treatment or habilitation (344 F. Supp. at 375):

1. A humane physical and psychological environment,
2. Qualified staff in numbers sufficient to administer adequate treatment, and
3. Individualized treatment plans for patients.

Conditions at the Alabama State facilities for mentally ill and mentally retarded persons were found to fall far short of meeting those standards in all three respects. In addition to the basic lack of programs for the treatment of individual patients, the conditions under which residents were obliged to live were dangerous and debilitating. Four mentally retarded residents were found by the court to have died as a result of understaffing, lack of supervision, and brutality:

"One of the four died after a garden hose had been inserted into his rectum for five minutes by a working patient who was cleaning him; one died when a fellow patient hosed him with scalding water; another died when soapy water was forced into his mouth; and a fourth died from a self-administered overdose of drugs which had been inadequately secured."[10]

Restraint of the residents without doctor's orders was found to be commonplace: one resident was regularly confined in a straitjacket for more than nine years. Others suffered malnutrition. Patients in all facilities had virtually no privacy. Unsanitary conditions such as insect infestation in the kitchen and dining areas, and urine and feces on the floors of the living areas were found to exist in one facility. In contrast to the recommendations of the expert witnesses that there should be one psychiatrist, one graduate level psychologist, and one masters level social worker for every 30–50 patients, one institution had only one medical doctor with some psychiatric training for 5,000 patients, one social worker for every 2,500 patients, and one Ph.D. psychologist for every 1,670 patients, 503 F.2d at 1311. Nonprofessional staff were similarly scarce with some aides covering from 100–200 patients and unable to meet even minimum patient needs. One of the expert witnesses referred to the overall condition at the facility for the mentally retarded as simply "storage" of persons not even rising to the level of custodial care, 503 F.2d at 1313.

Conditions equally atrocious were found to exist in the Willowbrook State School for the Mentally Retarded in New York,[11] which was the subject of litigation in which the United States has participated as a litigating *amicus curiae*, and which was mentioned in connection with Congressional consideration of the Bill of Rights for the Developmentally Disabled.[12] There the court found that mentally retarded residents have a constitutional right to be free from harm while they are in state custodial institutions, whether they are there voluntarily or involuntarily. The failure of the state to protect the physical safety of the children housed at Willowbrook was evidenced by testimony of parents that their children had suffered "loss of an eye, the breaking of teeth, the loss of part of an ear bitten off by another resident, and frequent bruises and scalp wounds . . ."

The conditions in Alabama and in New York are not intended to single out those states for special reproach. We have found similar conditions in twelve other cases in eleven states.

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[9] In Summary of A Report—Returning the Mentally Disabled to the Community: Government Needs to Do More, January 7, 1977, at page 7, the Government Accounting Office reported to Congress on the Department's efforts to secure this right in accordance with Presidential directions.

[10] *Wyatt* v. *Aderholt*, 503 F.2d 1305, 1311, n. 6 (5th Cir. 1974).

[11] *New York State Association for Retarded Children, Inc.* v. *Rockefeller*, 357 F. Supp. 752 (E.D. N.Y. 1973) and *NYSARC & Parisi* v. *Carey*, 393 F. Supp. 715 (E.D. N.Y. 1975) (consent decree).

[12] 121 Cong. Rec. S. 16548–9 (Daily Edition), Sept. 23, 1975.

CONSTITUTIONAL RIGHTS TO DUE PROCESS PRIOR TO COMMITMENT

The United States has been involved in litigating the constitutionality of commitment statutes in Iowa [*Stamus and United States* v. *Leonhardt and State of Iowa*, 414 F. Supp. 439 (S.D. Iowa 1976)], South Carolina [*Alexander and United States* v. *Hall*, C.A. No. C-74-147 (N.D. Ohio)] and Pa., *Bartley* v. *Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975) (three-judge court), vacated and remanded *sub nom. Kremens* v. *Bartley*, No. 75-1064, S. Ct., decided May 16, 1977. In each of the states in which the United States has participated in the challenge to a state commitment statute, the legislature has passed new statutes which have substantially improved the procedural standards by which its citizens are involuntarily committed.

CONSTITUTIONAL RIGHTS OF DELINQUENT JUVENILES WITHIN INSTITUTIONS

The United States was ordered by the court in *Morales* v. *Turman*[13] to appear as litigating amicus curiae to assist the court in determining the facts concerning the Texas state juvenile reformatories in which minors adjudged delinquent were involuntarily committed. The district court found that these children have a constitutional right to receive rehabilitative treatment to accomplish the stated objective of their confinement, i.e., their reintegration into society. The court also found that each individual had the right to the least restrictive treatment that is consistent with the purposes of his custody. On the basis of the evidence, the court concluded that the state's juvenile facilities had "been the scenes of widespread physical and psychological brutality", 383 F. Supp. at 77. The evidence included such practices as the tear gassing of juveniles in solitary confinement, beatings, forced hard labor such as pulling grass by hand without bending from the knees, deficient medical care, humilitating and demeaning treatment, and a prohibition against speaking Spanish in a population that was one-third Mexican-American.

In another case, the State of Louisiana was found by the court to have placed delinquent and dependent children in private child care facilities in the State of Texas where in some cases children were being abused and overdrugged and in which treatment was inadequate, *Gary W. and United States* v. *Stewart*, C.A. No. 74-2412-C (E.D. La.). the court entered a detailed order concerning the conditions of care and treatment to which such children are entitled, required the State to assure that out-of-state facilities in which its children were placed meet such conditions prior to placement, and ordered the State to remove children from the worst facilities.

Persons are committed to institutions for mentally retarded and mentally ill persons in theory for purpose of care, treatment and rehabilitation. Similarly, children are committed to institutions through civil proceedings, not criminal trials which result in convictions. Any state action of this sort which places children in the care of the state, and any compulsory confinement which follows should be for the child's own welfare and not for "punishment" purposes.

ASSISTANCE TO THE COURTS

I believe that it is significant to the subcommittee's consideration of the need for this bill that at least ten courts have called upon the United States to participate in litigation concerning the rights of institutionalized citizens. These courts have recognized that the issues in these cases are complex and that a comprehensive fact-finding process is necessary to develop a record upon which to determine whether confined persons are being deprived of their rights and, if so, what relief is needed. The *Wyatt* court described the participation of the United States as being an "exemplary service" to the court. 344 F. Supp. 375 fn. 3. The resources and expertise of the United States through its various agencies, including the Department of Health, Education, and Welfare, the Law Enforcement Assistance Administration and the Bureau of Prisons, have been of assistance to the courts thus far. We are committed to continuing that participation. If S. 1393 becomes law, the Civil Rights Division's Office of Special Litigation and Public Ac-

[13] 364 F. Supp. 166 (E.D. ex. 1973) and 383T F. Supp. 53 (E.D. ex. 1974); rev'd for absence of a three-judge court 535 F.2d 864; rev'd and remanded for further proceedings, —— U.S. ——, No. 76-5881, March 21, 1977.

commodations and Facilities Section will be able to use its staff of attorneys and paraprofessionals who have developed an expertise in this area of the law in a comprehensive program which will enable the Department of Justice to institute suits where they are most needed throughout the country to protect the constitutional rights of persons in these institutions.

I am sure that the subcommittee is concerned with the impact of the proposed grant of authority on the courts. I believe that the effect will be a positive one and may well result in relieving the caseload of the courts. As relief on an institution-wide or state-wide basis is implemented, the need for confined persons to bring individual suits will decrease. Our experience in the *Estelle* case, involving the Texas prisons, which I mentioned earlier gives an example of this. There, the district court had on its docket eight separate complaints drafted by inmates alleging violation of their constitutional rights by various means. The district court, discerning that these complaints indicated the possible existence of a pattern of deprivation of those rights, consolidated the eight cases, appointed counsel to represent the inmates, and ordered the United States to assist the court by investigating the facts alleged in the complaints. Thus, one comprehensive suit dealing with systemic conditions relieves the court from having to try the issues in eight separate duplicative law-suits, and, possibly, many others which had not been filed, but which might have been filed had there been no comprehensive effort. I think that a pattern such as this will emerge if the United States is authorized to develop a systematic litigation program.

Again, we cannot, and do not intend, to solve all institutions problems through litigation. We intend to be selective in our cases so that we bring to the judiciary those matters which we believe can be ameliorated by the judiciary.

I would like to discuss briefly some of the specific language of this bill.

EXHAUSTION BY "AGGRIEVED PARTIES"

Section One of the bill which authorizes suits by the Attorney General also provides that the district courts shall exercise jurisdiction without regard to whether "the aggrieved party or parties" shall have exhausted any administrative remedies provided by law. We agree that the Attorney General, who, in these kinds of cases, represents the United States rather than individuals, should not be required to exhaust administrative remedies which may be provided by states. In fact, the kinds of widespread, systematic wrongs which these suits would address are not likely to be remedied by institutional grievance procedures which, where they exist, are likely to be oriented toward individual complaints, and the arguments which could be made in favor of an exhaustion requirement for suits under 42 U.S.C. 1983 could not be made for Attorney General pattern or practice suits.

But this sentence raises another interpretive question. It implies that the Attorney General would be acting, in the suits contemplated by this bill, as an attorney for individuals. While the immediate beneficiaries of such suits would be individuals confined to the institution in question, the Attorney General, and the attorneys acting under him, represent the United States in the legal sense of representation, and any contrary implication should be avoided in the history of the bill.

Regardless of what the Congress may enact, with regard to exhaustion by individuals, the intent of S. 1393 should remain with regard to Attorney General suits. I raise this because there was testimony before a committee of the House of Representatives in support of such a requirement given in connection with hearings on bills similar to S. 1393. One of those bills has an exhaustion requirement in it for suits brought under 42 U.S.C. 1983 by institutionalized persons.

Because the exhaustion issue is before the House of Representatives, and because a distinguished court of appeals judge testified in favor of such a requirement for prisoners, I believe I should say something about such a proposal.

I wrote a letter to the House subcommittee on exhaustion which has already been made available to this subcommittee staff. Briefly, I do not favor an exhaustion requirement for institutionalized juveniles and mentally incompetent persons. There is some merit to such a requirement for prisoners, but I believe more needs to be known about how it would work as I described in my letter to the House subcommittee.

I think it is particularly important that if there is to be an exhaustion requirement for prisoners, that it be made clear that it wold not apply if the administrative remedy is not adequate to address the problem complained of, and that there must be exhaustion only of "plain, speedy and efficient" remedies—not those which serve only to delay the resolution of grievances.

DETERMINATIONS BY THE ATTORNEY GENERAL

By the terms of Sections One, Two, and Three, the Attorney General is empowered to make certain determinations in deciding whether to institute or intervene in litigation. In Section One, the Attorney General is authorized to bring suit when he has reasonable cause to believe that certain conditions exist in an institution operated by a state; in Section Two, he must determine that the suit is in the public interest and must be satisfied that the state officials have been given a reasonable time to correct the conditions alleged to be depriving confined persons of their rights; and in Section Three, he must certify that a case is of general public importance prior to seeking to intervene therein.

Such Congressional directions to the Attorney General as pre-conditions to suits are in line with prior civil rights legislation. These sections are similar to those found in the other statutes under which the Attorney General has "pattern or practice" authority or authority to sue upon receipt of complaints by citizens, some of which I enumerated earlier, and the courts have consistently concluded that these kinds of determinations are matters for the Attorney General's judgment, considering the specific facts of each case, and are not a proper subject for judicial inquiry, see, e.g., *United States* v. *Greenwood Municipal Separate School District*, 406 F.2d 1086 (5th Cir. 1967) (Title IV of the Civil Rights Act of 1964, 42 U.S.C. 2000 C-6); *United States* v. *Bob Lawrence Realty, Inc.*, 474 F.2d 115 (5th Cir. 1973), *cert. denied*, 414 U.S. 826 (1973) (Title VIII of the Civil Rights Act of 1968, 42 U.S.C. 3601, et seq.). I believe it is important that the subcommittee make clear in its report on this bill that the determinations of the Attorney General with regard to potential institutions suits are intended to be similarly unreviewable.

I would interpret this to mean, however, if the bill is passed, that Congress intends for the Attorney General, or those attorneys under him, to engage in realistic pre-suit negotiations, and that investigation of the facts and sound legal analysis be performed, before suit is filed. I would like to suggest that language be added to section two which would assure that notification of the alleged violations would be given to the appropriate governor and state attorney general as well as to appropriate officials of the institution, and that language be added to section one indicatiing that a complaint pursuant to the authority of the bill would be signed by the Attorney General (or in his absence by the Acting Attorney General). These suggestions are made in recognition of the important issues inherent in litigation by the federal government against a state or its officials.

[The proposed guidelines previously referred to by Mr. Days were marked "Exhibit No. 3" and are as follows:]

[EXHIBIT NO. 3]

U. S. DEPARTMENT OF JUSTICE,
Washington, D.C., July 28, 1977.

Hon. BIRCH BAYH,
Chairman, Subcommittee on the Constitution,
Committee on the Judiciary, U. S. Senate,
Washington, D.C.

DEAR CHAIRMAN BAYH: During my testimony before the Subcommittee on June 17, 1977 concerning S. 1393, I was asked what guidelines might be followed by the Attorney General in our litigation program concerning the constitutional rights of institutionalized persons in determining whether to institute a suit and, if so, what relief might be obtained.

1. Standards for Filing Suits.

As I stated in my testimony, the participation by the United States in suits such as contemplated by S. 1393 has been largely at the invitation of courts

to appear as *amicus curiae* or through intervention in pending litigation instituted by private individuals. However, the Department has initiated a small number of suits where no private action was pending, based upon the theory that the Attorney General has inherent authority to bring suit to protect the interests of the United States, a theory which has long been accepted by the courts in other contexts. We have determined that the interests of the United States required the initiation of a suit where the following factors are present:

1. A significant number of individuals are being subjected to deprivations of rights secured to them by the federal constitution or federal statutes;
2. Such deprivations are pursuant to broadly applicable policies, procedures or practices;
3. Such deprivations are of an extremely serious nature, so as to include, but not be limited to, at least one of the following:
   (a) Individuals are confined under conditions which amount to "cruel and unusual punishment," within the meaning of the Eighth Amendment,
   (b) Individuals are subjected to confinement or to other severe restrictions of liberty without lawful justification, e.g., failure to provide treatment to persons committed for the purpose of being treated,
   (c) Individuals are denied basic freedoms, e.g., freedom of speech, freedom of religion, freedom to petition the government (including reasonable access to the courts); and
4. There is no realistic prospect of an effective, timely remedy without the involvement of the United States.

We would expect to follow similar guidelines if a bill such as S. 1393 becomes law. I do not believe that it is necessary to incorporate such guidelines in the legislation itself. As I stated in my testimony, the Attorney General has had "pattern or practice" authority for some time in other areas of civil rights enforocement, and the Department of Justice has therefore had extensive experience in operating under that standard. I believe that the guidelines which I have outlined would meet the "pattern or practice" standard. The subcommittee could, however, include in its report on the bill language indicating its understanding of this term.

2. Relief.

During my testimony, concern was expressed about the scope of the language of Section One of S. 1393 which authorizes the Attorney General to institute a civil action "for such relief as he deems necessary to insure the full enjoyment of" any rights, privileges, or immunities secured by the Constitution or laws of the United States by persons confined in an institution. This language is quite similar to that of many other civil rights statutes which authorize civil actions by the Attorney General, e.g., 42 U.S.C. 2000a5 (discrimination in public accommodations; 42 U.S.C. 2000b (discrimination in public facilities); 42 U.S.C. 2000c-6 (desegregation of public education); 42 U.S.C. 2000e-6 (discrimination in employment); and 42 U.S.C. 3613 (fair housing). This language would, therefore, have established meaning and its use would serve to ensure that, in any appropriate case, the Attorney General would not be limited in his authority to seek full relief for any violation which is within the terms of the statute.

It is, of course, the court in which suit is brought which would determine the extent of relief which would be granted to remedy a violation of constitutional or statutory rights. Thus, although the language of S. 1393 gives authority to the Attorney General to seek such relief as he deems necessary, the courts, under general equitable principles, would be required to fit the remedy to the violation which is proved. For example, in recent decisions involving conditions in prisons, courts have ordered relief which corrected unconstitutional lack of medical care, required internal due process for imposition of disciplinary measures and placed population ceilings on institutions which were so overcrowded as to amount to cruel and unusual punishment. Where conditions exist which violate the constitution, an injunctive order must be entered which would cause the conditions to be brought within constitutional limits.

The constitutional standards as interpreted by the courts are, of course, the measure of violations of constitutional rights. Frequently, however, the trial coourts have been guided in determining what constitutes unconstitutional conditions by evidence of acceptable norms for institutions-published in the form of "standards." The expert witnesses who have testified in our litigation concerning correctional facilities have referred primarily to the following published standards as measures of the minimum conditions which should exist

in those institutions: the American Public Health Association's Standards For Health Services In Correctional Institutions (1976), the American Medical Associations Standards for the Accreditation of Medical Care and Health Services In Prisons and Jails (1977), and the American Correctional Association's Manual of Correctional Standards (1973).

In the area of non-correctional institutions, the Department of Health, Education, and Welfare, which grants substantial financial assistance to such institutions, has prescribed, pursuant to the authority conferred in 42 U.S.C. 1302, "Standards for Intermediate Care Facilities", 45 C.F.R. 249.13. Those "Standards" are a useful and frequently applicable measure of minimal requirements for facilities in which mentally retarded, mentally ill, and aged persons are confined.

Thank you for the opportunity of appearing before your subcommittee. If I can be of further assistance, please feel free to contact me.

Sincerely,

DREW S. DAYS III,
Assistant Attorney General,
Civil Rights Division.

Senator BAYH. As we should have anticipated, the hearings are going to take a good deal longer than we had programed. We will do a little shuffling to try to expedite the convenience or inconvenience of our witnesses.

We would like to ask Mr. Geraldo Rivera, and Mr. Carabello, and Dr. Wilkins if they would go next. Then I understand Mr. Rivera has to be out by noon. We will ask Mr. Donaldson, whom we had scheduled as the second witness, to come in the third spot because has has to be out by 1 o'clock. In fact, I think we may lose our room at that time. Then we would ask the other witnesses if they would help us by going together in the No. 4 spot. I regret that it is necessary to expedite this in this way but we have no alternative.

Mr. Rivera, of course you are a common figure on television. What a lot of people don't know is that before he turned TV newsman and personality of some significance, Mr. Rivera was a lawyer involved in the kinds of concerns that have always concerned this committee. He was largely responsible for much of the disclosure relative to the *Willowbrook* case.

Mr. Carabello is a former resident of Willowbrook, a cerebral palsy victim who was mistakenly diagnosed as mentally retarded and spent 16 years in Willowbrook before that injustice was righted, or I should say discovered, because I don't know how that injustice can ever be righted.

Dr. Wilkins is a former doctor at Willowbrook who was discharged, as I recall, back in 1971 or so for participating in the protest designed to remedy the particular conditions which existed in Willowbrook.

Gentlemen, why don't you proceed as you see fit. I appreciate the inconvience to which you have been put. I want to thank you for your cooperation with our committee.

TESTIMONY OF GERALDO RIVERA, BROADCAST JOURNALIST, ABC NEWS

Mr. RIVERA. Thank you, Mr. Chairman.

I will say very briefly off the top that my expertise is obviously law or news. It is not so much the care of the mentally handicapped. But what I saw in 1972 for the first time really in my life, and my

experience, and what I have seen in the years subsequent to that clearly indicates to me the need for this kind of legislation. I will briefly describe what I saw that first visit to the Willowbrook State School in the supposedly cosmopolitan and progressive State of New York, a State that formerly prided itself on the humane care of people in institutions.

Thanks to Dr. Wilkins who was on the staff there, I went into the institution and into building No. 6, the B ward, and in a room that was perhaps the same size, more or less, of this hearing room, there were 50 or 60 severely and profoundly retarded young boys. Most of them were wearing tattered remnants of institutional clothing or hand-me-downs. Many of them, however, were absolutely naked. They were basically unattended, that is to say, there was one attendant in the room, a woman who had a mentally retarded youngster under each arm and another was pulling at her skirt. So she obviously was totally overwhelmed by the horrid conditions there.

The stench in the place was overwhelming. These naked and seminaked young people were smeared with their own feces because they were unsupervised and they were knocking their heads against the walls and hitting themselves and hitting each other. They called Willowbrook a State school at that time and now it's called a developmental center which is the new rhetoric. It was not a school. There was no education and no rehabilitation going on. The only thing that was happening at that particular institution was the human beings were being kept. They were being warehoused. They were being sustained in life barely but no meaningful work was being done to make their condition and plight in life any better to alleviate the terrible misery that they were suffering in that dreadful place.

Well, we began doing exposé. All the news media did exposé. We did exposé after exposé thinking that the outraged citizenry would be enough of a force to compel the State of New York to alleviate those conditions and correct those conditions. We were wrong.

Those exposés did not succeed in meaningfully changing that place. It was not until the Justice Department lawyers in association with the mental health law project, brought a suit before Federal Court Judge Oren Judd that anything meaningful happened. Only then did the State of New York put rhetoric aside and get down to the business of complying with the Federal court order to specifically correct specific conditions.

The power of the press, which is often spoken about and oftentimes written about, I think was grossly exaggerated in this particular case. It was the power of the Federal court judge, only at the urging of attorneys general, that brought about any meaningful changes in Willowbrook.

He, as you know, Senator, ordered the institution shrunken to manageable size and manageable proportions from over 5,000 residents. He demanded that by 1980 or 1981 the population be reduced to 250.

But again I stress that that was only because of the Federal court action, brought by the Department of Justice personnel, that this result finally happened.

I would like now to introduce Dr. Michael Wilkins who is working for the Wayne Miner Neighborhood Health Center in Kansas City, Mo. He was a staff physician at Willowbrook and he testified to some of the conditions that existed during the time he worked there and during the time I first began my exposé.

Senator BAYH. Without objection, a copy of your story will be inserted in the record at this point.

[Mr. Rivera's article was marked "Exhibit No. 4" and is as follows:]

[Exhibit No. 4]

Excerpted from A Special Kind Of Courage: Profiles of Young Americans, by Geraldo Rivera. Simon and Schuster, New York. Copyright 1976 by Geraldo Rivera.

THE scene at the institution had been horrible and revolting. In three years as a newsman in New York City, I had seen poverty, hunger, and people dead from fire, drug overdoses, and gunshot wounds. They were things that seemed the absolute pits of human misery and despair. But this had been worse. Willowbrook. It was such an ironically lyrical name, much more befitting a pastoral painting than a foul and overcrowded human warehouse. It was the world's largest and one of the nation's worst institutions for the mentally retarded.

Filled to overflowing with almost six thousand children, the air in the place had been heavy with the stink of feces and neglect. The two dozen buildings were all divided into four wards, each haphazardly littered with naked or barely dressed boys and girls. The wards are large rooms, maybe thirty feet square. Into that space were jammed between sixty and eighty children. Most were severely or profoundly retarded. They had either never learned to speak or had lost the ability, but their nightmarish moaning echoed from the hard cinder-block walls.

Concentration was necessary to perceive them even as human children. They were so filthy, and frighteningly out of control.

The kids who weren't groping toward our camera lights were just sitting on one of the four wooden benches strategically placed in the corners of the otherwise furnitureless space. These rocked back and forth, oblivious to everything and everyone around them.

There was virtually no supervision, just one hopelessly overburdened attendant. She was a heavyset black lady, who held a squirming child under each chubby arm, while patiently trying to

talk with a third retarded child who was pulling insistently at her uniform skirt. I tried to listen in on what she was saying, but the undulating moans in the background, like the sounds of a crashing sea, made it impossible to hear.

With that sound, and the nauseating smell, the institution would have been more at home in Dante's *Inferno* than on Staten Island, in the supposedly cosmopolitan and sophisticated city of New York.

When our unauthorized filming was completed, we dashed out the back door of B-ward in Building 6 and into our waiting car. I was driving. To avoid trouble from the institution guards, we were off the grounds of the huge facility in less than sixty seconds. We drove with the windows open to purge our clothing of the wretched smell. Nobody spoke. For a long time the only sound was the rush of the wind and the screech of the tires.

"It's hopeless. Isn't it?" I finally asked Dr. Mike Wilkins, who was sitting alongside me in the front seat. He was the staff physician who had asked me to bring my cameras into Willowbrook. "I mean . . . nothing can really be done to help those kids . . . can it?"

"Geraldo, you'd be surprised at what can be done—if people care." When Dr. Wilkins spoke, even about an issue he was so deeply and emotionally involved in, it was always in a quiet, scholarly way. He was the teacher. I was the student, made willing to learn by the frightening spectacle he had just shown me. "Those kids weren't freaks," he continued. "They just have brains that are damaged or retarded. Some more than others." He gestured, pointing to me and then back to himself. "They have the same feelings we do, and if you give them half a chance, they respond the same as normal children do to things. They get happy. They get sad. And they need love and attention."

Dr. Wilkins was a young man, bespectacled and slightly built. But as with Gandhi, the strength of his convictions more

than compensated for his physical frailty. He went on carefully, conscious of the fact that I had been deeply shocked and needed to be convinced that things didn't have to be the way they were.

"Willowbrook represents the worst possible care for the mentally retarded. That institution just holds them until they die. There is no attempt at education or rehabilitation. Nothing. Just abuse and neglect." He paused for a second. Taking his glasses off, he rubbed his forehead, as if trying to ease the pain of a bad headache. He shook his head. "You know something? The largest single cause of death at Willowbrook is pneumonia. You know how the children get it? They gag on the slop they're fed, because there's nobody around to teach them how to use utensils. Food particles get into their lungs, and it causes an infection. The infection eventually causes the pneumonia, and that causes death."

As we drove, Mike interrupted himself to give me directions. There was one other place where he wanted us to film before going back to the newsroom. It was only about fifteen minutes away from the institution.

"But the ultimate tragedy at Willowbrook," he explained, picking up where he had left off, "is the children who never should have been there at all."

"What do you mean?" I asked, hoping I had heard him wrong. I hadn't.

"Many of the residents aren't even mildly retarded."

"Don't tell me that," I said, almost pleading. The thought that some of the kids in that dreadful place might be there unnecessarily was appalling.

"I know it's terrible even to think about, but we have to think about it, because it's true." Mike went on regretfully, "There was a bad diagnosis when they were very young, or they have some kind of physical disability. Because there was no other, more appropriate place to put them, they get dumped in Willowbrook. . . . Well, after a couple of years spent on one of

those wards, they get to seem retarded." Always the professor, Mike spared me none of the unhappy details. "Environment can retard a person almost as much as physical brain damage."

"That must really kill you—to see kids who aren't even retarded, rotting away on those wards."

"Let me answer it this way." He paused for a second, trying to find words. "I think this thing is going to change. As soon as we bring this story to the American people, they are going to be angry, and they are going to demand that that place and others like it be cleaned up."

The three other members of my film crew were sitting in the back seat of the car. Usually when this type of job-related conversation was going on in the front seat, these hard-nosed photojournalists would be completely tuned out—looking out the windows, or napping, or reading the New York *Daily News*. Their personal involvement in a story usually ended when they left the scene, but this was obviously different.

They had been as deeply affected by what we'd seen as I was, and as Mike spoke, they listened intently.

"But the most frustrating aspect of the whole thing is that change doesn't happen overnight," Mike continued. "It's going to take time. Years, probably. And in that time, people who never should have been in that place are going to grow up, grow old, and die there."

I stammered, "But . . . I mean . . . can't we do something to get some of them out in the meantime?"

"We're getting some of them out."

"How are they doing?"

"Not badly. Considering where they've been. You know, it's not easy to adjust to life outside a hellhole like that one. Especially if it's the only life you've ever known."

"Can I meet some of the kids who've gotten out?"

"That's where I'm taking you now. I want you to meet Bernard."

"Who's Bernard?"

"He's twenty-one years old. And he just got out of Willowbrook."

"How long was he in there?"

"Sixteen years."

"And he's not retarded?"

"No. He's not retarded."

"Goddamnit."

"This is where we get off."

We turned off the highway, and I pulled the crew car into the driveway of an old house. It was about three in the afternoon. It was biting cold out, and the January sky was already getting dark. The house was sort of run-down, but at least it had a big yard, filled with trees and shrubbery, which in the summer, especially, would lend a real country feeling, not uncommon in the relatively suburban borough of Staten Island.

The house belonged to Bill Bronston, another young activist doctor from Willowbrook. We walked up to the porch. Mike was leading me; Bob Alis, the cameraman; Davey Weingold, the sound man; and Ronnie Paul, who did the lighting. Hustling in the cold with our portable TV equipment, we went in the front door and into a warm old living room crowded with people.

They all knew we had planned to go into Willowbrook earlier that afternoon to film the conditions there. Since that was expressly forbidden by the Department of Mental Hygiene, everyone had been anxiously awaiting word of our expedition.

"How did you make out?" Dr. Bronston nervously asked before we had even set the equipment down.

"All right, I guess," cautiously answered Dr. Wilkins.

"Great!" I put it more emphatically. (A word of explanation: In the news business, with some exceptions, there is a direct relationship between the importance of the story and the grimness it portrays; so if a cameraman has successfully filmed

something that is horrible, a newsman can classify his story as "great.")

"You mean you got the cameras inside?"

"Yeah. We sure did."

"Fantastic!"

Bernard was sitting on the couch. As a living, breathing example of all that was wrong with Willowbrook, he was the star of the show, lavished from both sides with solicitous attention. It was a pleasant but unsettling change of pace for the young man who had spent most of his life living a grotesque nightmare.

I walked toward him, Mike and Bill guiding me through the crowded room.

"Bernard. I'd like you to meet Geraldo Rivera." Then, looking to me, Mike completed the introduction. "Geraldo, this is the friend I've been telling you about. Bernard Carabello."

"How ya doin', pal?" I asked him, energetically flashing what passes for a warm, friendly smile in embarrassing public situations. I extended my hand, and he tried to do the same. Bernard wanted to shake hands, but his arm and his thought processes seemed badly connected. Finally, after an embarrassing moment, he grabbed for his semiextended right arm and guided it toward me with his more controlled left. It was shaking as I reached for it, pretending not to notice anything extraordinary.

"So what's new, partner?" I asked. He struggled to answer.

Bernard's affliction is cerebral palsy, not mental retardation. His mind is perfect; it's just badly packaged, and that afternoon his handicap was painfully obvious. His speech is severely distorted during the best of times, and that day his physical handicap was compounded by his nervousness. After sixteen anonymous years in the ward, he was unaccustomed to being the center of attention.

"Nnnahot Mmmuch." He painfully forced speech out as I released his hand. Holding it had been unpleasant. Even though

I had already done some stories about the physically handicapped, I still wasn't entirely at ease with them. It would have been difficult to estimate which of us, Bernard or me, for our different reasons, was more uneasy.

Although he had greatly improved his ability to control his movements since leaving the institution, this high-pressured situation caused him to relapse temporarily. Much to the dismay of the people sitting next to him, Bernard's arms flailed about in involuntary perpetual motion as he sat there on the old couch. Only with great effort did he manage to get both hands underneath himself, stopping their movement by sitting on them.

Bill asked the eager kids next to Bernard to get up so we could talk with him. As soon as I sat down next to Bernard, Mike skillfully avoided an awkward lapse in our fledgling conversation by telling me the story of how this twenty-one-year-old young man had come to spend most of his life in an institution worse than the worst prison.

Things were bad for Bernard from minute one of his life. There were complications. He had been badly positioned in his mother's womb, so doctors at New York's Bellevue Hospital had to struggle for hours to deliver him. When he came out, it was elbow-first, and his mother, Pedra, was left exhausted and sick from the experience. For five days she was listed in critical condition.

Bernard was the fifth child born to her and Louis Carabello, the janitor of a six-floor walk-up on Broome Street on the Lower East Side of Manhattan. So desperate was the family's financial situation that things would have been impossible for the Carabellos even if Bernard had been a normal child, born without complications. In return for maintaining the tenement building they lived in, Louis was given a three-room apartment, rent-free, and $120 a month. Two adults and five children, crowded into a one-bedroom apartment, trying to get by on less than thirty dollars a week.

Mr. and Mrs. Carabello slept on the fold-out couch in what served as the living, dining, and utility room. Bernard slept next to them, in the same cheap crib that had served his brothers, Louie, Tony, and Howard, and his sister, Beverly.

The children, including Bernard, had been born with depressing regularity—one a year for the past five years. Each one made the situation more untenable. Bernard had escalated the deteriorating situation by having been born abnormal.

The week after she got out of the hospital, Pedra went to work. Still weak from her ordeal, she got a job for eighty dollars a week packing underwear at a run-down old factory near their home. The task of watching the children was shared by Mr. Carabello, when his duties around the building permitted, and by Louis junior, age 5½, the oldest of the kids.

Since Mr. Carabello disliked the domestic work, Louis had to diaper and feed his infant brother, whose handicap was already becoming apparent. Pedra would relieve him of his premature and arduous responsibility when she came home from work about six in the evening. She would be exhausted, but before resting she had to make dinner for everyone, including her husband, who was beginning to drink too much. The menu was almost always the same: rice and beans, and once a week, either dried fish or stringy beef.

After the meal, she would put the kids to bed. The four oldest, ranging from 5½ to 1½, all slept on the same big bed that had originally been shared by Pedra and Louis senior when they had first gotten married. The kids' room was sparsely decorated with cheap, shiny furniture. The bed itself was fringed in red pompons and nestled under a plaster-of-paris statue of Jesus.

With Mrs. Carabello bringing a few extra dollars in each week, things started marginally to improve. Then, as often happens in ghetto families with neither the recreation of television nor the protection of birth control, she got pregnant again. Pedra worked until the last minute, because she had to.

Jenny was born almost exactly one year after Bernard, who demanded increasing attention and care as his handicap became more and more pronounced. The house was impoverished and chaotic. The family was held together only by the patience and grim determination of the inexhaustible Pedra.

With relentless timing, David followed Jenny, and Margarita followed David. When there were eight children, all born within less than ten years, Louis Carabello left home.

In a knavish but, in the slums, common maneuver, he left Mrs. Carabello to make the best of the impossible situation by herself, with some public assistance. Bernard was five years old. He still couldn't walk or talk, and he was not toilet-trained. Pedra had to diaper and change this normal-size five-year-old several times each day.

Concerned about Bernard's lack of development, Mrs. Carabello began taking him every two or three weeks to the public-health clinic at Bellevue Hospital. Doctors there had told her that Bernard's only hope for even seminormality was constant physical therapy.

In the beginning, getting her nonambulatory son to the clinic on East Twenty-fifth Street was a difficult but manageable proposition from her relatively nearby home on Broome Street. But because their old apartment there was far too small for all nine of them, Pedra had to move her brood to Brooklyn.

She had applied for and was granted a large two-bedroom apartment in the Scholes Street City housing projects in the Williamsburg section of Brooklyn. As a neighborhood, Williamsburg is neither better nor worse than the Lower East Side. Like the Carabellos' old neighborhood, this new one was predominantly Puerto Rican, with a substantial minority of Eastern European Jews, the two ethnic groups joined by their common poverty.

The projects were located within sight and sound of the old Broadway elevated subway train, which cut a rumbling swath through the area every fifteen minutes or so.

The new apartment was far larger than the one the Carabellos had left behind, but it was still far too small. Another and ultimately more important disadvantage was its distance from the clinic at Bellevue Hospital. Now, not only did Pedra have to struggle to dress and carry the deadweight of her growing son, but they also had to endure a combined subway and bus voyage of an hour and a quarter each way, every two weeks.

At the time, Pedra spoke no English, and since none of the young doctors at the public-health clinic spoke Spanish, an interpreter was always needed. Sometimes Pedra would just find somebody who happened to be at the hospital on the afternoon she brought in Bernard. Other times, she would bring a neighbor along to translate.

In the rushed, harried atmosphere of the clinic, the overworked interns sympathized with Mrs. Carabello's misfortune. But they still avoided serving her and her child whenever possible. She was a brash woman, given to concerned but noisy outbursts at doctors who were patiently trying to explain Bernard's lack of progress. Even when she was docile, it was an inconvenience dealing with Mrs. Carabello. Since she spoke no English, talking with her took twice as long, conversations having to be translated by a middleman, sometimes a stranger.

Finally, one afternoon when Pedra came in complaining loudly, as she usually did, about the slowness of the Broadway train, she quieted abruptly when she saw the head of the clinic somberly walking toward her. With him was the stern-faced Spanish-speaking officer of the hospital's community-relations department. Neither of these exalted gentlemen had ever waited on her and Bernard before.

With the help of a girlfriend, Pedra had plopped Bernard onto one of the waiting-area benches and was in the process of taking off his outer coat when they came up to her.

She awkwardly stopped what she was doing. At the doctor's request, translated into Spanish by the community-relations

man, Pedra anxiously and with uncharacteristic quiet followed them into the head man's glass-partitioned clinic office. Before walking off, Pedra had nodded to a friend and then at her son. The body language was easily understood; the neighbor walked over and finished taking Bernard's coat off and kept a protective hand on him.

Inside the glass walls, all the hyperactivity was still visible outside; only the crying and the clanking noises of the busy clinic seemed abated. The community-relations official was a shorter, darker, more active man than his pale and properly professional colleague. He carried the conversation; the doctor just listened. Looking at whoever was talking, the clinic doctor seemed to be following the intense emotional conversation. Even though he couldn't understand Spanish, he could easily approximate what was happening, because he had instructed the other man what to say.

"Señora, these trips all the way in to Manhattan are difficult. Are they not?"

"Yes. Of course, they're a pain in the neck," answered Mrs. Carabello, quickly recovering from her initial uneasiness at being called into the office. "You think it's easy to drag that kid in from Brooklyn all the time?"

"We know you're having a tough time. That's why we called you in here today."

"Why? You got a better way?"

"Yes, Señora, we think we do."

"What? Can you get the city to give me some more money? . . . How do they expect me to feed eight kids with $230 a month?"

"That's not what we have in mind."

"What, then?"

"Bernard should be placed in an institution."

"What institution?" she asked, softly now, as if recovering from a punch in the stomach.

"One close to where you live. A place where he could get the kind of help he needs." Mrs. Carabello's brashness was completely gone. Her eyes were beginning to shine wetly. Recognizing the danger signs of a potentially embarrassing emotional outburst, the official started patting her arm smoothingly. "It will be much better for everybody this way," he continued, buttressing his honey-coated presentation still further. "You can't really take care of him at home. Not with all the other children."

Pedra knew he was only saying what was more true than she wished to admit. Recognizing his advantage, the community-relations man pressed home his most convincing argument. Nodding to the silent man sitting next to them, he said, "The doctor thinks it would be much better for Bernard. He knows that you try very hard to care for your son, but you have your hands more than filled." Then the coup de grace: "Think what's best for your son."

"Where will he go?" Pedra's question was phrased in the defeated syntax of a mother whose natural resistance toward giving up her child had been overcome.

"There's a place on Staten Island. You could take the ferry to see him there."

"What's it called?"

"Willowbrook."

"That's a nice name." It was the only thing she could think of to say.

Bernard was only one of thousands of children who grew up almost completely within the institution. At the time he was admitted, at the age of five, there was only a perfunctory screening of prospective residents. So the fact that Bernard was not actually retarded understandably went unnoticed. He had some handicap, and that was more than enough to qualify him for admission.

At the age of 5½ Bernard was placed in Building 25 at

Willowbrook. Half of it was used for teenage girls, and at the time, the other half was occupied by younger boys and girls. Until his tenth birthday, Bernard's routine was established, harsh and unrelenting.

At five o'clock each morning, the last official act of the night-shift attendant was to walk through the crowded dormitory area, switching on the lights as she went, shouting, "Wake up! . . . Wake up!" The sixty children were expected to be out of bed before the vigilant attendant made her return trip through the ward. For some of the kids, like Bernard, getting out of bed was a difficult and time-consuming project, because they couldn't walk. But after incurring the painful prodding and pushing of the tired and impatient attendants, Bernard soon developed a technique to get him out of bed and onto the floor within the requisite time period.

Lying on his back, he would start rocking back and forth, picking up momentum until he had rolled almost onto his side. At the farthest point in his motion, he would reach out and grab for the metal frame of the bed. Sometimes he would miss and have to start the rocking movement all over again. When he had finally taken hold of the frame, Bernard would pull himself over to the side of the bed. Poised there, he would make one final roll, off the bed, down onto the hard tile floor, maintaining his hold on the frame as he fell. Bernard did that so that the bottom half of his body, not his head, would hit first, absorbing the punishment of the impact.

Once out of bed and lying on the floor, Bernard had successfully fulfilled the requirements of reveille, but he still had the problem of navigating the one hundred feet to the bathroom. He still hadn't learned to crawl, and the attendant, even if she wanted to help Bernard, couldn't. For one thing, he was too heavy for her to carry. And besides, with sixty children under her supervision, there was simply no time for personalized attention.

Bernard had to use the only method of movement available to him. Rolling. Like normal children at play in a heavy snowfall, he would squirm until his body was pointed in the right direction, and then start flopping over and over. He would frequently have to stop, either from dizziness or to correct his direction. And the trip was fraught with other dangers. In the sleepy, early-morning hours, he wasn't easy to spot on the floor, and would often be stepped on accidentally or tripped over by the attendants or other residents hurrying to do whatever they had to do.

The bathrooms of Willowbrook are the single most unpleasant aspect of life in that institution. They are filthy, and they stink. Many of the residents aren't fully toilet-trained, but they realize that defecation is more acceptable in certain areas than in others. In the long, old-fashioned nightshirts worn by all the children, Bernard would have to roll around, or over, the feces of his co-residents as he made the long trip to the toilet. There, he would have to grab the rim of the bowl and struggle to pull himself onto the toilet seat. The only help he got was from the iron-stomached attendant who wiped him and the others and then lifted him off and back onto the floor. There to endure the three-hundred-foot odyssey into the dining area for breakfast.

The morning meal consisted of an oatmeallike substance. Once Bernard had successfully pulled himself into one of the chairs at the long dining table, an attendant would feed him with a shoveling motion: scoop, force open his mouth, drop, then scoop again. Bernard quickly learned that the secret to not gagging and choking on the rapid-fire feeding was to swallow as soon as a mouthful was placed on his tongue, whether he wanted to or not. Delay meant that the next spoonful would be dumped on top of the lump already in his mouth, parlaying it into an unmanageably large mass in his throat. According to Bernard, this forced feeding wasn't the work of sadists.

"Naaahot all the aahtendants are baaad peeeople," he explained. "Ttthhere wwwaahsan't enough help." The newly arrived morning shift, two people for sixty children, had to rush if they were to feed everyone and get them ready for the day. Some of the attendants were more caring and compassionate than others, although kindness under those circumstances is really remarkable, considering that they took home less than a hundred dollars a week to work in a cesspool.

"Theyyy had it rough . . . really rough," said the young man who had every reason to hate them. "I don't know why theyyy wooooorked in that place."

After surviving the ordeal of breakfast, Bernard would roll back into the "dayroom." It was the large and virtually empty space adjacent to the dormitory area. When all the children had assembled there, the attendants would dump the clean laundry into a large pile near the center of the room. The hill of clothing would be a haphazard collection of garments: gray shirts, pants, and nightshirts provided by the state, mixed in with more colorful and diverse garments donated by the Benevolent Society or some other charitable organization.

The ambulatory, higher-functioning residents would select their own clothing from the pile, often with tragicomic results. Little boys would often select brightly colored old ladies' dresses, while the little girls would frequently end up wearing a man's work shirt. The costumes just added to the insane, surrealistic-nightmare quality of life in the building.

Bernard could only roll himself into reasonable proximity with the clothing distribution point; he couldn't make the selection by himself. The attendants dressed him, almost always selecting an open hospital gown. He usually didn't get underpants. That way, he could go to the bathroom and manage most of that process without their help—help that would have been needed if the hard-pressed attendants had given him a pair of pants to wear.

Willowbrook, until 1974, was called a state school, even though very little formal education went on there. It's now called a developmental center—a much less ambitious and more realistic label. But there was a half-day of classes, even in Bernard's day, for those children who could make it to the classroom. For him, that meant more rolling, and more struggling once he got there, to get himself into his assigned seat. Because these young and very handicapped kids could neither read nor write and would have needed a tremendous amount of individual attention to obtain those skills, the classes consisted primarily of supervised play with educational toys: fitting the circle into the appropriate place on the board, the square into the square, and so on.

"Yaahhou noo whhat ahheye liked best?" asked Bernard. "The readin'." He answered his own question.

The teacher would read fairy tales to the ten children in his class. Most of the time, Bernard had no idea of what was being said. But the gentle, friendly voice was in dramatic and refreshing contrast to the din of the wards. For him, that was enough to make the long roll from the dayroom to the classes, located on the other side of Building 25, worth the trip.

The most unbearable aspect of his early years in the institution was the summers. First of all, there were no classes to relieve the plodding monotony of the dayroom. Then, there was the heat. New York's summers are naturally hot and sticky, and the constant hosing in the bathrooms, much like the keeper's hosing of the animal cages in the zoo, added dampness to the already oppressive humidity in the wards. There was no air-conditioning, and no screens on the small windows near the top of the walls. Mosquitoes and flies shared all Bernard's meals in Willowbrook.

Some of the ambulatory children were occasionally permitted to play outside the building. But only occasionally, since there weren't sufficient attendants to supervise them and still

94-420 O - 77 - 5

watch for the inevitable crises among the children left inside the building. So the grounds of the huge institution—green, open spaces dotted with big old trees—always seemed deserted. From the outside it still looks like an abandoned, haunted suburban college campus. In any case, Bernard never got out. To him, outdoors was the small, enclosed concrete patio adjacent to the dayroom.

Bernard's day always ended with a shower. The administration had decreed this mandatory—a daily shower for everybody. It was an effort to cut down the incidence of infectious hepatitis, which at the time was striking 100 percent of Willowbrook's residents, being transmitted by the human feces lying in piles everywhere.

In order to comply with this requirement, Bernard had to roll into a shower stall. The water would already be running. Once inside, to prevent himself from drowning, he would be careful not to lie on his stomach. Eventually, years later, he learned to pull himself up off the bottom and onto his knees. It was a milestone, and it led finally to his first heroic breakthrough. When he was about nine years old, he learned to crawl. Imagine his wonder at finally being able to point himself in a direction, and then move without undergoing the disorientation of rolling over and over again to get there. He had learned how to crawl by watching the babies and the very young children living around him. What had come naturally to them was mastered out of necessity by Bernard in just under four years. Even so, he was a very inefficient crawler. His poor coordination caused exaggerated movements in his arms and legs. When he moved, he looked like an old-fashioned steam engine spinning furiously but slowly up an icy grade.

But his newfound skill was important as more than just a means of locomotion. When the physical therapist on one of her weekly visits to the building noticed him crawling, he was implicitly taken off the list of the totally hopeless cases. It

ultimately led to a big change in his life. Within a short time he was transferred out of Building 25 and into Building 2, the big building that also housed the hospital.

Everything was better for him in his new home. There were fewer kids in each ward, and a much more comprehensive educational program. The 2½ hours of classes were supplemented by an hour or two of speech therapy or physical rehabilitation. But for Bernard the happiest thing about the whole move was that his best friend, Joey, was transferred along with him.

Joseph Cucchiara is the same age as Bernard, and, like him, is a victim of cerebral palsy, not mental retardation. Even before these boys learned how to speak, Bernard and Joey seemed somehow to understand each other, to take comfort in the other's presence.

They were constant and mutually entertaining companions. Cowboys and Indians was their favorite game. Bernard was usually the Indian/bad guy. They didn't have any of the usual trappings—no cap guns, cowboy hats, or anything like that. But pointing their cocked fingers at each other and ducking behind the benches or under their beds, they did manage to pass the time.

The boys taught each other also. They struggled together to verbalize, one of them learning a new word, then teaching it to his friend as they crawled along the floor.

Joey was the first one to walk. He took his first faltering steps at the age of eleven. Bernard, with the inspiration and guidance of his friend, learned shortly afterward. He would pull himself erect, holding onto his bed, or the back of a bench, or Joey's arm. Once he was standing, he would lurch forward, sometimes taking two or three or four awkward steps before careening back down to the floor. But he always got up. When the surface is slippery, Bernard still sometimes loses his balance. But he'd rather risk injury than resort to a wheelchair.

When they were about twelve years old, Bernard and Joey were transferred to Building 6. The prevailing feeling among the staff of the hospital building they had been living in, apparently, was that all that reasonably could have been done to rehabilitate the youngsters had been done. Besides, the space was needed for other, younger children who didn't even know how to walk.

Number 6 is the building I had seen on that first trip to Willowbrook. It was filled with older, bigger boys, some of them prone to violent, unreasoned outbursts; Joey and Bernard were terrorized there. Constant harassment and physical abuse became part of their daily regimen. The attendants, with some glowing exceptions, also seemed a more cold-blooded bunch. Perhaps it's understandable. In Building 25, at least, some of the children had been cute, or anyway smaller and easier to handle.

As Bernard's vocabulary grew, so too did his problems with the attendants. He would often complain to the building physician when one of them had been unnecessarily cruel to this or that resident. He and Joey were also becoming more doggedly independent. They would, for instance, sneak out of their beds after the official seven-o'clock lights-out. Sitting in a corner of the crowded dormitory or in the dark, empty dayroom, they would often talk for hours.

Their favorite conversation was about what they were going to do when they got out of Willowbrook. After a hundred evenings spent in grand speculation, they decided on a mansion in California. Since they had never consciously been off the grounds of the institution, it was a magnificent triumph of their collective imagination. With just the limited knowledge of the outside world gained from the old television set in the dayroom, they constructed an ideal future for themselves. Bernard was even thoughtful enough to provide them with a made-up maid and a conjured butler to help with the housework.

Late one night, as Joey and Bernard whispered and giggled about their blissful futures, an attendant caught them. While most of his co-workers would have either overlooked or dealt mildly with this minor rules infraction, this man exploded. It was as if the boys had been conspiring to humiliate him.

"What the hell is going on here?" he shouted upon discovering them sitting on one of the benches in the half-lit dayroom. "You again, Bernard? This time I'm going to teach you to stay in bed when you're put in bed!" Whap. He slapped Bernard across the face.

"Yyyyuuu kah . . . kahrayzee," was all Bernard could manage as he uncoordinatedly lifted his hands to protect his face.

The attendant pulled Bernard off the bench by his ankles, slamming him to the ground. Joey reached toward him to help. "You want some too?" asked the attendant menacingly.

"Leeeave himmm alone!" cried Bernard as he squirmed on the floor to free his ankles.

Distracted by Bernard's surprisingly vigorous struggle, the attendant started dragging him toward the dormitory, taunting him as they went. "You ain't going to get out of bed anymore. Are you, big boy?"

When they finally reached the sleeping area, he roughly tossed Bernard into a pile at the foot of his bed. With the skirmish over, the attendant walked out of the dormitory, laughing softly at his small victory.

Sticking to the shadows, Joey, who walked with the same awkward gait as Bernard, did his best to make his way to his friend's bed without being noticed. When he got there, he helped Bernard to straighten out. Since they were both so poorly coordinated, the effort caused them to jerk sideways and up and down like two dancers in an amateur puppet show. Finally, after a struggle, they were sitting alongside each other on Bernard's bed.

"You okay?" asked Joey.

"Yeah," answered Bernard. "You okay?"

"Yeah. I'mmm goin' to bed."

"Gaanite, Joey."

" 'Night, Bernard."

When Bernard was nineteen, he was transferred to Building 7. Similar in most respects to Building 6, it was located about a quarter of a mile away. By this time Bernard had learned how to dress himself fairly well, although he could not tie his shoes and had difficulty buttoning his shirts. But this achievement, however limited, added an extra dimension to his life. Since he could dress himself and was basically ambulatory, Bernard was permitted to walk outside his building. That meant he could still see Joey, either on the grounds or by visiting him in Building 6, where he still lived.

It went that way for a while, until Joey told Bernard the big news. He was leaving the institution. His family had signed the consent forms, and Joey was moving into an apartment on Staten Island. Bernard greeted the momentous tidings with an understandably mixed reaction. He knew that Joey, like himself, wanted desperately to be out of Willowbrook, but he was afraid he wouldn't see his friend anymore. Joey made everything right when he told Bernard that he would still be coming to the institution every day. The administration had given him a paying job as a janitor.

Joey's freedom was an inspiration and a goal for Bernard. Whenever he saw his old friend, Bernard would eagerly ply him with questions about what his apartment was like, and the buses, and the movies, and everything else. Now that Joey was experiencing what life on the outside was really like, they didn't talk about their California mansion anymore.

Bernard was still going to school. He wasn't as advanced as Joey, and still had problems with his reading. So for two and a half hours each day he went to his classes. Until he reached his twenty-first birthday. When he passed that milestone, Bernard

was no longer permitted to go to school. He was too old. The fact that he still was in dire need of more instruction was irrelevant. The rules were the rules, and Bernard was out.

When he had first been placed in the institution, his family had paid Bernard frequent visits. But these had gradually tapered off, until he saw his mother and brothers and sisters only occasionally. When he was informed that he could no longer go to school, Bernard did something he rarely did: he called his mother at home. He asked her to sign him out of Willowbrook. It was a dead-end street for him now, he explained; he couldn't even get an education.

Concerned and confused, Pedra came out to Staten Island to see her son and to talk with the staff social workers. They told her what she expected to hear. Bernard was ill-prepared to survive in the rough, tough world outside the institution's gates. So he stayed in Willowbrook, his first real attempt at getting himself out ending in failure.

Despite his disappointment, Bernard chose to follow Joey's example, at least in part. He also got a job as a janitor. But while his friend qualified for the minimum wage, Bernard, as a resident of the institution, did not. He worked three hours each afternoon, cleaning the slop in the bathrooms of Building 7, and for that he was paid two dollars a month. If you break it down, it comes to less than fifty cents a week.

At the time, Bernard was living in a twilight zone. As a working and relatively high-functioning person, he was in a social stratum above most of the residents, many of whom were severely and profoundly retarded. But he was also far below the exalted level of the attendants. This ambiguity, coupled with his intense disappointment at not being able to get out of the institution, caused Bernard great loneliness. The only person he could talk with was Joey—that is, until he met some of the new breed of committed young social workers who had started working in Willowbrook after the public outrage over

conditions there generated by Senator Robert Kennedy's visit in 1965. The kids were different from those usually attracted to positions that not only are low-paying but have the additional fringe detriment of atrocious working conditions.

These social workers worked hard to change Willowbrook from the inside. They knew they couldn't change the crusty administration, but they felt they could meaningfully affect the lives of some of the residents. A group of them spotted Bernard one afternoon hard at work with his mop and his pail in the bathroom of Building 7. One of them started complimenting Bernard on his thoroughness, speaking in the simple, flattering sentences grown-ups use when they talk to babies or house pets.

Bernard's response, after he got going, was, to them, surprisingly intelligent. Shocked, almost as if a friendly dog had started suddenly to speak to them, the social workers began to perceive him as a person of some potential. They offered Bernard a job as a messenger, at a heady new salary. Taking up a collection among themselves, the social workers were able to pay Bernard five dollars a week, which qualified him, by Willowbrook's standards, as a member of the nouveau riche.

More important than the money, Bernard, for the first time in his life, was spending time with people who had grown up outside a mental institution. Elizabeth Lee, Tim Casey, and Ira Fischer were all in their mid-twenties, and all were militantly committed to improving conditions at Willowbrook. They were political activists who had decided to channel their activism into something socially beneficial. Bernard became their resident expert on just how bad the quality of life was inside.

He angered and frustrated the social workers with the hapless story of his own experience, and curiously, these conversations had exactly the same effect on Bernard. It was as if he were also hearing the story for the first time. All his life he had seen and lived amid the crap, but the crap was always the norm. It didn't make him angry, because he had nothing with which to com-

pare it. Watching Liz and Tim and Ira reacting to his descriptions, Bernard came to realize a bitter, central truth. He'd been duped. All the pain and most of the unpleasantness in his life had been unnecessary. Willowbrook was not the best that society could reasonably offer the mentally or physically handicapped. It was the worst.

To fill the time when he was picking up the pieces of his emotional life, Bernard began getting more involved in the extracurricular activities of the institution, such as they were. The sewing class had scheduled a show of fashions made by some of the residents. The teacher, to stir up interest, had offered a prize of a new pair of shoes to the resident who sold the most tickets. While Bernard was too old to attend the class, there was no age discrimination against ticket sellers, so he energetically began canvassing the grounds. He needed a new pair of shoes, and besides, he didn't have anything better to do.

After work, late one afternoon, Bernard decided to go over to Building 6 in his search for potential customers. The social workers had told him that the staff physician there might be interested in a ticket or two.

Walking into his old home, the B ward, Bernard greeted Thomas, a mildly retarded young man who had been one of his closest wardmates. They talked for a while, their conversation interrupted occasionally as Bernard said "hello" and "how are you?" to passing attendants and residents he recognized from his tenancy in the building. Finally Thomas pointed out the doctor Bernard had been looking for. As he walked past, Bernard called after him, and with Thomas' help got quickly off the bench to talk with the white-coated young doctor.

"Excuse me . . ." he said. "Mmmy name is Bernard."

"Well, Bernard. It's a pleasure meeting you finally," answered the young man, smiling. "Elizabeth Lee has been telling me all about you. My name is Mike Wilkins."

"Helllo, Dr. Wilkins . . ."

"Just call me Mike."

Bernard, put completely at ease by the friendly manner of Dr. Wilkins, so unlike most of the other staff doctors, felt no embarrassment at making a pitch for ticket sales. The doctor, while explaining that he would probably not be able to attend the fashion show, did say he would take a few tickets anyway. Mike asked Bernard to bring them over the next day, which was payday.

Bernard was there first thing in the morning. Mike laughed at his promptness. "What did you think—that I was going to skip town?" Bernard laughed with him, explaining, tongue-in-cheek, that he knew the doctor was very busy, and he didn't want him to forget. Mike decided that he wanted six of the tickets, which were selling for $3.50. The purchase was a big boost in Bernard's sales campaign, and helped him, eventually, to win the pair of shoes, with total sales of fifty tickets. But more important, Bernard had made a friend. With their business dealings over, Mike told Bernard that they should get together. Bernard, thinking the doctor was just being polite, said sure, thanked him warmly, and walked back to Building 7.

The next day, Bernard had to make a phone call. It was his sister Jenny's birthday, and he had promised he would call her. She probably had no idea how great a sacrifice that promise was for Bernard. In order to make a phone call, he had to walk in his careening shuffle the half-mile that separated Building 21 from his home in Building 7. The phone outside 21 was the closest to his ward. After he had made his call, Bernard was resting outside the phone booth in anticipation of the long trek back home. Just as he was about to take his reluctant first step, he heard a familiar voice. "Hey, Bernard!" He turned. It was Dr. Wilkins.

Mike asked Bernard what he was doing, then asked if he would like to join him and another friend for lunch at Palermo's, an Italian restaurant out on Victory Boulevard.

"Nooo thank youuu, Mike," answered Bernard calmly, the tone of his voice giving no clue to what he was feeling inside. "I'mmm not dressed propurrly."

"That's okay. What about tomorrow?"

"All right." Bernard's heart was racing as he and Mike ironed out the details of time and where they'd meet. Bernard had never been off the grounds of Willowbrook before, aside from several short rides with his family when he was very young. Mike was offering a real-life view of a world Bernard had seen only secondhand.

The removal of a resident from the grounds, even if it was by a doctor, and even if it was only for a short time, was a discouraging project requiring compliance with a mile of red tape. First Mike would have had to fill out a volunteer form, because he was spending his own time on a resident. Then he would have had to ask the supervisor of Bernard's building for permission to remove him from the grounds, stating their prospective destination and expected time of return. Bernard, it should be recalled, was twenty-one at the time, and perfectly capable of making his own decisions about whom he was going to lunch with. This procedure was just another of the countless minor outrages at the institution.

To avoid the bureaucracy, Bernard met Mike outside, about twenty feet down from Building 7, and climbed into his car. Liz, the social worker, was already there, sitting alongside Mike in the front seat. In a happy mood, they drove to the Italian restaurant and sat down at a table for three. Although Palermo's can best be described as modest, it was full of wonders for Bernard. There were colorful prints of Italy on the walls, glittery goldlike little chandeliers that brightly lit the red-vinyl decor, and a menu filled with scenic shots of the Mediterranean.

After Bernard had been scanning the menu for a few minutes, Mike asked him what he wanted to order. Since Bernard was still having trouble with his reading, but was a bit embarrassed

saying so, he said, "Roast beef." It was the first thing that came into his mind, and while it wasn't exactly the house specialty, it was, luckily, on the menu.

After the meal, which Bernard describes as "fantastic," he began telling Dr. Wilkins the story of why he was in Willowbrook, and what it was like for him. Mike listened, not with anger so much as with anguish.

When one of the assistant directors of Willowbrook later reprimanded Dr. Wilkins for taking Bernard off the grounds without permission, the almost always composed young man experienced a rare outburst. "I had Bernard's permission. And, sir . . . so far as I'm concerned, that's the only permission I needed."

A month after that, in late December 1971, with Bernard as the catalyst and Dr. Wilkins and Elizabeth Lee as the leaders, many of the professional employees staged a low-keyed protest over living conditions at Willowbrook. The protest took the form, finally, of a list of grievances submitted to the administration, specifying the most glaring deficiencies. The official response was to terminate the employment of Mike and Liz, while temporarily suspending some of the other, and presumably less guilty, "troublemakers."

If the administration had calculated that the firings would end this infant upheaval, they had guessed very wrong. The protesting employees were joined on the newly established picket lines by hundreds of parents with children in those wards being cared for by Dr. Wilkins. He was a good doctor, they said, who only wanted to make things better for the children. It was the beginning of the first large-scale protest in the institution's history. When the administration refused to back down, more and more parents and employees joined in what was essentially a spontaneous expression of revulsion at conditions that for years had seemed inevitable. "We can do better . . . we must do better" became their unspoken slogan.

I was called to do the story, just a week after Mike had been fired; to be exact, it was January 5, 1972. I had met Dr. Wilkins a year or so before while covering a different story at the Public Health Service Hospital, where Mike had been working at the time as an intern. I was probably the only newsman he could think of when things started happening at Willowbrook, so he telephoned me with the information.

"Geraldo. You have to see this place."

"Tell me a little about it." I was frequently called with tips about supposedly "hot" stories, but after a couple of years in the news business I was more cautious and slower to excite than I had been in the beginning.

"It's awful here."

"How is it awful, Mike?" I was polite but slightly impatient.

"Well . . ." There was so much to say, I know now, that Mike's frustration was at having to select which of the many horrible realities to talk about. "The children . . ." he chose. "You should see the way they treat the children."

"Oh?"

"There are sixty or seventy retarded kids to a ward. And most of them are naked and smeared with their own mess."

"Can I get my cameras inside the place?" Children being abused had always been a "favorite" story of mine—the word "favorite" being used in the inverted news sense I spoke of earlier.

"I think so," Mike answered, and we set to planning how we could secretly get inside to film the conditions he had started to describe.

The next day, by the time Dr. Wilkins and Bernard had finished telling me some of the details of the time he'd spent in the institution, it was already four o'clock and dark outside. I looked at my watch, realized how late it was, and jumped up. "I've got to split, or I'll miss the deadline."

The early edition of the local news goes on at six in the

evening. We hurried, so we made it into Manhattan in forty-five minutes, with another forty-five minutes once we got in for developing the film; there was less than a half-hour to write the script and edit the film and get to the studio.

In the beginning of the report, I was fairly calm in my delivery. But as I talked about the conditions I had seen that day, calm exploded into fury. When I got to the part about Bernard, my voice cracked with pain and slurred with sorrow.

It was the start of one of the most massive local-news exposés in recent history. Within a few days every local newspaper, television news program, and national news magazine was reporting the obscene story of Willowbrook. When the story was first breaking and the public was learning the full magnitude of the horrors within the institution, I interviewed Bernard no less than four times. Although his speech was strained and difficult to follow, nobody, not even my news director, complained. Bernard was the undisputed expert, and he had earned the patience of the viewing audience by spending sixteen unnecessary years in what Senator Robert Kennedy had earlier labeled a "snakepit."

At first, the reaction of the State Department of Mental Hygiene was scandalously to resist the demands that Willowbrook be cleaned up. They claimed initially that the press reports were overstated and that conditions were not nearly as bad as we were telling people they were. But finally, in late February 1972, with extra millions appropriated by the state legislature on an emergency basis, the department dropped all pretense of denying the reality of the institution, and the painfully slow process of change began.

A month later, in March, Bernard's family signed him out of Willowbrook for the last time. He got an apartment on Staten Island, near his friend Joey, whom he still sees all the time. On the outside, Bernard didn't become Pollyanna. It was an extremely difficult time for him; nothing came easy, and there were

times when he wondered whether he hadn't been better off inside the institution. Willowbrook had been grim, but at least it was predictable, not like the mile-a-minute, dazzlingly uncertain outside world.

Finally, with help from his friends, things started to work for Bernard. He took additional speech therapy, improved his reading, and eventually got a job with One to One, a charity we had established to fund humane alternatives to institutional life for the mentally retarded. Now he's sort of the goodwill ambassador/public-relations man, giving speeches at high schools and colleges in the New York metropolitan area, drumming up support for the movement to improve the plight of the retarded.

On April 22, 1975, after more than three years of relentless pressure from the media and the federal courts, the Department of Mental Hygiene capitulated. The commissioner resigned, and the newly elected governor, Hugh Carey, announced that he was signing a consent judgment settling a federal lawsuit that had been filed on behalf of the residents of Willowbrook, shortly after Mike and Liz had been fired.

The federal court commanded that "straitjackets never be used again in Willowbrook, nor shall any resident be tied spread-eagled to a bed, or subjected to either corporal punishment, or degradation, or seclusion." It went on to prohibit "physically intrusive, chemical or biomedical research or experimentation," and to demand that "health and safety hazards be corrected, radiators and steam pipes covered to protect residents, windows repaired and screened, lead paint removed, buildings air-conditioned, and cockroaches and vermin be eradicated."

The major sections of the agreement stipulated that the population of Willowbrook, which had been more than six thousand, be reduced to no more than two hundred and fifty residents. It further stipulated that training programs be immediately instituted to prepare more than three thousand residents for their

return to society. And finally, the agreement called for the funding of more than two hundred small, community-based residences for the retarded, each housing no more than ten people.

Bruce Ennis, the counsel for the New York Civil Liberties Union, who had argued the case on the residents' behalf, said that the agreement "recognizes that retarded persons are capable of physical, emotional, and social growth." It was a historic agreement that stated, essentially, that there would be no more Willowbrooks in New York State.

The next day, I helped Bernard send off a telegram to Governor Carey, thanking him for his great humanity. We were all pleased, Bernard most of all.

TESTIMONY OF DR. MICHAEL WILKINS, INTERNIST, WAYNE MINER NEIGHBORHOOD HEALTH CENTER AND FORMER STAFF PHYSICIAN, WILLOWBROOK STATE SCHOOL, NEW YORK

Dr. WILKINS. It is very difficult to describe the conditions at Willowbrook which were in the utmost chaos, with any degree of order. The experience that the residents who live there have each day is unbelievable. Even if you work there your level of denial is so great that you find yourself not fully comprehending the atrocities.

I have grouped their experiences into the area of slavery, deceit, detainment, lack of privacy, disease, assault, absence of training programs.

First is detainment. Many of the people of Willowbrook were incapable of living independently on their own and required considerable amounts of guidance, although variable amounts. Many of them required minimal guidance.

This need for guidance was misinterpreted into a license by the institution to detain the people at Willowbrook in the same room and same building for the rest of their lives. They do not leave those rooms. They stay all day except for one brief period every day for what was called recreation which was to walk around the building. Some people did not get that everyday.

So that freedom to leave one's place of abode and walk down the street is not had by them. Those doors are locked.

The other aspects of detainment, as Senator Bayh referred to, was the "mental handcuffing", the overmedication which I can assure was widespread. It's almost universal because, if any of us living in this room couldn't go—we would probably need some of that medicine. It wasn't because they were retarded, it was because they were there. Straitjackets were for the same reason. Most of those people, in my opinion and I admit there is a wide diversity of medical opinion, but I think that anybody could go in there and say that there was no need and it wasn't right to have that number of people in straitjackets.

As for the lack of privacy—

Senator BAYH. Excuse me, could you give your medical assessment of the degree of abuse of that handcuffing by the drugs?

Dr. WILKINS. I don't think it has to be a matter of opinion. You can compare the percentage of retarded people of the same level of retardation who are not in institutions who receive those kinds of medicines which is on the order of about 5 or 10 percent and those people who are institutionalized. At Willowbrook about 60 or 70 percent of the individuals were receiving strong tranquilizers. Many more were receiving medications which were supposed to be for seizures but which also had the side effect of strongly tranquilizing the person.

The same kind of people in other settings do not require that kind of medicine.

As for lack of privacy, I would say this. The rooms were the size of this hearing room. There were two rooms in each unit, and within each building there were four units. Each unit held 60 to 70 people at that time.

The dayroom was where they spent their time during the day. It was bare except for some church bench seating arrangements. There were not as many church benches as there were individuals there. So many of them had to sit or lie on the floor.

Their beds were lined row by row. At that time there was no space between them but now because there is less overcrowding there are 3 or 4 feet between the beds. It looks like a barracks only worse. There is no place where they can put their personal belongings. They do not have any personal belongings. Many of them don't. Those who do, they are kept in a separate cage and it's released to them on Sundays when someone visits them. They can wear their own clothes then.

The lack of privacy is universal. Yet, at the same time they are not communicated with. They are never alone and there is never anyone who really spends time talking with them. The attendants are so overburdened.

It was my experience that in attempting to evaluate the people as individuals in order to decide what kind of programs might be appropriate for them, I would ask the attendants, "Does this individual talk and can they obey instructions?" She would say, "No, he has not said a word."

So I would take out my pencil and say, "What's this?" They would say "pencil." I would say "turn the light off" and they would turn the light off. No one knew what they were capable of doing. They were lying there.

As for disease, it was mentioned that 100 percent of the people within one of the State institutions contracted hepatitis. That was Willowbrook. That is probably the only institution where the question has been studied because of the research program on hepatitis. I strongly believe that that exists in every institution where the toilets are shared by 60 or 70 people. Those are the conditions under which hepatitis is spread. We do not have a vaccine for it so if one becomes exposed to it, one gets it.

There is choking because of too-rapid feeding. There are intestinal parasites. These were other common problems.

These are the kinds of public health problems that one encounters in underdeveloped countries where there is overcrowding and smearing of feces from one individual to another was the kind of thing that one found.

As for assault, those who have visited institutions for the retarded have probably been struck with the number of scars on the bodies of the inmates there. That was because of the beatings that they encountered both from other patients and occasionally from attendants who worked there. There is sexual assault. It is extremely common. One of the ways that you spend your time if you are a doctor there is sewing up lacerations.

As for the absence of developmental programs let me say this. These places are called hospitals and schools and yet 70 percent of the people in Willowbrook, half of them were juveniles, but 70 percent were not in any program. They were not going to school. Those who were in a program had a short-lived program. It would be a few hours a day and they would go back to the ward where nothing was happening. So the question I had was this, What good

was it doing them? The whole message was that this was a place where they were going to live their life out in that room and they would die. There was no hope. There was no point in sending them to school. That's one of the reasons why these institutions do not have very much school.

As for slavery, let me say this. These are called working boys and working girls. These were the less retarded people who were used to do the nitty-gritty work at Willowbrook. They cleaned the feces off of the residents. They hosed them down. They stripped them of their clothes after a meal. They had to wake up at 5:30 in the morning to get ready to prepare the meals and to clean up the latrine and get the clothing ready and so on. They were not being paid for that. They had to work long hours. They had no recourse. There was no one who would protect them from that.

It was not that the people who were doing these things to the inmates were bad people. It was just what was logical based on the conditions in the institution. The work had to be done. There were not enough attendants to do it. The attendants were not inclined to do it nor trained, certainly philosophically, and they had problems of their own. They were often recruited from ghettos. Their ability to work with other people was limited.

Let me talk about deceit. It's probably not a violation of a law but that is one of the chronic characteristics of institutions. The double-speak is really offensive. They call the place a school or developmental center when it's really a prison. You have euphemisms used by the staff in front of parents or visitors. They would call straitjackets camisoles. People who were in seclusion were said to be "sickbay." If someone was having a fit and needed to be subdued by three or four male attendants, it would be said "they are disturbed now would you please go and see them." Some attendants would go behind a locked door and subdue the individual.

As for the tranquilizers, not only is it a bad practice but it is deceptive. It is a lie. It is not a thing that will help those people. It is not helping them.

I have referred to more of the deceptive practices that went on inside of Willowbrook but I will close now because of lack of time.

Senator BAYH. We thank you very much Dr. Wilkins. Without objection, a copy of your written testimony will be inserted in the record at this point.

[The prepared statement of Dr. Michael Wilkins follows:]

PREPARED STATEMENT OF MICHAEL WILKINS M.D.

Conditions inside Willowbrook State School in New York were vividly displayed on television in 1972 when Geraldo Rivera boldly brought TV cameras into its closed wards. At that time Willowbrook was the largest institution for the mentally retarded in the world.

As the physician who gave Mr. Rivera the passkey to the closed wards, it is my conviction that the inmates of Willowbrook and similar institutions are systematically deprived of their rights. I am here today to review with you my observations of inmates' life at Willowbrook gained from my one and one-half years' employment there.

I have grouped the inmates' experiences into categories: detainment, lack of privacy, disease, assault, absence of training programs, slavery and deceit. Some of the conditions are criminal, others are shameful without actually violating the law. They all constitute an inhuman situation which badly needs reforming.

DETAINMENT

Most of the inmates of Willowbrook are incapable of independently living in society, so some limitation and guidance of their behavior is necessary. Characteristically in institutions, however, this need is interpreted as license to confine the retarded individual to a single room in a single building with locked doors for the duration of the individual's life. The inmates languish through hot days and cold, unstimulated by anything except the changing of attendants' shifts, meals, TV and other inmates. "Recreation" is a fifteen minute walk, supervised by employees, around the building or down the block. Less severely retarded persons are allowed one recreation session daily; those with profound retardation often are not taken out of the building for weeks at a time.

A corollary of this detainment policy is the need to medicate the inmates with strong tranquilizers in order to prevent "acting out". Thus when one walks on to the wards one sees many inmates sleeping on the floor along the walls, others sitting on church pews rocking as they stare aimlessly and only a few of the brighter inmates looking out the window, kibbitzing with the attendant or perhaps attempting to gain the visitor's attention.

A further corollary of detainment is the need for straight jackets. These were liberally used on many wards, and certain inmates wore them constantly.

LACK OF PRIVACY

The buildings in most state mental hospitals are designed to accommodate herds, not individuals. The day room is separated from the sleeping room by the latrine, ward office and utility closet. The day room is gymnasium-like, with a hard floor, seats in a row, a TV set and a couple of tables. The sleeping room is barrack-like, with beds in a row, separated by no space or by only several feet, depending on the degree of overcrowding. No drawer is available for inmates to store possessions except a central supply cage, where clothing is stored and where some inmates have a metal basket for their possessions. Inmates sleep in a different bed each night unless they are assertive enough to stake one out.

There are four such units in each building. Each building houses about two hundred and fifty inmates. A central dining hall serves all four units, with twenty minutes for each unit to feed. At no time can an inmate be alone, yet paradoxically it is seldom that anyone ever speaks to the inmates. I found several inmates who were considered mute but who could talk in sentences when prodded. No one had bothered to try to talk to them. Most attendants had favorite inmates to whom they devoted time and attention, but had to ignore the majority in order to achieve anything with a few.

In this nightmarish society, canons of behavior developed among the inmates which involved complex pecking orders based on one's physical prowess, one's standing with the attendants, one's ability to bluff and one's ability to find a symbiotic protective relationship with one of the stronger inmates.

DISEASE

One hundred percent of inmates contract hepatitis within six months of entering Willowbrook. This fact was used to justify a hepatitis research project in which fecal material and blood known to contain the hepatitis virus was injected into new arrivals to study the natural history of the disease. Aspiration of food due to rushed feeding, intestinal parasites, epidemic diarrhea and viral diseases were institution-caused diseases to which all inmates were subject.

ASSAULT

Visitors to Willowbrook and many other state hospitals are struck by the maplike scars on most inmates' bodies. The sewing up of lacerations is one of the principal tasks of institutional physicians. Pokes and blows from other inmates as well as beatings from attendants are the source of these blows. Every inmate lives in fear of being beaten. The more capable inmates are beaten by the attendants if they do not work, and the profoundly retarded inmates are beaten by the more capable inmates.

Sexual assault of weaker inmates by the stronger is common practice. Resistance led to many of the lacerations which were seen.

ABSENCE OF DEVELOPMENTAL PROGRAMS

Only thirty percent of the inmates of Willowbrook were involved in a program when I was there. Most of these programs lasted just a few hours a day. The remainder of the day, the inmate remained idle in the day room along with the majority who had no program. The message was clear to the inmates: the program is a hoax, because there's no future for you but the day room. Why learn anything?

SLAVERY

The "working boys and girls"—brighter inmates who were used as laborers by the staff—awoke at four thirty each morning. Some went to the kitchen to begin preparing breakfast, some sorted out day clothes for the naked sleeping inmates, some cleaned up the latrines' nightmess. They would work at their assigned task seven days a week if it involved ward work, because life on the wards went on endlessly. The luckiest workers were those assigned to the main administration building or as messengers. Theirs was an eight-hour day. Inmates performed the distasteful tasks at Willowbrook, but received no compensation in most cases.

DECEIT

The crowning outrage of Willowbrook and similar human warehouses is the dooublespeak. This is seen in the admixture of artefacts: near the front door of each building is a well-equipped medical treatment room with nurse and doctor in attendance. But beyond the metal doors of the dayrooms one encounters keys, broomhandles, wrist restraints, gallon jugs of liquid tranquilizers, straightjackets, heavy wirecovered windows, wet towels used as whips and open latrines.

The place was called a school, but the conditions were the antithesis of a learning environment . . . . attendants' white uniforms were a mere reminder of cleanliness and hope in that pit of filth and despair . . . . tranquilizers were dispensed with great fanfare as if the next dose might bring a cure, when in reality it was for ease of containment that the inmates were medicated . . . . misleading institutional euphemisms were used when parents or visitors were present (straightjackets were camisoles, a disturbed inmate was one who needed immediate subduing by several attendants, solitary confinement was called sickbay) . . . . tours for visitors were limited to model programs . . . . the oldtime supervisors always had pious sounding reasons for refusing permission for day trips: "Last time we tried taking them to the park one got shortchanged by a hotdog man, so we put a stop to their going" . . . .

Committee members are invited to view the films which have recently documented these conditions. I believe that our Willowbrooks point to a crisis of will in our society more than merely a gap in legislative coverage. In human rights, however, it is law that sets the norm. Perhaps by filling in the legislative gap which has deprived our institutionalized citizens of their human and civil rights, we can redefine their situation in a way that will inspre us all to see them as people. It is only when such a redefinition occurs that the conditions I've outlined here today will become obsolete.

Senator BAYH. Mr. Carabello?

Mr. RIVERA. I met Bernard Carabello when Dr. Wilkins first brought me to the working school. At the time I met him he was 21 years old and he had spent the 16 years between age 5 and age 21 in the institution, totally because his condition had been misdiagnosed as mental retardation when in fact he is a victim of cerebral palsy. The packaging may be bad but there is nothing wrong at all with Bernard's mind.

So, Bernard, would you give us your testimony.

TESTIMONY OF BERNARD CARABELLO, VOLUNTEER ONE-TO-ONE, FORMER RESIDENT, WILLOWBROOK STATE SCHOOL, NEW YORK

Mr. CARABELLO. The time was overcrowded and there were severely mentally retarded people in the ward. There were only two attend-

ants to take care of the people. It was impossible for them to take care of all of them.

We had only 2 or 3 minutes to eat because they had fed something like 40 residents who could not feed themselves. When they fed a resident they would mix his or her food, bread, soup, or whatever else, all together on one plate.

There was no time for them to teach him or her how to feed themselves.

Senator BAYH. Let me get this clear. I think the message comes through loud and clear.

What you are saying is that for those who were physically unable to feed themselves, there was first of all no effort made to try to teach the individuals how to feed themselves?

Mr. CARABELLO. Right.

Senator BAYH. And second, the food was cut up and mixed up on the plate without any reference to whether it was dessert or main course. It was all mixed up.

Mr. CARABELLO. It was mixed all together.

Senator BAYH. And they shoveled it down in 2 or 3 minutes.

Mr. CARABELLO. Right.

I could feed myself but I'm speaking about the other persons who could not feed themselves.

It was shoveled in and it took 2 or 3 minutes to do this.

We have been taught to eat like that through the years.

Mr. RIVERA. If I may interrupt, one of the results is this. The most common cause of death was pneumonia caused by food fragments getting into the lungs and subsequently becoming infected and causing pneumonia and death by pneumonia.

Mr. CARABELLO. When feeding time came it would be four wards—A, B, C, D and then 01 and 02 and so on.

C and A would be the high functional. Those would be the people who could go and pick up their own trays. The other wards would be the nonfunctional.

If a patient would run out into the dining room and grab the food off somebody else's tray, then he would take that food and shove it down his throat.

If an aid would not get to that patient in time, then he would automatically choke to death. I have seen it happen.

Most of the time—and I know this for a fact—the parents would ask about "How did my child die?" They would have to say, "Natural death."

They covered this up so they would not get in trouble with the people in Albany.

The conditions were of no clothes, kids laying on the floor, and if a kid was not in an activity like a school or a program, then they would stay and mess in their own feces and urine. The attendant would get a "working boy" to clean up. Half of the time they did not want to do it.

As Dr. Wilkins said, he talked about the straitjacket.

I was in a straitjacket for a month. I know people who were in straitjackets for 5 years. They do come out of a straitjacket but only for a half-hour and after the half-hour is up they go back into the straitjacket.

Senator BAYH. Mr. Carabello, I know it's difficult for you and I appreciate the extra effort you're making.

I understand that you said that there were incidents of people actually having food thrust down their throats and their windpipes and actually choking to death.

Mr. CARABELLO. I said if the door was left open to their ward, then they would run out into the dining room and grab the food and shove it down their throat and choke to death if nobody would see it.

One time a "working boy"—residents who work—was feeding another resident. The "working boy" continued to feed the resident while the resident was having a seizure and the resident consequently choked to death. This incident was not reported in this manner.

Senator BAYH. I see.

Dr. Wilkins, did this kind of occurrence happen while you were there? Did you actually have patients choke to death because of lack of attention?

Dr. WILKINS. Yes. The younger residents within the first year or two of coming to Willowbrook either learned, as Bernard referred to, how to swallow a large amount of food rapidly or they died. It was that simple.

Mr. Rivera filmed this as part of his series on Willowbrook. It was a feeding. It is commonplace. The attendant did it as they always do it. That is the way it is done but very rapidly. In about 2 minutes you have eaten your whole meal. You ladled it in large spoons into the person's mouth, and they sit there like little birds in a nest with their mouth open and it is shoveled down their mouth. They swallow it without chewing it and then they are ready for the next portion. That's the way everybody—the severely and profoundly retarded people—eat that way. Naturally sometimes the same thing that causes them to be retarded might not let their muscles work as they should and they might aspirate and get pneumonia. It's common.

Senator BAYH. Is that a normal way to ingest food even if you're not mentally retarded?

Dr. WILKINS. Obviously not.

Mr. CARABELLO. I live in my own apartment now but I still eat like that after 16 years. It is so hard to break out of that habit. When my friends and family come over and they tell me that the food will not run away from me. They will tell me that I have 4 or 5 hours to eat. It is hard for them to understand that after doing this for so many years, it is hard for me to break out of that habit. I do choke on my food. I have to run into the kitchen real fast to get a drink of water so I can get the food down.

Senator BAYH. We thank you, Mr. Carabello.

Mr. CARABELLO. I forgot one other thing. When they shower, I have in my written statement that they scrub the floors with this material. They would use the same material to scrub the residents themselves. They would be so sure about this and it happens all over the place.

Senator BAYH. We thank you.

Gentlemen, frankly, I do not think I have any questions. Answers are evident and so is the problem.

Senator SCOTT. Mr. Chairman, I would share your thoughts and thank each of the gentlemen for being here.

Senator HATCH. Likewise I thank you. It has been a revelatory meeting.

I would like to compliment you, Mr. Rivera. I read most of your article on "Profiles of Young Americans." Dr. Wilkins, we appreciate your coming.

Mr. Carabello, we certainly appreciate your presence.

Senator BAYH. Thank you very much. I can't tell you how much we appreciate the contribution.

Without objection, the prepared statement of Mr. Carabello will be inserted in the record at this point.

[The prepared statement of Bernard Carabello follows:]

PREPARED STATEMENT OF BERNARD CARABELLO

This is just a brief statement. I will have more to say when I testify at the sub-committee, Friday, June 17, 1977.

A DAY IN WILLOWBROOK

I got up at about 5:00 a.m. in the morning. I got dressed first then I had breakfast. We had 4 to 5 minutes to eat because of the lack of help and the over-crowded residents. The way they woke us up in the morning was—they put the lights on (3 rows of lights) or sometimes when they put the lights on, they got wet towels or sticks and they hit us with it to wake us up. Sometimes there would be one attendent to 67 or 70 severely and profoundly retarded people. Sometimes I, myself, would have to be an attendant. I would have to do the same work as they did, but not being paid a salary they got. We were paid about $2 per month. If you did not help, they got mad. Sometimes they would hit us to force us to do what they wanted us to do.

I was one of the lucky ones because I had something to do during the day. There were a lot of residents that did nothing but sit on a wooden bench and rock all day. Some people were picked by their I.Q. It depended on the kind of people doing the picking. There was activity once in a while but not that much.

At lunch time, when they fed the residents, they would take the food and mush it all together and then feed it to the residents because to them it was the only quickest way to feed the residents that could not feed themselves. There were 30 to 35 people that could not feed themselves.

There was very little clothes on the wards. Sometimes it was hard to keep clothes on the residents because some residents did not like to stay dressed.

There was 3 shifts—the day shift, the 3:15 shift, and the night shift. At the 3:15 shift, they would come in and take over the day shift—they would have a head count sometimes. By state law, a head count is supposed to be taken after every shift. There were times a head count was impossible because the kids would still be out with the gym men. When the 3:15 people came in, they had 45 minutes to one hour sometimes doing nothing. Some people came in standing around and doing nothing when they knew there was something to be done every minute of the day. From 3:15 to feeding time, there was really nothing to do for anyone at that time.

At feeding time they would set up lines of the trays in the dining room on the rail, which was not supposed to happen. They were supposed to wait until we entered the dining room and then if a resident would walk up to the counter and get their own tray and bring it back to the table. This happened the majority of the time in Willowbrook. Everything had to be done so fast so that they could sit down for the rest of the night with nothing to do. After we ate, then they would go out for their dinner. By state law they were supposed to have ½ hour for dinner, but sometimes they took more than the ½ hour. When they came back they gave us a shower.

They got a pail they used to scrub the floors and they filled it up with soap and water (the same pail). They used this to clean the residents and then they would stick them under the shower. Sometimes they had towels to dry them off or sheets or they went to bed drip-dry.

I had to get my own clothes and hide them so that I had something for the next day. There were times I had to look out for myself.

Senator BAYH. Dr. Wilkins, I understand you were discharged for bringing this matter up. What are you doing now?

Dr. WILKINS. Yes; I was discharged. I work in the Neighborhood Health Center in Kansas City and I am a specialist now in internal medicine.

Senator BAYH. I would think you would have had a lot of experience with internal medicine with the kind of problems you have described to us.

Our next witness is Mr. Kenneth Donaldson. For the record, Mr. Donaldson was confined involuntarily to a mental institution for 15 years before being released. I think you would call the case that Mr. Donaldson brought to the Supreme Court, *Donaldson* v. *O'Connor*, a landmark case. It held that an individual who has committed no crime, is not dangerous to himself or others, and who could survive in society alone or with the help of willing family members or friends, has a constitutional right to his freedom, and that this right may not be abridged by any State commitment statute or other procedure.

Mr. Donaldson, I know you are under time constraints. It has been an inconvenience to you and I appreciate the fact that you are here and the fact that you have provided us with your book. It makes dramatic reading.

Why don't you proceed?

TESTIMONY OF KENNETH DONALDSON, AUTHOR, LECTURER, FORMER PATIENT, FLORIDA STATE HOSPITAL AT CHATTAHOOCHEE

Mr. DONALDSON. I am glad that I followed these people who have testified because they tell poignantly what I saw for 15 years.

I have been out 6 years from the hospital after spending 15 years there. I would like to say parenthetically that I am in the same condition today as I was when I first went into the hospital. There was absolutely no need for me to be locked up. The State law said I could not be locked up and it's the same with hundreds and hundreds of my friends on the ward.

I see more and more——

Senator SCOTT. Mr. Chairman, might I interrupt the witness and ask this? How were you committed? Was there a complaint by some relative? Could you tell us that?

Mr. DONALDSON. Yes. After I had been locked up for 3½ years in the hospital, I got a copy of my commitment papers from the Florida State Supreme Court. I found out that my father had signed a paper requesting that I be examined. It was not an arrest warrant or a commitment order at that time.

Senator BAYH. How was that?

Mr. DONALDSON. I was put in the Pinilis County jail.

Senator BAYH. At what age?

Mr. DONALDSON. On an illegal paper.

Senator BAYH. But how old were you?

Mr. DONALDSON. Forty-eight years old.

Senator SCOTT. Was there a court hearing before you were put in the institution?

Mr. DONALDSON. I had two kangaroo court hearings while I was held in the county jail for 5 weeks. That's the only place they had to hold the so-called crazy people at that time. During that time on two separate occasions, there were 2-minute interviews with doctors that were making the rounds in jail and stopped and talked to me through the bars of the jail cell. They were not doctors who, as far as I know, were the ones who had signed a sanity committee report.

Let me go back a few days to tell the legalities.

The third day I was held in the jail—I didn't know why I was there in the first place. But the third day I was held there the county judge appointed a sanity committee of two doctors and a deputy sheriff. They swore under oath that they had examined me thoroughly mentally and physically. They found these various things wrong with me. They had never seen me. I would not know them and they would probably not know me.

I was locked up 2½ years before I knew that much.

The county judge came by on the regular visit to the jail, after I had been in there several weeks. I didn't know who he was until he got through talking to me. He asked me a few questions. He said that because my father thought that I needed a little rest or that there might be something wrong with me that he was sending me up to the State hospital.

He walked out of the jail cell. I yelled at him. I did not know what Florida law was. I was a resident of Pennsylvania and New Jersey.

I demanded a trial or a sanity hearing or some kind of a trial. He asked me if I wanted one on the court house steps. I said that that would be better than this.

Anyway, he relented to the extent that he had another hearing for me down in the visitors' room. I was held in a caged-in section of the visitors' room. We had the judge and the lawyer who had agreed to be my counsel and they walked in. The lawyer said nothing during the interview and walked out when the interview was about half over.

When we got through, the judge unlocked the cage of the cell that I was in or the wire enclosure and started talking to me and he said he was going to send me up to the State hospital for a few weeks. He knew that after I took some new medications that I would be all right and be back on the street again.

That is as much as my constitutional rights meant.

Of the four of us that went up to the State hospital together, two deputy sheriffs woke us up in the middle of the night and drove us up. I was the only one of the four who had even had that much communication with any official. Florida law at that time said that such a thing could not be done. I was the resident of a northern State and Florida law said at that time that I could not even be put in the State hospital.

I get around the country quite a bit now and I speak and I meet ex-patients. I meet groups in many cities here and there around the country. Groups are doing something now. We have new laws which supposedly guarantee that these things cannot happen to people. But these laws are not being respected. They are not being lived up to.

The doctor at the hospital says that the law does not apply to whomever he happens to be talking to at the moment. There are

lawyers provided by the States in several States. New York State is one but I'm not sure about Pennsylvania as to what they furnish for patients.

But these lawyers almost invariably, after they have talked to the patient, will go talk to the patient's doctor and will listen to what the doctor says. I hear this from patients who are still locked up. I hear it from ex-patients from around the country.

The doctor will say that the patient is not quite ready to leave. That is the end of the patient's legal and constitutional rights.

There are not enough people available to guarantee the rights that the Supreme Court ruled in my case. The Supreme Court said that people could not be locked up against their will if they are not dangerous. There are not enough people to enforce this.

As to how to determine the problem, Senator Hatch asked about the toothbrush. It's not a matter of getting a toothbrush. It is a matter of people who do not want to be locked up. No one is listening to them.

You talk about there being jailhouse lawyers. But the courts do not accept these petitions very often. They go into the wastebasket.

Next Monday, I'm going to see a patient who has been locked up over here in Jessup, Md. He thinks that maybe I can bring a little influence to help him. He has had his petitions in the court. He does not want to be locked up. He writes a lucid letter, but the courts do not listen. There is no lawyer to take his case. He is not dangerous. He doesn't want to be there.

Senator BAYH. Mr. Donaldson, let's make sure we keep the record straight. You mentioned jailhouse lawyers but you were not in the jailhouse. You had not committed a crime. I'm talking about your particular case; is that right?

Mr. DONALDSON. Yes.

Senator SCOTT. You say the judges throw the petitions in the wastebasket. Do you have any evidence to support that? I'm talking about a habeas corpus petition. Do the judges throw that in the wastebasket?

Mr. DONALDSON. Yes. Florida State law guaranteed me that right to a habeas corpus.

Senator SCOTT. I think this committee would be interested in having any evidence of that with the names and the instances.

Mr. DONALDSON. Nineteen times during the 15 years that I was locked up—alone and with the help of lawyers outside—we petitioned the courts both State and Federal. Never once did I have a hearing in court that the Florida law guaranteed me.

As I pointed out in my written statement, the Justice Department several times refused to enter the case. Four times we appealed to the Supreme Court of the United States and four times they refused to hear the case.

Senator SCOTT. You're saying that the U.S. Department of Justice refused to enter the case?

Mr. DONALDSON. Yes.

Senator BAYH. How did you get out?

Mr. DONALDSON. The Federal reasoning was at that time that they couldn't handle cases pertaining to mental illness and the Justice Department went along with that.

CONTINUED

1 OF 12

I kept pointing out that in my case it was not a case of mental illness.

Senator BAYH. How did you get out?

Mr. DONALDSON. Eventually Dr. Morton Birnbaum who was both a doctor and a lawyer in Brooklyn took an interest in my case. He took charge of the case about 4 years before I finally got out.

Then in the 19th round of appeals to the Supreme Court, the American Civil Liberties Union and three other organizations came in with amicus curiae briefs.

Then, as we figured, the Supreme Court must have realized the case had been around so long and all these people were getting interested that there must be something to it.

They allowed us to go back to the local district court. The Supreme Court did not send it down but they gave us permission.

After some skirmishing, the Federal judge in Tallahassee let us institute a suit for habeas corpus. About 10 days before I was to appear in the court room, the hospital released me. Bruce Ennis from the ACLU said that I was "miraculously cured."

I would like to say something that is a little bit further than what this committee is requesting. I feel very strongly the need for this legislation because I see that no one else is able to do the job at the present time. But my friend Morton Birnbaum, who more than anyone else is responsible for my being here today, asked me, after I had submitted my written statement, to add this addendum.

He points out that all of the criminals in this country are guaranteed legal representation, before they are in their prisons and out. I mean before they are put away and after they are in the prisons.

Those like myself—and I want to underline that most of the people who were locked up with me are no different than I am except that I was more literate—need help. He suggested that the next step which he thought was even more important than the law that you have today and I'm giving his opinion because he has been one of the fighters out in front in this field. He suggests that the Justice Department be able to step into any case to help these people.

As your first witness today said, just the fact that they are successful in one case and they threaten to bring another case, then people would be guaranteed their constitutional rights.

Senator BAYH. You mentioned, Mr. Donaldson, that there were other nondangerous patients capable of coping outside of an institution who are like you. They were confined and yet could have sustained themselves outside the institution. You were released. Have all these other people been released or are some of them still there?

Mr. DONALDSON. Most of my friends died there, but quite a few have been released. The population around the country is down about two-thirds from the time I was first locked up—from around 600,000 to around 200,000 today. That is the same ratio in the hospital I was in—from 6,800 to around 2,000 today.

However, while most of the people who are still locked up are either geriatric or emotionally disturbed, many of them got that way just because they were confined.

Many people have problems, but these people were not so-called "sick" before they went into the hospital. Many of them have been destroyed.

When I went to Harrisburg State Hospital for the first time about 3 years ago, I spoke up there. I have been up there twice since and visited on the wards. These people are still locked up although the total population in the Pennsylvania hospitals is down, probably in proportion with the rest of the country. But these people come up to me when I'm here and tell me that they cannot get out. They are not dangerous people. They do not threaten anyone. It was the same problem I was up against.

Laws are dealing with the problem, but the laws are not being lived up to. We still have a misconception and as long as the public has the misconception as to what the State hospital is and what it is supposed to be doing, then these people will stay there under the misconception that it is a medical problem. It is not a medical problem. They are there for social problems. These people are socially unpalatable. The Supreme Court says that they have the right to be on the street. I would like to see this law passed so that someone would help them.

Senator BAYH. You mentioned the absence of treatment. During your 15 years of confinement, did you receive any psychiatric treatment or did the other persons?

Mr. DONALDSON. No, sir, there was no such thing.

Senator BAYH. There is something called milieu treatment; what is that?

Mr. DONALDSON. The Supreme Court defined it in their opinion on the case that "milieu therapy" meant being locked up with other crazy people.

Senator BAYH. That's the kind of treatment you were getting?

Mr. DONALDSON. Yes. We talked about people being overdrugged. Drugs were used as a housekeeping matter to keep peace and quiet on the wards.

Senator BAYH. Was the terminology "milieu treatment" used in response to a question to the staff of the hospital when asked what kind of treatment you were getting?

Mr. DONALDSON. What is that?

Senator BAYH. It is my understanding that the "milieu treatment" terminology was not first phrased by the court. It was phrased how?

Mr. DONALDSON. In their defense that is what the doctor said.

Senator BAYH. They said you were getting treatment and it was that kind of treatment; is that accurate?

Mr. DONALDSON. That is the only kind of treatment that they had for me.

Senator BAYH. In other words, the kind of treatment they were relying on was to lock you and others up with crazy people and they called that treatment; is that right?

Mr. DONALDSON. Yes.

The thing that is almost universally used is the tranquilizer drugs. They are powerful. They are harmful. Anyone who takes them for a long period of time will have one part of his body destroyed.

As I understand it, they affect the heart of one person and the brain cells or the kidney or the liver of another person. Nobody takes them for very long but what he is permanently hurt.

Senator BAYH. Senator Scott?

Senator SCOTT. You indicate that you travel to various parts of the country. Do you find this to be a general situation? Are you describing the exceptional case? To what degree do you feel that the conditions you have described happen around the country?

Mr. DONALDSON. I would say that the condition is still the same as what I was up against. I get letters every week. I get phone calls quite often from ex-patients and from family members of patients from different parts of the country. All have the same problem.

I know of only two people, of all of those who have come up to talk to me after I have lectured—and there have been no telephone calls the other way—of two people who have ever said that they were glad they went to the State hospital.

Senator SCOTT. I have had limited experience but I have attended a number of hearings when I was in private practice of law. What was then called our county judge is called a district court judge now and he was very scrupulous in observing the law in Virginia. He would ask the person who was under consideration for commitment by some relative and in each instance there was a relative, a husband or wife, and they were bringing the action in the county court. He would ask the individual whether or not they wanted an attorney.

I suppose there were perhaps about four instances that I was present at. These are private hearings. But there would be some private physician. There would be a public physician and there would be the judge. They worked as a board.

The individual against whom the action was being brought would be asked what they had to say. Then the person who was bringing the proceeding would be given an opportunity to be heard.

I saw no irregularity at all in these instances. Ordinarily the court would commit them for a temporary period of time. The statute under which the action was brought was this. If in the opinion of the court they would constitute a menace to themselves or to society because of some problem dealing with intoxicants and if they were a habitual drunkard wherein they might be caused to harm themselves or others, then that would be the case. I have not had much experience outside of my own local jurisdiction in Virginia.

Is that the general procedure used or are you saying that that is an unusual situation where this exists?

Mr. DONALDSON. You mean that these people got a hearing and had a chance to talk themselves and had a chance for an attorney?

Senator SCOTT. Yes. Usually the instances that I have participated in were such that the husband or wife bringing the action are in tears because it is somebody that they love. They're having them committed for treatment. They are unable to deal with the situation.

This is the reverse of what you have been telling us. I just wondered to what extent the conditions you mentioned are true and to what extent the conditions that I have mentioned are true because there is a considerable difference. Admittedly I have had little experience here.

Mr. DONALDSON. From what I hear, Senator Scott, it is still largely the way I say. There are instances like that. I was up in Williamsport. I was on a panel up there. I talked to parents of some 20-year-old man whom the county judge would not commit under the new

Pennsylvania commitment laws because the man had not been dangerous.

But they are very rare.

Senator SCOTT. Do you think that the bad conditions that you describe are general throughout the country?

Mr. DONALDSON. Yes.

I have been serving with another ex-patient and quite a few professional people on the committee for the American Bar Association—the Commission on the Mentally Disabled. They have been supervising the allocation of funds to set up pilot advocacy programs for so-called mental patients. All of these applications from 50-some bar associations across the country say the same thing.

You have some people here from southern California who will talk more about their problems. But the bar association there in Los Angeles County said that patients' rights are merely cosmetic. It is written in the laws. But they are getting around it.

Senator SCOTT. Mr. Chairman, I would commend the witness for being here and sharing the experience that he has had. I want to thank you for coming.

Mr. DONALDSON. Thank you.

Senator BAYH. We thank you very much. We appreciate not only the contribution you are making to our committee regarding this bill, but also your continuing efforts on behalf of mental patients across the country. We are like the Lone Ranger and we hope we can bring in the cavalry.

Without objection, a copy of your prepared statement will be inserted in the record at this point.

[The prepared statement of Kenneth Donaldson follows:]

PREPARED STATEMENT OF KENNETH DONALDSON

I am pleased to testify about the need for passing S. 1393.

I speak from intimate knowledge gained during nearly 15 years of illegal and unconstitutional incarceration in a state insane asylum in Florida, whose name was changed during my stay from asylum to hospital, in many ways merely a euphemistic transition.

My involuntary stay in the mental hospital was from January 1957 to July 1971. There were Florida statutes, all during those years, that said such a thing could not be done to me. Yet, in 19 rounds of appeals to both state and federal courts, during those 15 years, including on four occasions to the Supreme Court of the United States, no court would give me the first honest and aboveboard hearing to see whether I needed to be locked up. My several appeals to the Justice Department were met with the reply that there was no federal matter involved. Some of my appeals were brought to the attention of the Attorney General by his close personal friends. Invariably, the reply always came from some lower level saying that there was nothing the Department could do. I don't know what brought the change in the Justice Department, but I am nevertheless pleased that they have been bringing—and winning—some of these cases. My testimony is for the need for legislation enabling the Justice Department to continue to bring such cases in the fact of adverse rulings in 2 lower federal courts.

While my own battle for freedom was finally won in federal courts as an individual, it has also been brought as a class-action in behalf of thousands of my fellow patients in Chattahoochee, Florida. As it was then, so it is now. My steady flow of mail and phone calls from around the country, from people being held—and abused—in institutions, and from their families, shows that the same conditions as obtained in Florida in 1957 still obtain in much of the country in 1977.

My own case came to trial in federal courts after my release from the institution. Morton Birnbaum, a doctor and lawyer in Brooklyn, got the case into court in the first place. Bruce Ennis, lawyer for the New York Civil Liberties Union and the Mental Health Law Project, handled it in the courtroom, and won. He was assisted by Paul Friedman, lawyer in charge of the Mental Health Law Project. Based on the facts in my case, the Supreme Court ruled, June 26, 1975, that a nondangerous person has a right to his liberty from a mental institution. The Court said:

"A finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."

(and further)

"In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." [*O'Connor* v. *Donaldson*, 422 U.S. 563 (1975)]

Members of the Committee, let me tell you some of the things I learned about denial of Constitutional rights during the 15 years.

I am just as crazy today as I was then. I was locked up on the sworn report of doctors who had not seen me. For 15 years, one of the reasons hospital doctors said I was sick was because I kept saying that the committing doctors had not seen me, whereas the commitment papers showed otherwise. My case varies in details only from those of thousands of my fellow patients. I was more articulate than many of them. Otherwise, they were no more mentally disturbed than I am today—no more disturbed than members of this Committee.

As I have said, I am the same person today. But I would not be here if the hospital doctors had forced medication on me. Except for a 10-day period during my tenth year, the doctors respected by belief in Christian Science and did not force medication on me. (Incidentally, there were no court rulings nor statutes to that effect in 1957, I believe.) Most of my friends on the wards would have been unable to appear with me because they died in the institution, from the strong medication combined with the abuse of confinement—poor food, noise, crowding. I emphasize that these were men who were not so-called "mentally ill." These were men who did not want to be locked up, men who did not want medication, men who died in the institution because there was no one to step in and fight for their right to be alive and free. Occasionally today, former institutionalized patients stop in to see me or I meet them in other cities. I mean, these are expatients who bemoan the fact that they have been permanently crippled by the hospital medication, some hurt permanently physically but at least off the stuff, some permanently addicted and being gradually destroyed as surely as if they were on narcotics. I am saying people today are still being forced to take these medicines against their will, people who do not want them, who do not need them. This is one of the basic Constitutional rights that is still going by the board for many of the 800,000 people who go thru our state psychiatric systems every year.

By 1977, there are a few state laws here and there that allow institutionalized patients to refuse treatment. How well they are being lived up to, I could not say. In Massachusetts, a group of expatients has a case in Federal District Court, in its second year now, in behalf of 7 patients patients in Massachusetts State Hospital, in Boston, for their right to refuse medication. As for other states where laws now give this right to patients, I would venture the guess that these new laws are no more widely respected than other laws concerning mental patients.

I will cite some incidences. I am presently serving on a governing board, along with another expatient and many professionals, with the American Bar Association Commission on the Mentally Disabled, governing a grant from the Clark Foundation setting up pilot legal-advocacy programs around the country for mental patients. Reports to the governing board from bar associations around the country state that such laws guaranteeing Constitutional rights to the mentally accused are not being obeyed. For instance, take some of the reports from California, a state long out in front with model laws in this field. For one thing, in order to get around the stricter commitment laws, people

are being slapped into conservatorships. The conservatee has no chance to defend himself before the judge. He has no control over his affairs. He can be slapped into the hospital by his conservator. Another thing, some prisoners are being transferred from jail to hospital without notice to lawyer or family, sometimes without being allowed to appear at hearings where bail was set, thus forfeiting bail too. There has been unlawful use of medication, such as, during the 72-hour waiting period while a person is held in psychiatric facility for evaluation, such persons being drugged so that they are out of their mind when they go for their psychiatric evaluation. In like manner, from state to state, in varying degree and detail, the reports go on.

Out in Wisconsin last year, I saw a film made for the Civil Liberties Union showing the commitment proceedings in Milwaukee. This is a state with some of the most progressive laws in this field. Yet this film, portrayed by professional actors with the script the court records, shows case after case of people being pronounced sick by a doctor who had never seem them before he faced them in the courtroom. These doctors used the very same words in every case, no matter what the mentally accused said. One such was a woman in her twenties, who refused to say anything on the witness stand in her defense, knowing the cards were stacked. She was working and saving her money for a college education. One day her parents drew the money out of her savings account and bought a piano, deciding she should study music rather than go to college. In symbolic protest, one day when her parents were not at home, she burned the bank book. In the courtroom, the doctor who had never laid eyes on her before he faced her in the courtroom, using the identical words he had used in case after case, said that because she had burned the bankbook she had to go to the state hospital for treatment.

Since my release from Florida, I have visited twice at Harrisburg State Hospital, nearby to my home in York, Pennsylvania. The first time was to speak to the staff and patients. In the question-and-answer period, two patients asked if I could help them get a lawyer. Both had a job waiting and a place to live. Both were in the same strait as mine in Florida. All the doctor would tell them was that they were not ready for discharge yet. On my second visit, this time with a group to inspect some of the wards, the first person I saw as we entered a locked ward was a man in his twenties who came up to me and said, "I have a lawyer. He is going to get me out. I have a job and a place to go to. I have a lawyer. He is going to get me out." That is another class of patients whose constitutional rights are being ignored.

In some of our states, half of the patients are voluntary now; however, it is only thru coercion. They are led to understand that if they don't sign in as voluntary, they will be committed involuntarily—then let's see them try to get out. Nevertheless, even the voluntary patients generally cannot leave when they want to. This is another large class of patients who have no advocates, by and large. There just are not enough lawyers with both the time and the knowledge to help these patients.

Behind the locked doors of our state hospitals, and their heavily screened windows, as well as on the open wards, the patients are at the mercy of the attendants, many of who are recruited from the less educated, more than a few with the least sensitivities to the point of sadism. In hospital after hospital around the country, there are still in 1977 case after case of physical mistreatment of patients, even cases of murder against attendants. Patients so subjected want out. And there is no one to get them out.

On a typical ward, the patients are not like those in the "Cuckoo's Nest" film. In the film, all but two on the ward had some hang-up and did not want to go back to the outside world. In reality, most patients on the wards want out. Many do not often see a doctor. When they do, it could be minutes in the office, or only seconds if they catch him only as he walks thru the ward. On my ward, there was no Big Nurse. There was no nurse at all for 1,350 men in one department, from the day the hospital was built until just the month when I was discharged. The role of Big Nurse in real life is played by the attendants. Some of them believe as the doctors and some attendants say, from the moment one enters the hospital until one leaves, "If you hadn't done something you wouldn't be here." If the one who is there had not done something and objects to his treatment, meaning, incarceration, the doctor and often the attendant thus view him as sick. After weeks and months and years, the patient perhaps becomes more determined to get out. Then he could wind up as did McMurphy with shock treatment—and worse.

I have not been talking about the so-called sick people. The Lord knows there are enough people today who can't cope. So many people live alone, especially in our larger cities, with no one to talk things out with or get advice from. They likely gravitate to the state psychiatric system or get sent there by well-meaning thu usually misinformed people in authority. Also, there are some few who are schizophrenic or have depressions or imagine things to the point of being underachievers. Of the sick ones I knew in the hospital, most knew when they needed help and would ask for it. But in the state hospital there was no help available except massive doses of tranquilizers prescribed by a doctor who might not see them for months—might not have seen them before he prescribed medication. Or there is the treatment McMurphy ended up with. Even the sick, if they don't want what's available, can't get out.

I close with two facts. In a 1974 task-force report, the American Psychiatric Association said that 95 percent of those in our state mental hospitals are not dangerous. In 1975, the Supreme Court ruled in my case that the nondangerous cannot be held involuntarily in a psychiatric facility.

We could use more help from the Justice Department to see that those two facts get reconciled.

Thank you, Senator Bayh and Members of the Committee.

Senator Bayh. I would like to introduce into the record a copy of a newspayer article from the Washington Post that recently described in some detail an experience of Mr. Donaldson.

[The newspaper article from the Washington Post was marked "Exhibit No. 5" and is as follows:]

[Exhibit No. 5]

[From the Washington Post, Feb. 5, 1977]

First Mental Patient To Win Right to Liberty Is Awarded $20,000

(By Morton Mintz)

The first mental patient to win a constitutional right to liberty will get damages of $20,000 from two state psychiatrists who refused to free him for 14½ years even though they knew he was harmless and got no treatment.

The damage award may lead lawyers to seek the release of thousands of other mental patients who were committed against their will and who are dangerous neither to themselves nor others.

That prospect—not the cash—accounts for "my happiness today," said 68-year-old Kenneth Donaldson, who had been kept in a chairless, crowded, ward in Florida State Hospital in Chattahoochee from 1957 to 1971.

He and his lawyers met with reporters yesterday less than two hours after federal Judge William Stafford in Tallahassee approved a settlement with the widow of former hospital superintendent J.B. O'Connor and with John Gumanis, the staff physician who "treated" him.

In addition to the $10,000 each defendant must pay Donaldson within 60 days, Judge Stafford may order them later to pay attorneys' fees—estimated at between $50,000 and $200,000—under a 1976 federal law.

In behalf of the Mental Health Law Project, a nonprofit, Washington-based group, and the American Civil Liberties Union, Bruce J. Ennis Jr. represented Donaldson for six years, and Paul R. Friedman, managing attorney of the law project, represented him for three years.

They told a press conference in the law project's offices that an award of attorneys' fees would help to make it possible for others to try to free involuntarily committed patients.

They cited data indicating that about 500,000 such persons are committed annually, some for brief periods. About as many are in institutions at any one time.

Overall, they said, 90 to 95 percent of such patients—a higher proportion than in the population at large—are not dangerous. The key problem is that in identifying the patients it's unsafe to free, psychiatrists admittedly have a batting overage of only about 5 per cent.

In a unanimous decision on the Donaldson case in June, 1975, the Supreme Court held that a mere judgment of mental illness "cannot justify a state's

locking a person up against his will and keeping him indefinitely in simple custodial confinement" if he "is capable of surviving by himself" or with the help of family or friends.

Three years earlier, a jury had awarded Donaldson $38,500, including $10,000 in punitive damages. Acting on a challenge by the physicians, the Supreme Court, while proclaiming the "right to liberty" for patients such as Donaldson, sent the case back to the trial court on the issue of damages. The settlement was reached two weeks before the scheduled start of a second trial.

Donaldson, who lives in York, Pa., wrote a book last year "Insanity Inside Out," Crown), lectures, and is working on two more books, one of them an account of his experiences in fiction form. "I'm retired," he said with the sense of humor that pervaded his exchanges with reporters.

His parents had committed him. The initial diagnosis was that he was schizophrenic/paranoid, had delusions, and was possibly dangerous.

He slept—when "screaming and hollering" inmates permitted—in a 60-bed room. For a year, he worked in a locked kitchen from 6 a.m. to 7 p.m., seven days a week. He got no pay. In 14½ years, doctors spoke with him for a total of not more than five hours.

Like most mental patients, he was too poor to hire a lawyer. He learned to do his own legal work, but his requests for a hearing were rejected 18 times by state and federal judges and three times by the Supreme Court.

He asked the help of 50 separate lawyers in "sensible, coherent" letters, Ennis said. Understandably, he said, they turned him down because none would or could afford to spend thousands of dollars to try to win the first money damages from a doctor for violation of a constitutional right.

When Donaldson filed his third appeal in the Supreme Court, physician-lawyer Morton Birnbaum represented him without fee. Then the ACLU entered the case with a friend-of-the-court brief.

Senator BAYH. Our next witness is Mr. William Thomas, a former patient of Farview State Hospital for the Criminally Insane in Pennsylvania.

Mr. Thomas, we appreciate the fact that you are here with us. I understand that your efforts and the efforts of one of the Nation's distinguished newspapers resulted in a prize-winning piece relative to your experience.

TESTIMONY OF WILLIAM J. THOMAS, LECTURER, FORMER PATIENT, FARVIEW STATE HOSPITAL, PENNSYLVANIA

Mr. THOMAS. I submitted an original statement. After listening to the various witnesses I would like to expand my original statement.

Senator Scott was interested in what prompted Mr. Donaldson's commitment to the institution so I imagine he is going to ask me the same question. I would like to get that out of the way. I will go into the situation in the three hospitals that I was in.

At the age of 19 I went into business for myself after having a long period of conflict with my father during my early childhood. It was something I was endeavoring to do that he was not interested in having me do at the time. He wanted me to go on to college. There were many, many problems between my father and I during my growing up years. I loved my father on one hand and on the other hand I hated him which created a tremendous conflict inside of me.

Immediately after I went into business, my father died, which was an extremely traumatic experience for me because the day that he died I had gotten down on my knees and I begged him to forgive me for anything that I had felt bad about him and anything

that I had done against him. For a brief moment he said that he would never forgive me.

I think at that particular point in time I became schizophrenic. A lot of people look at the word "schizophrenia" and they say that he has a dual personality. I think more in terms of separating myself from reality, the reality of my guilt involved with it and I was not able to deal with it realistically. So unconsciously I guess I withdrew from the reality of it.

A short time after that I had a little girl born mentally retarded, severely retarded. She is a crib case today. She is 17 years old: In my own twisted way of thinking I felt that my father had reached out from the grave and was punishing me through the little girl.

At the same time I was still trying to conduct my business. The business started to grow by leaps and bounds in spite of the fact that I was becoming disturbed mentally. The one man who had helped me in the business embezzled me out of business.

Senator BAYH. What kind of business was it?

Mr. THOMAS. A large auto body rebuilding and refinishing company. I had nine people working for me at the time.

That was the third traumatic experience that I went through. At that point I became so disorganized mentally that my wife decided to leave me. She took my other little girl with her. That was the fourth traumatic experience in a short period of time. I was not able to cope.

Senator BAYH. Is your other little girl here with us?

Mr. THOMAS. Yes. It is because of her that I am here today. I owe an awful lot to her.

Senator SCOTT. Do I understand that you feel that you did have a mental problem?

Mr. THOMAS. Yes, absolutely.

I then had a lot of misconcepts about what they do to people when they die. Since I had a close association with a death in the family, there was the need to find out what they did to people after they died and it became an obsession with me to the point that I broke into two mausoleums looking for my father. Some of my testimony might sound like I'm contradicting myself but I'm trying to relate how a disturbed mind is actually functioning at the time.

I then started to call the State police and threatened them that if they didn't pick me up for what I had done I would blow up the State police barracks. I was making random bizarre threats to various people.

Senator BAYH. Mr. Thomas, I think you have made the case as to how and why. Because of time limits, could you zero in onto the Farview situation. Tell us how you qualified for release. We're trying to find out what happened and why you were in the institution.

Mr. THOMAS. I finally attempted suicide and after that they sent me to the Farview State Hospital in Pennsylvania which is for the criminally insane. I felt that I was sick but I felt that I was not a criminal in the sense that we think of someone as a criminal stealing and robbing and that type of thing. I gained nothing in a monetary way.

For about the first 3 years I was not able to really get it together. I had the feelings of depression. I felt totally worthless. I thought it was a tremendous burden in being there and thinking that the Commonwealth of Pennsylvania was thinking so little of me to send me to a place like that.

It was a nightmare. Eventually the young lady sitting back there, my daughter, was starting to communicate feelings to me as her father. These were enough feelings to want me to get up and brush myself off and start figuring out what was wrong with me and get my head back together.

While in the institution, I realized immediately that there was no help available in spite of the fact that I had asked for help. I didn't want to feel like I was. I wanted to feel different and better.

My cries for help fell on deaf ears because there was none available. It was called a hospital but there was no treatment.

You mentioned earlier about "milieu therapy." It was that "treatment" that made you want to get out of there. The things that I had witnessed in the institution from guards ripping off patients and taking their clothing to beatings taking place every day. These were brutal beatings. The guards looked like a pack of hyenas attacking their prey.

I had witnessed one murder in the institution which I testified before a special grand jury in Pennsylvania yesterday. I had uncovered an awful lot of corruption in the institution like misappropriation of patient food moneys. I have documented the beatings. I finally found that I could not get out of this place.

I tried various ways. I tried the right way by appearing before the staff. The staff, in my estimation—and I'm not a doctor—I think was totally incompetent. Senator Cianfrani from Pennsylvania visited the place and his statement was that he would not request an aspirin from any of the staff at Farview. That can give you some graphic illustration of what the place was like.

After trying the right way to get out of the institution and by convincing them that I was well enough to leave after a period of about 3 years, I found that I could not get out so I decided to start studying law and how it pertained to my particular case.

I filed numerous petitions which were rejected. The rebuttal sent in by the district attorney's office were actually representations of the superintendent of Farview and were just flatly denied. Each allegation I made was denied with no clear reasons as to why they were being denied. I was attacking the legality of the 1951 and 1966 Mental Health Act of Pennsylvania which is an ambiguous piece of law. I found that the judge in my case made a statement that was in the newspaper. He said that after listening to two attorneys speaking about the Mental Health Act, that he knew less about it then than he did before. That scared me to think that I was under the control of the court and these doctors and they did not understand the law.

I thought I had no recourse but to try other methods of getting out. That was to attempt escape.

I was unsuccessful. In one case I jumped out of a building 2½ stories high. I was beaten prior to that. I was attempting to make

another escape through a tunnel at Farview. I almost drowned going through that ordeal. I finally decided that I could not get out of this place. It is considered maximum security.

Senator BAYH. I understand you got some films about what was going on? Could you tell us about that?

Mr. THOMAS. I decided I could not get out the right way or the legal way through escape. So then I decided I would try to blackmail my way out of the institution. I felt there were so many things going on in there that people would not believe, especially the beatings and the killings that were taking place. The official cause of people dying was that they died of a "coronary occlusion" which is a heart attack. Being a patient, I knew different and so did the other people.

Back in 1963 I saved a guard's life in the institution and 7 years later I thought I would go to the same man and ask him for a big favor which was to bring me in a tape recorder, a movie camera and a small Minox camera. For 6 months I got the goods on the people. I baited them into talking about the beatings, the killings, I took pictures. I took over 100 still photographs of the conditions in the institution. I have 6 hours of tape recordings with 16 employees. I took 150 feet of color movie film which I brought with me today.

I eventualy figured out a way to actually escape from Farview, which I did. I went to California. I was picked up by the Los Angeles Police Department and placed in the Metropolitan State Hospital. I think it was 4 days later on the basis of a telegram, they tried to transport me out of the State under the influence of drugs. They drugged me on a Sunday night and handcuffed me and took me down to the international airport and tried to take me back on a jet to Pennsylvania.

I put up a tremendous struggle at the airport. As a result the airport authorities would not permit me to get on the airplane. They took me back down to Metropolitan Hospital and the next day the staff examined me and released me. That was 7½ years ago.

I have been free ever since. I have not seen a phychiatrist. I have not had any type of therapy. I have been making my way in life.

Senator BAYH. Are you supporting yourself?

Mr. THOMAS. Yes.

Senator BAYH. What is the legal status as far as you and the State of Pennsylvania are concerned?

Mr. THOMAS. The 1951 Mental Health Act has one section which has not been repealed concerning escapes. It states that if a patient in any State-owned institution escapes and is gone 1 year and 1 day that they are automatically discharged from the record.

Up until I appeared before the Pennsylvania Senate Committee in November of last year, I was still on escape status from the institution. Because of the tremendous amount of publicity generated by the Philadelphia Inquirer the hospital gave me an official discharge. So I have no legal responsibility to Pennsylvania.

Senator BAYH. You are familiar, I assume, with the Farview findings of the Philadelphia Inquirer?

Mr. THOMAS. Yes; I am.
Senator BAYH. Is this an accurate assessment?
Mr. THOMAS. Very accurate.
Senator BAYH. Senator Scott?
Senator SCOTT. I'm interested in the grand jury proceedings but I don't want you to disclose anything that would be improper about the pending investigation. But do I understand that you were in Pennsylvania yesterday and testified before a State court grand jury?
Mr. THOMAS. The Commonwealth of Pennsylvania empaneled a special investigation grand jury in Honesdale, Pa. I flew in there on Wednesday. I appeared before the grand jury all morning yesterday. Obviously I cannot tell you what the nature of my testimony was. I left late last night.
Senator SCOTT. Insofar as it is public information which has appeared in the newspaper or is generally known, what is the purpose of the grand jury investigation? Has this been publicized?
Mr. THOMAS. They are investigating many different areas. One area that they are investigating is the fact that the Pennsylvania State Police had the information that I had in this attaché case back in 1970 and made no further investigation into the allegations on these tapes, pictures, and movies. They are investigating a coverup by the Pennsylvania State Police.
Senator SCOTT. What prompted the grand jury investigation? Was it something that the county or State legal department caused to happen?
Mr. THOMAS. After the first four major articles appeared in the Philadelphia Inquirer, I'm not sure who initiated it but the Senate of Pennsylvania developed a committee to take testimony on these allegations that were being lodged against Farview State Hospital employees from the superintendent on down.
From those hearings, their findings were that these abuses, murders and things deserved further investigation by an official panel.
At that time the Supreme Court of Pennsylvania appointed Elliot Goldberg as special prosecutor. He is the district attorney in, I think, Montgomery County. Then they appointed a special judge out of Philadelphia to handle the proceedings. Then a grand jury was empaneled by use of Federal funds.
Senator SCOTT. Do you feel that there might be an effort to remedy this situation?
Mr. THOMAS. Yes. Yesterday there was an article in the Philadelphia Inquirer stating that they had handed down four murder indictments against four different employees, or three employees and one patient at the institution.
Senator SCOTT. I notice that you do lecture from place to place. Are you familiar with what might be happening in other jurisdictions outside of Pennsylvania? Are the States around the country becoming more aware of conditions in mental institutions? Are there any changes insofar as you know? Are you in a position to express any views on this?
Mr. THOMAS. That is a very complex question to answer. The only experience I have is with Harrisburg State Hospital, Farview State Hospital, and Metropolitan State Hospital.

Senator SCOTT. Let me commend you for coming here today. We very much appreciate your testimony. Thank you, Mr. Chairman.

Senator BAYH. Thank you, Senator Scott.

Mr. Thomas, you have made a significant contribution, We appreciate it very much. We thank you.

Without objection, your prepared statement will be inserted in the record at this point.

PREPARED STATEMENT OF WILLIAM J. THOMAS

First, let me thank this committee for inviting me to appear before you to offer a first hand account of the numerous legal problems facing thousands of men and women confined in mental institutions throughout the country.

My name is William Thomas and I have been residing in Los Angeles for the past seven and one half years. Prior to coming to California in 1969, I spent almost nine years in Farview State Hospital in Pennsylvania before escaping to California. Seven months out of the nine years I spent in Harrisburg State Hospital, also in Pennsylvania.

My primary intention at the forthcoming hearings is to focus attention on the plight of untold numbers of mental patients who would like to seek adequate recourse through the courts to test the validity of their commitment and continued hospitalization.

To my knowledge, most patients are without sufficient funds to retain legal representation to challenge the authority detaining them. The problems in this regard are bi-lateral. On one hand you have a patient who feels that he or she is being unjustly deprived of freedom and without funds to employ counsel, and on the other hand this same patient is faced with a hospital administration that views this type of legal pursuit by the patient as sick behavior. In this connection, various methods are used by the hospital staff to either delay or prevent a patient from exercising their state and/or federal rights in seeking relief from deprivation of freedom.

Not only are "word games" used by the hospital staff in the form of written rebuttals, but many patients are physically and psychologically intimidated by the psychiatric security aides employed by the hospital. Still another method used by the hospital staff is the actual destruction of hand-written petitions by the patients. At times a patient's petition has been altered to make it appear that the patient was so mentally disabled that he neglected to complete the document properly. Drugs have also been misused to curb a patient from airing their grievances through the court. Letters from patients to relatives, friends, outside psychiatrists, attorneys, etc. have been destroyed when it contained requests for financial assistance.

The entire process is self-perpetuating and cannot stop itself. Whatever it is, it is not psychiatry. These people are not "troublemakers," they are not a bunch of anti-social psychopaths. The trouble already exists and we are endeavoring to compel social remedy. They are not against authority, they are against the misuse of authority.

It is with confidence that I appear before this distinguished committee and hope that the good people of these great United States will take positive action and alleviate these deplorable conditions which have plagued us for too long.

Senator BAYH. Our next witness is Joyce Murdock. She will be accompanied by Mr. Ted Boushy.

TESTIMONY OF JOYCE MURDOCK, FORMER PATIENT OF CASWELL CENTER FOR THE MENTALLY RETARDED; ACCOMPANIED BY TED BOUSHY

Mr. BOUSHY. I want to thank you for this opportunity of appearing before your committee on behalf of Joyce Murdock.

I would like your committee to take a silent look at the woman next to me. Joyce is mentally retarded but is not ashamed of that. She has lived in institutions for more than 15 years. This has cost

the taxpayers of our country more than $150,000. She has been involuntarily sterilized and was so at the age of 14.

While she has lived in prison and mental hospitals and alcoholic rehabilitation centers and jails, Mr. Chairman, Joyce decided that her unique contribution could be in the area of her articulation of the violation of civil and constitutional and human rights of the mentally retarded.

I am condensing my remarks today because I understand that you have severe time limitations.

Senator BAYH. Without objection, your prepared statement will be inserted in the record following your testimony.

Mr. BOUSHY. I would like at this time to share brief excerpts from Joyce's institutional records because I think in those records we can see the nature of the violation of a multitude of rights.

Mr. Chairman, our society wanted to care very much for Joyce and on March 16, 1954, a school psychologist said, "This child greatly needs the specialized care and training provided by Caswell Training School in order to develop to the limit of her abilities. She would probably be much happier in this simplified environment where she would be among children more like herself and could attain some success and status."

Joyce was a slow learner in school and they felt that Caswell was the most appropriate place for her.

Joyce and I have made a number of films and video tapes. We are working on a book together. We are very used to talking with each other. I should like to request the liberty from you, please, to initiate a few questions to her because I am sure she is a little nervous in this situation.

Senator BAYH. That would be fine. Go right ahead.

Mr. BOUSHY. Joyce, I think the chairman would like to know what you were told Caswell would be like by the welfare worker who first described it to you.

Ms. MURDOCK. My home life was not too happy. So the welfare took me out to a foster home first.

Senator BAYH. You had a mother and father?

Ms. MURDOCK. I don't know who my father is.

Senator BAYH. You were living with your mother at the time?

Ms. MURDOCK. Yes, but she couldn't support me very much and I had a lot of sickness. I had a very slow learning in school. I couldn't learn quick.

So when she took me to Caswell she told me that I was going to have a private room and a dresser because at home I didn't have very much or anything hardly.

Chairman BAYH. How old were you when you were sent to this institution?

Ms. MURDOCK. I was 13 years old. I went there and was really happy to leave home because I was not too happy. But when I got there it was not really what it was supposed to have been like. People were retarded and some were behind high fences. When we were 14 we had to feed these people.

I went to school an hour a day and then finally I got a job in the laundry at 25 cents a week. We worked there and went to school just an hour a day.

I did not really learn anything because I was confused by all of the people who were in worse shape than I was.

Then when I became 14 years old I was taken for a blood test. They said they were going to take my tonsils out. From Caswell they took us to another hospital in town and I was sterilized. They didn't explain it to me because I was 14 but the other girl was 17. She was in another dormitory, but she told me that she wished she would die. But I did not understand because I was so young.

When I got 17, I came out into the world and I met a guy whom I loved but I was sterilized and I wanted children. I had two small brothers when I was real little whom I took care of.

Senator BAYH. How did you find out you were sterilized?

Ms. MURDOCK. They told me later on. The other girls were older than I was and they told me.

Senator BAYH. After it was done they told you?

Ms. MURDOCK. Yes, but I didn't know it at the time. I thought it was tonsils.

The girl next to me, after we got back to Caswell, told me it was sterilization. She told me she wanted to die. But they did not explain to us. It has happened to a lot of people.

Senator BAYH. Did you say that she died?

Ms. MURDOCK. She said that she wished she would die. She was older than I was.

Senator BAYH. Did she have any choice in this matter?

Ms. MURDOCK. She didn't know. A lot of times they told us it was tonsils. I was young. A lot of it was going on back then.

When I came out and I kept going back and forth between the institutions because I didn't really know how to live. I wasn't ready for the world. I didn't think I had much to live for.

Mr. BOUSHY. Mr. Chairman, I would like to interject here, as Joyce instructed me to do when we were putting our manuscript together, a direct quote from her record:

> On April 15, 1957, Joyce was evaluated by a clinical psychologist at Caswell who wrote: 'Age 14 8 months, on the Revised Standard Binet Scale L, she made a M.A. (mental age) 6 years and 2 months, I.Q. 44, which shows that she is feebleminded on the mid-grade level. Cora Joyce Murdock will never be able to understand human relationships. She is innately amoral. She is and will continue to lack conception of values in life situations."

Senator BAYH. Do you concur in that assessment?

Mr. BOUSHY. I do not concur, Mr. Chairman; this is not a psychological evaluation. The phrase "innately amoral" does not refer to any kind of psychological functioning.

I think that the very nature of the institutionalization may have provided Joyce with an experience which indicated that she may not be able to understand human relationships.

At Caswell Center now, as was the case in 1957, there are not human relationships which are present because the Joyces of our society are not treated as human beings. They are treated as subhuman beings. Joyce mentioned to you that she was forced to work for 25 cents a week, that she had only 1 hour of school a day, and that she was involuntarily sterilized. She also tried to run away.

When she tried to run away, they caught her and locked her up in isolation rooms and forced her to feed the nonambulatory people that we have heard so much about today.

I want to remind you that this institutionalization began because of a failure of the family situation and also because of the school situation.

Most importantly, Joyce had no advocate at the community level and no legal representation. Once she was institutionalized she wanted to be sent to a foster home, but, she had no one to write letters for her to help her leave that particular setting.

Mr. Chairman, let me remind you that it all began because "This child greatly needs the specialized care and training provided by Caswell Training School in order to develop to the limit of her abilities."

She spent 5 years, 9 months and 9 days in that center. That cost the American taxpayer, at present rates, more than $60,000.

Mr. Chairman, in a film that Joyce and I made, I asked her how she felt about that. You might tell Senator Bayh about how you felt about that money being spent on institutionalization.

Ms. MURDOCK. I thought it was a loss because you see I thought if I had a home or was put into a foster home then it would be better. I didn't have the home life. I thought it would be better in a foster home.

When I came out of the institution I was not really prepared for the world. I had been down there and when I came out here it was so much different. I did not have the people to help me or to pull for me.

I didn't even know how to cook until I met Mr. Boushy and his wife. I feel like there was a great loss with the money situation because a lot of people are retarded but they are not really retarded. Some are retarded and some are like me. Some are worse.

Senator BAYH. What are you doing now?

Ms. MURDOCK. I housekeep and work in a cafe.

Senator BAYH. Are you providing for your own needs and sustaining your own self?

Ms. MURDOCK. Yes. I have an apartment of my own.

Senator BAYH. You're not on welfare or not the ward of any institution?

Ms. MURDOCK. No.

Senator BAYH. Do you pay taxes?

Ms. MURDOCK. Yes. You know I pay taxes.

[Laughter.]

Senator BAYH. I saw you were breathing and I thought taxes were equally inevitable.

[Laughter.]

Mr. BOUSHY. Mr. Chairman, Joyce has been in our world for 5 years as of August 28 of this year. She has not been in any institution since August 28, 1972. Prior to that she was institutionalized for 15 years.

I would like to point out that when Joyce and I first met we began to design a program that we thought would teach her the basic living skills which had been denied her in the institution. She did not know that women in this country could vote. She did not know what a savings account was, or a checking account, or how to shop or even how to use the telephone. She did not know how to use the multitude of things which you and I use every day.

She knows those things now. But I would like to point out too, Mr. Chairman, that in 1972 when Joyce Murdock voted for the first

time in her life—and I mention this in my prepared statement for her—she did not vote for Mr. Nixon. She voted for McGovern. She told me at this time——

Senator BAYH. I'm glad you waited until our colleagues had left the room before you disclosed that imperfection in her character.

[Laughter.]

Mr. BOUSHY. That she didn't trust the eyes of the other guy. I think that Joyce even though she is retarded may be wiser than more than half of America.

[Laughter.]

Senator BAYH. Mr. Boushy, I know how concerned you are about this kind of problem. I would like to ask you to give us your professional opinion about how this kind of legislation which we are holding hearings on and presenting here, could be helpful in relieving the situation.

Here we have a young lady who was institutionalized at age 13 with a mother who apparently provided little or no support financially or otherwise. The young lady was involuntarily sterilized without even being informed as to what was happening. She received 1 hour of schooling per day. Apparently she received no job-oriented training, and had no opportunity to learn a skill or trade or otherwise to acquire the knowledge necessary to sustain herself. She was subjected to the lack of privacy and all of the other kinds of institutional abuses that have been described here today.

Furthermore, I understand, from what she said and I assume that you concur, that her experience was not unique. There were similar cases.

Now she is out of the institution and providing for her own needs.

How do we prevent the Joyce Murdock situation from reoccurring and if such situations do occur how do we relieve them? How will this bill be helpful?

Mr. BOUSHY. Mr. Chairman, the treatment which America now extends to the Joyce Murdocks of our society is primarily institutional in nature. I think we need to understand that institutional treatment does not equal individual compassion and acceptance.

I think that Joyce's life, which represents millions of lives, illustrates over a 15-year period of tragic institutionalization that the lack of advocacy, that the lack of public awareness as to the violation of Joyce's rights, that the lack of anybody in her own world to provide her with pull, that the lack of her having recourse to ordinary patterns of communication with people in the outside world generated for Joyce the kind of educational experience—if we can call it that—that perpetuated her failure for 15 years.

Mr. Chairman, I think that what the Joyces of our world need are what this Joyce got: The attention and the understanding and the advocacy of individual Americans.

Mr. Chairman, Joyce is very much in favor of your bill. I am very much in favor of your bill, Mr. Chairman, because I know that various State institutions are making grave mistakes. I do not think that we can expect the State attorney generals to bring suit against the State in the same State in which they live.

What this means to me is that we would have to rely on the individual attorneys within those States to initiate suits. But, Mr.

Chairman, I do not believe that the individual attorneys within the States know about the Joyces and I believe if they did they might be embarrassed to try to represent one.

I'm not a lawyer but my understanding is that the Justice Department is established to protect basic constitutional and judicial rights of American people. I believe that this Government was founded by people who did not want to throw away the Joyces and who wanted to protect those rights and to establish the appropriate departments to take care of that.

I think that your bill could help the hundreds of thousands of people who are in mental retardation centers upon whom, incidentally, we spend more than $1 billion annually for simple maintenance.

I believe that your bill could help those people, as Joyce puts it, "to get their rights too."

I believe that it is the only source insofar as I knew which would be in a position—and I'm referring now to the Justice Department—to help the Joyces of our world have a voice in the legal world and in our society.

I don't know if I have answered your question accurately.

Senator BAYH. I think you have answered it not only accurately but eloquently.

Mr. BOUSHY. I would like to do one other thing, Mr. Chairman, if I could request one more brief statement here.

At 7:30 tonight a film called "A Death Within," which is Joyce's statement on involuntary sterilization, will be broadcast on WJLA in a program called "Seven Thirty Live." On Monday WJLA will be broadcasting a video tape which Joyce made herself called "A Tape for the President" which this morning was delivered to the White House by North Carolina Congressman Steve Neal.

I would like to read two paragraphs from that statement. These are Joyce's own words, no one wrote them for her, and the statement is unedited. It is a statement of a woman whose rights have been violated in all kinds of ways. I think it would be very helpful for this statement of forgiveness that she makes to be introduced into the record.

Senator BAYH. We will certainly do that.

Mr. BOUSHY.

I feel that all retardeds like me that just has a reading problem and are a little slow learning should be out in the world because this is their world too, and, we don't want to be treated no different or people to feel sorry for us. But we don't want to be knocked around just because we're bornt this way.

We do not like these operations. We don't like to have to be sterilized and not be able to have a family and have marriage life just like you or your wife and family or like any other family, because, we are normal, and we got feelings. But people really just looks at us and says we are retarded and all this and says she can't do this and she wouldn't know how to do that. But they really don't trust us or give us a chance to show what we really know.

We're not crazy just because we can't read or maybe just a little slower in school.

All we would like to have the opportunity for you to help us get opportunity by helping us get rights and not feeling sorry for us and anything.

I can't read or write but I do go to church and I see how you and your family go to church and I have saw you and your family go to church on TV and I have been in church that I wish I could have a family to take to church

with me too. But I know it cannot be possible now. That's destroyed, but I still have feelings.
I know God created this world.

Mr. Chairman, keep in mind this is dictated into her camera by a mentally retarded American person whose rights we have grossly violated because of the lack of appropriate legal advocacy in her behalf.

But I know that God created this world and he has given you the power to help run this country and given you the willpower to help run the country and give us rights. And I hope you can work it out where 'institutionals' can have rights too.

And I know God died on the cross for us and he gave his only life not just for some people but for all of us and I don't think God intentioned that this should happened to our world.

He gave you a lot of power to help run our world and help us with our country. And I think we need to have more rights and have a family; and, institutions, maybe, could just be closed and we could all live out here. Because all the world is all of us's.

I feel that I look through the Bible and I see pictures and I learn and see where he was nailed on the cross and I learn he rose and he came back from the dead. And he came back, and I think he wants all of us to understand that we are all his children and we should not be taken from our world and our own society.

Thank you for allowing me to include this meaningful statement.

Senator BAYH. Thank you. Where is the television station?

Mr. BOUSHY. That is Channel 7 here in Washington.

Senator BAYH. Thank you.

We want to thank both of you very much.

[The prepared statement of Joyce Murdock and Ted Boushy follows:]

PREPARED STATEMENT OF JOYCE MURDOCK AND TED BOUSHY

Mr. Chairman, Joyce and I are proud to be a part of these distinguished and important hearings. We sincerely thank you for providing us with the opporaunity to endorse publically S. 1393, a bill to grant the United State Justice Department standing to initiate suits brought to enforce constitutional and federal statutory rights of persons confined in state institutions.

Mr. Chairman, as Joyce and I discussed our appearance here and explored the more than four feet of institutional records which relate to the approximately 15 years she spent in North Carolina state institutions, it seemed to us that Joyce's unique contribution would be her articulation of the violation of civil, constitutional, and human rights of the mentally retarded.

I personally have found Joyce to be an articulate advocate for the more than six million mentally retarded Americans. Together, we have produced three films, a four-part video series, and are presently completing the second draft of a manuscript of a book, quite simply entitled *Joyce*.

Because Joyce is functionally illiterate, I have worked with her to express her sentiments in the following narrative. The following *italicized* passages are verbatim quotes lifted from the above mentioned works.

While we are paying particular attention to the deprivation of rights within the mental retardation center to which Joyce was sent, it should be noted in passing that during confinement in two North Carolina mental institutions she was involuntarily subjected to shock treatments and forced medication. She was denied access to a telephone, locked in isolation rooms, and confined in wards which were inappropriate to her needs.

Mr. Chairman what I am about to share with you on behalf of Joyce is a detailed evaluation of the first six years of this fifteen-year period. I should like to say that were these materials representative of only one person it would be wasting the valuable time of this committee. But these details, events, records and emotions reflect the tragic denial of basic constitutional and human rights of the institutionalized mentally retarded people who are presently

living in state institutions for the retarded for which we pay an annual maintenance cost exceeding one billion dollars.

Joyce's narrative begins with the remembrance of her childhood:

I was really unhappy when I was little. I had so many problems. A broken home. We was poor, my family was poor. We had coffee grinds for breakfast.

I had four brothers, two half brothers, two whole brothers, I was the only girl. I reckon I should have been a boy. Seemed like I couldn't find what I wanted.

I'd go down to the creek to make turtle houses and sit around and dream of the things I wanted. Back then I really wanted parents. I wanted love. Wanted to grow up and be somebody important with just so many things.

I thought I wanted to be a doctor. I thought I wanted to be in the army. I thought a lot of things I wanted to be.

I went to school. Mostly I'd be tired. Ruby, that's my mother, was workin third shift and us kids'd sleep in the back of the car. But there was one real nice lady who lived next to the school. She'd fix me a sandwich at lunch. And one time she gave me a dress.

I'd go home every day and I'd be so tired. It was unhappy. I felt mostly like I was in the dark.

On March 16, 1954, a psychologist wrote the following letter to Brent P. Yount of the Iredell County Welfare Department:

"Joyce Murdock was given a psychological examination at your department on February 16, 1954 because she is unable to even do first grade work in school. . . . Joyce is a quiet child with some speech difficulty of eleven years six months, who is in the third grade by social promotion.

"According to the Revised Stanford Binet Intelligence Scale, Form L, Joyce has a mental age of six years no months . . . This child greatly needs the specialized care and training provided by Caswell Training School, in order to develop to the limit of her abilities. She would probably be much happier in this simplified environment, where she would be among children more like herself and could attain some success and status."

Nearly two years later on February 9, 1957 the acting superintendent of Caswell wrote to Albert Kine, then Superintendent of the Iredell County Welfare Department:

"At a recent meeting of our council on Admissions we reviewed Joyce's case. . . . If you still feel Joyce needs our services, we can now initiate the procedures for her entry."

The first time I heard about Caswell was from the welfare lady who came and took my picture one day. She said they was gona send me to this real nice place. She said I'd have my own private room. My own dresser. My own mirror. She said I'd have a special school with a lot of friends. She said they'd take care of me and I'd have toys and stuff to play with.

I was looking forward to it. I had big dreams of learning interestin things there. And I really wanted to go cause I wasn't happy living at home.

Going down there was fun. The welfare lady stopped on the way there and gave me a nickle so I could go in the store and get me some candy.

I reckon she did it cause I was cryin. I mean I wanted to go to Caswell, but I was missin my brother, the little one. You see I'd take care of him durin the day.

But I kept thinkin about my own private room. I always wanted my own room, you know like the way little girls room are supposed to be. Pretty. Fancy.

But when we got down to Caswell and I saw that it was really like I wanted to run.

They just had big rooms. Wards. The commodes was all lined up. One. Two. Three. Four. Without walls between em. They didn't have no private rooms. Just big room full of I'd say 30 beds.

They told me one of the beds was mine, and then they just kept looking at me when I asked em whether or not you could have your own mirror.

Then this man took me around and showed me the other people there. He showed me the rest of the place. A lot of people had big heads. A lot of people was just laying in bed or rockin on the floor. Some of them was yellin. Some was cryin. Some was usin the bathroom on the floor. Some of em didn't even know you was watchin em.

I wanted to run. I was scared. I kept askin why am I here?
I kept wantin to know why I didn't have my own private room.

On March 28, 1957, Joyce's mother received the following letter from Frederick E. Kratter, Acting Superintendent of Caswell:

"It was indeed a pleasure for us to admit your daughter, Cora Joyce, to our school on March 20th, 1957.

"Cora Joyce has been assigned to her regular living unit and seems to be adjusting nicely to her surroundings."

I run away several times but they'd always catch me. And then they'd put me on punishment or lock me up or make me feed kids who was in worser shape than me.

I was runnin cause I didn't like it there. I thought the place was hurtin me.

I tried to get someone to write a letter to my social worker. I wanted her to get me a foster home. But I never could get nobody to write a letter. So I just kept runnin.

After a while I just stopped runnin. I mean, I didn't have no where to run to.

On April 15, 1957, Joyce was evaluated by a clinical psychologist at Caswell who wrote:

"Age 14, 8 months, on the Revised Stanford Binet Schale L, she made M.A. (mental age) 6 years and 2 months, I.Q. 44, which shows that she is feeble-minded on the mid-grade level.

". . . Cora Joyce Murdock will never be able to understand human relationships. She is and will continue to lack conception of values in life situations. She is inately amoral . . . ."

After a while I just got used to being there. I stayed there for about six years. I just worked in the laundry. They paid us 25¢ a week. We'd work all day Monday to Friday and half a day Saturday. We didn't get to play or anythin. Just worked all our lives.

And we didn't have much school. Just an hour a day. And that was always in there between workin.

We'd just work, eat, sleep. That was all there was to it. And if you didn't work or do what they told you to do they'd lock you up or make you clean up after the kind that couldn't go to the bathroom theirselves. Stuff like that.

I didn't actually think it was fair to keep us in there. I mean there was a lot of us who was really normal. We coulda come out and had a happy life. I don't think it was fair to keep us down there just cause we didn't have no family which actually cared about us.

On May 30, 1957, two months after Joyce's confinement in Caswell, the Iredell County Welfare Department wrote the following letter to Frederick Kratter, Acting Superintendent:

"We enclose order for operation of sterilization of Joyce Murdock which we received today from Eugenics Board. Copy of their letter to us for you is also enclosed.

"We appreciate your services in following through with this protective planning for Joyce."

Sincerely yours,

ALBERT W. KING, *Supt.*

I was put in a cottage with girls older than me. That's where they put me. They'd talk about operations. But I really didn't know what kind they was talking about.

When they, the staff came and told me I'd have to get a blood test and get an operation I went right on with the other girls.

They told me it wouldn't hurt. They didn't tell me what was actually for. They just said it's be sorely like having your tonsils taken out.

I went on into town with the other girls. Some of em was real upset. But you couldn't run. If you did they'd lock you up or put you in a tie-up jacket. So you couldn't refuse.

In accordance with the provisions of Section 3, Chapter 224 Public Laws of N.C. 1933 and by the order of the Eugenics Board Joyce was involuntarily sterilized on June 25, 1957. The operation took place three months and five days after her commitment. She was 14 at the time.

Rachel, one of the girls who went with me, cried all the next day. She was layin in the bed next to the bed I was in. She kept sayin she wished she'd died on the operation table. I didn't know what she meant. I was just 14.

I was pretty sick right about then and I stayed in bed a long time. The welfare board heard about it and sent me some presents.

They sent me a ragdoll and a puzzle. I just lay in there in the bed and played with the doll and looked at the puzzle.

I'd be thinkin about what Rachel said.

She left not long after that. I never did see her again. But I always wanted to. I always wondered what happened to her. She was a pretty girl. And she could read and write, too.

Mr. Chairman, I should like to point out that one-half of the continental states of our country permit the involuntary sterilization of the mentally retarded. Many also permit the involuntary sterilization of the mentally ill. Mrs. Kay Johns, the legal research assistant at The New Life Video Center, Incorporated, will be forwarding to you and your committee a chart which indicates those states.

Approximately two weeks ago, a young mentally retarded resident of our city was involuntarily sterilized. I regret that I am not in possession of the necessary legal documents which would permit me to discuss the case further at this time.

Joyce's opinion regarding this issue—and I agree with her—is that it appears that the United States of America has little room to criticize the international violation of human rights as long as we continue to engage in what amounts to be genocide against a class of our own citizenry. When any state or other form of government can so blatantly abuse what appears to be the basic civil, constitutional, and human right to have a family; all individuals within that nation are in grave danger of losing their diminishing individual rights.

At Joyce's request, we will be forwarding you a transcript of a film, "A Death Within."

I will now resume subsequent time Joyce spent at Caswell.

Joyce was released from Caswell January 9, 1963, after having spent 5 years, 9 months, and 9 days there. During that time she had worked for 25¢ per week, although she received 30¢ per week beginning the third year. In addition, she had received only an hour of schooling per day; she was cruelly punished for having the sense to run away; she was involuntarily sterilized. Joyce spent the informative years of her adolescence watching children's heads being shaved, their teeth being pulled out, and their being forced into fenced in areas where they sat all day on concrete slabs.

Mr. Chairman, this experience was one no one wanted. Both Joyce and I realize that institutions for the retarded were formed out of the advocacy of committed persons who truly did want to enrich the lives of the retarded. These people believed that in some miraculous way the institutional care could replace individual acceptance and that confinement with other retarded persons could replace the compassion of non-retarded friends. In short, the mentally retarded were victimized by limited expectations of what a retarded individual can do and be.

You will recall that earlier in this statement I quoted the school psychologist's letter which read in part:

"This child greatly needs the specialized care and training provided by Caswell Training Center in order to develop to the limit of her abilities."

Mr. Chairman, at the present cost of institutional care, the specialized care, education and opportunities which the taxpayers of this country provided Joyce by sending her to Caswell cost $70,000.

When I asked Joyce how she felt about this expenditure, and she replied, "I think we both lost. The state lost a lot of money and I lost half my life. It just went down the drain."

For the next nine and a half years Joyce brilliantly succeeded in the only career for which Caswell has prepared her: public drunkeness. During that time she spent most of her life in jail, the North Carolina Correctional Center for Women; Dorothea Dix and Broughton (two mental institutions), and the Black Mountain Alcoholic Rehabilitation Center.

Like an executive working his way skillfully through one company to another and, thereby, accumulating promotions, Joyce moved from a center for the retarded, to jail, to prison, to mental hospitals, and finally, to an alcoholic rehabilitation center.

In each situation her only problem was that she had to leave. But she tried to find permanentce in a variety of ways. In prison she thought of: *Robbin a bank with a toy gun. I didn't actually want to hurt anybody. I just wanted to*

quit the comin and goin. I liked it in prison. It was like livin in a town. I had to go back to see what was happenin because I'd get homesick.

You see, in there I knew the rules to go by. I knew what I was supposed to do, but out here I didn't know how to live. I had it made in there. You have a place to stay. Friends. Somethin to do. You don't have no trouble getting a job in there. What else do you need? In there I had a lot of friends. Out here I didn't have nobody.

On Joyce's fourth return to prison a social worker wrote on March 16, 1970 (seven years after Joyce's release from Caswell):

"Fourth term in the correctional Center for women February 24, 1970, charged with public drunkenness, entered a plea of guilty and sentenced. . . . I imagine that her adjustment (here) will be good and she will probably go right out and stay a little while and come right back again."

I kept comin and goin out of prison and jail. Seemed like the only friends I had was in both places.

Then I got to thinkin maybe people would think I was a criminal or somethin. It was embarrasin to face to world. Nobody would hire you cause you're just comin out of prison. Course nobody'd want to hire you if you was mentally retarded either. So I kinda lost both ways, I guess. So I went on to mental hospitals.

I really got used to institutions. Institutions are just like your world after a while. You don't even think about life out here. It's just like goin to another world.

The only problem was I always had to leave. But they wouldn't let me stay. I told em I'd cook; I told em I'd wash; I told em I'd do anything I could for em. I even told em I'd work 6 days a week if they'd just let me stay. But they always told me I was gettin better and I oughta try out the world again.

There was one time I really did try. My aunt helped me get a job in a furniture factory. And I figured I could get me a house. So I paid this man some money for a house. You had to pay so much each week. It was a little house. It had its own little kitchen. It was beautiful.

I had big dreams of gettin me some furniture and puttin it in the front room. I wanted to live fancy, you know.

I got in there and I guess I was there for a day or two. I never had any furniture.

I found some magazines on the floor in the closet. They was pretty magazines with pictures in them. And they had all kinds of big fancy dinners. There was this one fancy dinner and it was hotdogs wrapped with little pieces of cheese. I went right down the the store right after I saw that and got some aluminum foil and some hotdogs and cheese and invited my family for a fancy meal. I put the stuff in the oven. But nobody came over. So I just ate the hot dogs—all six of them—by myself and cried.

I cried all night.

Here I was after bein locked up all my life in a house sorely tryin to learn how to cook by myself and I didn't have nobody to come in with me. So I got drunk and I went back to Broughton.

I told the doctor that I was just gettin tired, that I didn't want to live in the world anymore. I told him I just wanted to quit. I mean what's the use in livin and workin in the world when you aint got nobody close to you. I mean, all I was doin was sittin in a place starin at four walls.

I'd look at the old people in there and they'd just be sittin there in their rockin chairs and noddin their heads. And I'd think all these people's got to put on their tombstone is State Property. Or Institution Hooked.

I figured I'd just spend the rest of my life comin and goin. Until I got so old they'd let me stay in there with others and strap me down to a commode.

"I figured institutions—state places—was the only home I was supposed to have."

Mr. Chairman, were institutions to begin all over again with Joyce—as they are doing now with hundreds of thousands of people, to duplicate this entire institutional experience would cost, at present rates, in excess of $150,000. I really do wish that Joyce's case were unique, but *unfortunately*, it is not.

Joyce, Mr. Chairman, is mentally retarded, and because of a cultural expectation based on her limitations rather than upon her potential she was denied access to appropriate treatment which would have consisted of many

more appropriate events other than confinement, ridicule, sterilization, and forced labor.

I believe that Joyce's continual failure sprang initially from the unwillingness or inability of her family and community to take the time to teach Joyce how to live in our world. Institutionalization compounded the problem by stripping her of all rights basic to any successful growth: the right to privacy, the right to education, the right to treatment, the right to speak freely, the right to counsel. The list of rights violated in Joyce's experience could require more space than I have.

One thing is certain: Joyce suffered because she had no advocate.

Joyce's very presence here today suggests the human potential of the retarded when freedom replaces confinement, when trust replaces suspecion, when awareness replaces ignorance, and when advocacy replaces passivity.

In 1972 when I first met Joyce, she said she had nothing to lose but a name and sometimes, an address. She was only partially right. She had the right to pursue happiness and to be afforded an equal opportunity to become a contributing member of our society.

My interest in her initially was that of an artist to a subject—of writer and film maker to the institutionalized person. My goal was to deal, as so many others have since done, with the sensational side of institutionalization. But as Joyce and I began working on the book and on the film, I came to see her as a unique person worthy of the world, and deserving of a chance to succeed. After having thoroughly researched her institutional career, I felt that without advocacy at the community level, without friendship, and without a highly personalized form of education, Joyce was destined to die "strapped to a commode." I approached the Department of Vocational Rehabilitation (DVR) with a proposed program of intensive education and advocacy (ACCESS). DVR provided the two thousand dollars that was necessary to cover the basic expenses for a period of 9 months—monies which were spent paying nonprofessionals such as myself to share with Joyce the living skills others had shared with us.

In September of 1972, Joyce moved into our home. My wife and I were paid to teach her basic living skills and to advocate in her behalf for vocational and economical opportunities.

When she came to live with us she was not as she is now: she was ignorant of the world to the point that she did not know, for example, who Adam and Eve were; that women could vote; that people, as well as institutions and businesses, could have checking accounts.

That changed very rapidly. By the end of the first week Joyce became a taxpayer. And she had grown enough to complain about the taxes which were withheld from her first paycheck. A friend of ours, Robin Simpson, who at that time was teaching school, also worked with us in the program, teaching Joyce arts and crafts, music, shopping and cooking skills and providing my wife and me with time alone on designated weekends by inviting Joyce to spend the weekends with her.

By November Joyce had saved $200, had learned to read music, and had learned to cook more than twenty different meals from scratch. She had also voted for the first time in her life. Showing greater wisdom than half of America, she voted for McGovern because, as she said, "I don't trust that other guy's eyes. Besides when he talks about prices and I go to the store, soup's a nickle more a can."

By January she had saved $400 and was able, then, to borrow enough money from Wachovia Bank and Trust Company to furnish her first apartment. In January 1973 she moved into an apartment furnished tastefully with carefully selected used furniture and with necessary cooking utensils and living supplies.

Vocational Rehabilitation paid her rent for the next four months during which time she repaid her loan but with the understand that if she failed to meet her loan payments the rent payments would be stopped.

By May 30, Joyce had repaid her loan and saved an additional $150.

Since 1972 Joyce has worked for four firms—A.R.A. Food Service, Krispy Kreme, The Winston-Salem Convalescent Center, and The Zevely House. She has continued to maintain an apartment and relationships with many people who care for her deeply. She recently terminated her employment with the Zevely House so that she can undergo ear surgery, and will resume work following that at Ichabod, a gourmet restaurant, which will open shortly under the management of her present landlord.

Mr. Chairman, it is important to point out that more than 30 people in the Winston-Salem community were involved with and deeply committed to helping Joyce, that a variety of foundations and agencies have since participated in the sharing of this story and the demonstration of advocacy programs based on Joyce's experience. These include the Winston-Salem Foundation, The Forsyth County Mental Health Association, The Mary Reynolds Babcock Faundation, The North Carolina Department of Mental Health, Vocational Rehabilitation, and Mental Retardation, and DDSA.

Joyce will experience a unique celebration this year. August 28, will mark a five-year period which Joyce has not been institutionalized in any state institution. This has saved Joyce from a cycle of failure and an estimated $60,000 worth of institutional care.

Perhaps most important is the fact that Joyce herself has become an advocate for the thousands of people still remaining in institutions.

Together we have produced several films and video tapes dealing with her story and the story of many other institutionalized persons, many of whom she has interviewed.

As a direct result of her personal effort, members of Knollwood Baptist Church, became involved with taking four mentally retarded women from a state institution and into their homes and helping them adjust to community living appropriate to their potential. I should like to point out here that nearly 100 persons were involved in this experience and that their committment and dedication was largely a result of their coming to know Joyce's case study intimately enough to understand the great need of others like her as well as their own potential as non-professional helpers and advocates.

Mr. Chairman, Paul writes in I. Corinthians, "If you love someone you will always stand your ground defending them, you will be loyal to them no matter what the cost, you will always expect the best of them."

The lengthy part of Joyce's life which was spent behind locked doors illustrates how we expected the least, how we were unwilling to defend her, and that no one was loyal to her.

Joyce's life during the past five years, however, serves as a living human testament to the potential achievement of millions of mentally retarded people provided that we do defend them, that we are loyal in our commitment to them, and that we do expect the best of them.

Joyce has much to teach all of us. Her lessons are expressed in human terms; they go beyond our social theories and penetrate the heart.

Joyce will be pleased to respond to your questions.

Thank you, Mr. Chairman.

Senator BAYH. Our last two witnesses will serve as a panel. They have both traveled from California. We have Karen Freedom who is a former mental patient from California on the Board of the Mental Health Advocacy project; and David Garcia, also a former mental patient from California and is a Network Against Psychiatric Assault member who works with the Mental Health Advocacy project. We appreciate both of you taking your time to be with us.

You may proceed as you see fit.

TESTIMONY OF DAVID S. GARCIA, STAFF WORKER, MENTAL HEALTH ADVOCACY PROJECT, LOS ANGELES; FORMER PATIENT, METROPOLITAN STATE HOSPITAL

Mr. GARCIA. I would like to start out talking about something I was involved with last October, November, and December. There was a series of inquests into suspicious deaths that took place at a State hospital in California. It was the first time any such inquest or investigation had been done into a state mental facility for about 20 years, at least to anyone's memory.

The first three inquests rendered verdicts that the patients had died at the hands of others other than by accident.

The other two verdicts were somewhat split. Some jurors thought the deaths were accidental and other jurors thought they were not.

Let me go back just a little bit. The parents of these victims had tried contacting the hospital saying "What's going on with my son or what's going on with daughter? I want some kind of help. I do not think my offspring is receiving appropriate kinds of treatment. I want something done."

They appealed to the hospital and nothing was done. They appealed on the county level. Nothing was done. They went up to the State Department of Health and the Governor, where they received some personal attention.

The attention was, I think, was well-intentioned but it was not permanent and it was only for individuals.

After that, lawsuits have been tried. They have been tried on the local level. They have been tried on the county level, and absolutely nothing has been done.

No one has been arrested. No indictments have been brought down. The State is trying to clean itself up, but I do not think the State is able to.

My point in bringing this out is that local legislation, local rules really cannot solve the kinds of problems and the kinds of systematic violations, which were brought out at the inquests, which I believe your bill can.

On the county level it was not able to be done. On the State level, after about 1 year, it has not been done yet either.

I think that is perhaps one of my strongest arguments for the passage of your bill.

I also want to point out that the patients inside institutions, as I felt as a patient and as I have noticed in dealing with other patients—who to me are clients and I work with them as an advocate—have expressed to me a great deal of apprehension. They have told me about things which are systematically done on a regular basis where there are denials of rights and the denials are the rule rather than the exception.

They are not able to do very much about it. I think I have been able to help some. They often feel very intimidated. They often do not know what their rights are. The staff is often ill-informed. The staff members themselves do not know what the patients' rights are.

The people have trouble communicating with attorneys. Special skills are required to communicate with people going through crises. When an individual has some kind of organic brain damage and if their speech is impaired then an attorney may not understand him. In fact, sometimes the staff may not understand him.

I have a client I can understand quite well, but his own psychiatrist will ask me what he is saying. His own psychiatrist cannot understand him.

Mr. GARCIA. I do not believe the patients are in a position to institute lawsuits on their own. I have assisted in getting attorneys to act on their behalf. The attorneys have been terrorized. They have been threatened. Their car windows have been shattered. Their tires have been slashed. Threatening phone calls have been received. Family members who have tried to institute lawsuits have received similar threats.

Senator BAYH. Who has done this? Do you have any idea who is involved in this harassment?

Mr. GARCIA. Yes. I believe the harassment is done by other staff members.

There is a lot that is being covered up. There is a tremendous amount of pressure on staff members not to speak out.

If one speaks out, perhaps it's not an appropriate analogy, but perhaps Watergate is something like it. The staff are afraid if one person speaks out that it will blow the lid off the entire thing. They have received threats on their lives and they remain silent because of it.

I receive much of this information from other phone calls. Along with the threats there have also been phone calls saying "I like what you're doing. I have information for you. Here is what it is and follow up on it."

When it has been followed up, it has turned out to be accurate more often than it has turned out to be false.

I would like to make another point before turning the floor over to Karen Freedom. This is the issue of records.

Records in State hospitals are turned over only to other State hospitals. The local sheriff and the local police have a tremendous amount of trouble getting hold of them. If they get them, they are usually summaries and not the actual records themselves.

On another level, individual attorneys have had trouble getting records. They have been denied records. Staff members have said "We have a new policy and have to check it out with somebody up above." When the attorneys check back days or weeks later, the staff has not received word yet.

Sometimes records have been missing, and these are key records. For example, if something happened, suppose, on November 23, then we would look back and the records are missing from November 22 to November 25 or something like that. There are key things which have been pulled.

The records which have been obtained through subpoenas have been photocopied and the writing usually is not perfectly legible. The records have been hard to read.

Confidentiality is invoked as a reason for not releasing records, even though the patient says, "I want my records turned over to this attorney."

The hospital will often hold back.

Confidentiality is supposed to be something which protects the sanctity of the doctor-patient relationship, and it's supposed to be, in my mind anyway, for the benefit of the patient to honor that individual's privacy.

What was intended to honor and respect the privacy of an individual is being used as a tool and as a weapon to cover up abuses against that individual.

It is not being resolved on the county or on the State level. I hope something can be done on the Federal level.

I've heard a hospital administrator, an executive director, say to a group of psychiatrists that "It is a political reality that nothing will get done unless the public is outraged."

Public outrage within a State is the only force sufficiently powerful to get a State to clean itself up. I suppose Federal intervention can have some kind of clout, but no other thing, aside from public outrage within the State, can do it.

That is another reason I support your legislation.

I will turn it over to Karen unless you have questions.

Senator BAYH. Not at this moment.

Without objection, a copy of your prepared statement will be inserted in the record at this point.

[The prepared statement of David S. Garcia follows:]

PREPARED STATEMENT OF DAVID S. GARCIA

My name is David S. Garcia. I was involuntarily confined as a patient inmate at Metropolitan State Hospital in California for a period of about one and one half weeks in 1972.

I am one of the founders of the Los Angeles Chapter of the Network Against Psychiatric Assault (NAPA), an organization dedicated to the elimination of psychiatric injustice. For the past year and a half I have been educating community groups on the need for reform in state mental institutions.

In September and October 1976, I was actively involved in a series of inquests into the deaths of five mental patients at Metropolitan State Hospital who died under suspicious circumstances. I was personaly instrumental in notifying the local press of the probes. I arranged legal counsel for the families of the victims and provided family members with emotional support throughout the proceedings. As a consequence of this I have received numerous requests for advice and assistance from individuals who see themselves, or loved ones, in similar distress.

Presently I work as a coordinator of a pioneering independent advocacy project which provides legal services for patients in two state mental institutions in California.

PERSONAL EXPERIENCE AS A PATIENT INMATE IN THE STATE MENTAL INSTITUTION

While I was a patient inmate at Metropolitan State Hospital I spent my first three or four hours tied down to a bed in a small room by myself. My mind was in a haze due to heavy doses of medication I had been given. My body remained in one single contorted position so long that I temporarily lost all sensation in one of my arms.

The following morning I vividly remember feeling a perpetual sluggishness that made me want to feign sleep. A woman in her late forties rolled harmlessly back and forth on the floor in front of me, which prompted a staff member to brutally yank her by the hair and drag her out of the ward. She cried nearly all the way due to the interse physical pain inflicted.. My own stomach tightened from having witnessed barbarous injustice. Many other patients turned their faces and closed their eyes, so as not to see. Such incidents were common.

All the while there I sensed pervasive feelings of helplessness, degradation, fear, anger, hostility, shame, and bewilderment. A staff member would take out his frustrations on a patient. The patient would take things out on himself.

Absolutely nothing that even approximated therapy occurred during my stay. Patients were drugged, intramuscularly as well as orally, three or four times a day or however often the staff deemed necessary. Compliance was the rule and any questioning or complaining resulted in punishment. It was general knowledge that unofficially sanctioned beating of patients tied in restraints were common punishments on some wards. Not only did the patients have no rights, they lacked even the privilege to ask if they had any.

At that time I was separated from my family and friends. My contacts with the outside world were cut off. Family members (usually parents) of patients often feel guilt or shame that one of their own blood is in a mental institution. I have spoken with parents who have literally kidnapped their patient offspring from state mental institutions because they could not, in good conscience, allow them to endure conditions which they perceived as intolerable.

THE NEED FOR INTERVENTION

I believe intervention on behalf of the patients is necessary. Patients do not, and generally cannot, file law suits on their own behalf. Litigation is expensive and the patients seldom have very much money. Lawyers are unwilling to take such cases because there is extreme difficulty in finding witnesses which a court will accept as credible. Staff members never testify against other staff members or the institution in which they work. Instead they blatantly lie and further discount the validity of the patients' grievances. Attorneys who have taken on such cases have had the windows on their cars shattered and their tires slashed.

It is not unusual for patients to lack whatever intellectual or emotional sophistication is necessary to communicate with an attorney. They may have been drugged and/or electroshocked to the point where they have great difficulty putting words into sentences or ideas into paragraphs. These are compounded if the patient is blind, deaf, or mute. Injuries involving the teeth, mouth, jaw, and larynx (which are commonly caused by blows to the face and throat) render the patient unable to speak clearly and hence difficult to understand. Suffice it to say, few attorneys have the communication skills necessary to relate to mental patients who are victims of abuse.

Often the victims themselves do not consciously realize they are being abused. This is especially true of patients who have been in institutions for extended periods of time. The longer an abuse is practiced the more it becomes accepted as treatment. When a patient accepts degradation, then he—himself—feels he is entitled to no better care.

Finally, patients themselves deny they experience or witness any abuse. Like a natural reflex, they close their eyes and turn their heads when they suspect something ugly is about to occur. They instinctively blind themselves to the injustices and deprivations, because to see them would be too painful to endure.

THE NEED FOR THE INTERVENTION TO BE FEDERAL

I believe federal intervention is necessary because intra-institution, intra-county, and intra-state interventions and investigations have effected, at best, improvements which are less than adequate and not even reasonably permanent.

Intra-institution investigations are blind to long standing abusive practices, which are, as I earlier stated, usually perceived as acceptable treatment.

Access problems exist for city and county agencies. The local police and sheriff's departments are unable to ascertain the legitimacy of patient complaints because much of the needed information is deemed confidential, and thus out of reach. Of course, no official records are kept on the real crimes. It is somewhat ironic that confidentiality, which is supposed to be for the patients' benefit, can be used to their detriment.

The office of the county District Attorney has a record of being ineffective in prosecuting anyone for crimes committed against institutionalized mental patients. Nearly one year ago in Los Angeles county three separate coroner's inquest juries unanimously rendered verdicts that three mental patients met their deaths "at the hands of others, other than by accident," yet not one criminal arrest or indictment has resulted regarding any of them.

The county District Attorney is an official elected by the populace and therefore responds primarily to pressures imposed by the populace. Patient inmates in state mental institutions are politically impotent and hence receive little or no attention.

Any complaint or attempt to redress any grievances, made on behalf of state institutionalized mental patients, which is sent to either the Governor or the state Attorney General's office automatically gets turned over to the State Department of Health. In no case will the office of the state Attorney General ever threaten or bring a law suit against a state mental institution.

Staff members of state mental institutions, presently, have absolutely no effective agency or board to which they can take grievances without running the risk of being demoted or fired completely. Fundamental dissatisfactions regarding degrading working conditions may be expressed to the state Department of Health, but poor administration makes actual remedies unfeasible. If a staff member should testify before any outside agency, he is likely to lose his job and/or be ostracized by his colleagues.

THE NEED FOR S. 1393

In California, only massive public pressure precipitated by glaring news coverage of intolerable conditions within mental institutions has had any noticeable effect on implementing required reforms. Yet the reforms have been limited to policy changes and funding allotments. No legal mandate is preserving them and they can be wiped out at any time.

The executive director of one state mental institution has conceded that other needed changes fill not occur until additional intolerable atrocities emerge and hit the press. It presently is a political reality that widescale abuse, which has become part of the bureaucracy, will not be corrected until deaths result and the public is outraged. The existing California state hospital system requires an "involuntary martyr" before conditions will improve for involuntary mental patients.

I believe S. 1393 needs to be passed. It could provide statutory federal authority which could correct conditions without requiring more deaths to occur.

Special investigative expertise is required for probes into different institutions because they vary so widely among themselves. The average length of stay may vary from sixteen days in one institution to two years in another institution to ten years in yet another institution. The patients at one institution may be fully competent while at another, nearly all have been adjudicated incompetent. I believe the diverse range of investigative expertise required can be found only at the federal level of government and not at the state or county levels.

S. 1393 specifically provides that the aggrieved party or parties need not have exhausted other remedies before invoking the jurisdiction of the federal court. I believe this is necessary to investigate and redress violations in a timely fashion.

I fully support the passage of S. 1393.

TESTIMONY OF KAREN FREEDOM, COFOUNDER AND SPOKESPERSON FOR N.A.P.A. (NETWORKS AGAINST PSYCHIATRIC ASSAULT) LOS ANGELES COUNTY, MEMBER: HEALTH SYSTEMS AGENCY PLANNING COMMITTEE—PATIENTS RIGHTS ADVISORY COMMITTEE TO THE COUNTY MENTAL HEALTH DEPARTMENT—N.O.W. (NATIONAL ORGANIZATION FOR WOMEN) MENTAL HEALTH TASK FORCE, MEMBER, MANAGEMENT BOARD, MENTAL HEALTH ADVOCACY PROJECT, LOS ANGELES; FORMER PATIENT, UCLA NEUROPSYCHIATRIC INSTITUTE

Ms. FREEDOM. The first thing I would like to do as part of the project committee of the mental health advocacy project is this. I've been asked to tell you that in their interest in and support for S. 1393 the committee has asked me to submit this statement to you in the hope that it will assist you in your deliberations.

Senator BAYH. Without objection, it will be included in the record after your testimony.

Ms. FREEDOM. The project is the only independent wholly privately funded advocacy group working in the California State hospitals. The statement is based on its experience during its first 6 months in operation.

The project is jointly sponsored by the Los Angeles County and Beverly Hills Bar Associations and it is one of the 10 pilot projects funded by the American Bar Association Commission on the Mentally Disabled.

In May of 1976 at the "Fourth Annual North American Human Rights and Psychiatric Oppression Conference," these demands were

voted on unanimously as the "National Mental Patients' Platform," I will not get into that. I would much prefer to touch upon some aspects of my own incarceration.

First I would like to talk about how I got there. I was very much into being married and having children and working for no other reason than I wanted to do that to have a sense of independence.

I would find that every 3 or 4 months I would get depressed. Having had a punitive background as a child and not feeling much self-worth I assumed something was wrong with me. In one period of my depression I was concerned about this leading to a suicide attempt. It was then that I asked for family advise. I chose to address that issue to my husband and his family. They decided that they did not want ot make a decision and asked for me to wait until my father got back from the Bahamas in 2 weeks. I did not wait and overdosed on Seconal.

I wanted to bring that point out since apparently some people are concerned about how I came to the institution.

It was my mother who encouraged me to go to the Neuropsychiatric Institute at UCLA in October of 1972. The reason, being that I was not doing more than staring at a wall at her place. I was recovering from pneumonia, having taken Seconal and aspirating.

When I went to admissions, I asked "If I didn't sign myself in—which was what the admitting staff was encouraging me to do—then how were people forced into institutions?" I was told, "They are admitted against their will."

That was the only information I had at that time. So, I signed myself in thinking that I could leave when I wanted.

That was not the case.

When I got into the institution the first thing that happened to me was the so-called drug problem. I saw my psychiatrist, and I asked him how long did he think it would be useful for me to be here. He informed me of what he called the responsibility level. I was admitted as the status of a 3 and the scale went from 1 to 9. The 1 to 3's were suicidal.

While I was at the institution I did such things as question the drug program I was on. Any time I questioned the drugs, I had responses from the nursing staff that it was in my chart that this was what my psychiatrist prescribed and I was to take it. At one time my sleeping medication was changed and I asked about that too. Again, I was reminded that this was the discretion and the choice of my psychiatrist. It was not appropriate for me to ask and if I continued to harass them about the drugs I was told I would go onto liquid medication, or injections.

In the beginning, I was not bent upon an effort of moving up the responsibility level, even though I was aware that this was an obvious way—from what my psychiatrist said—of getting out.

Unfortunately, a crisis happened at home. My daughter, who was staying with my mother, pulled the coffee percolator cord and scalded herself and was sent to a special burn unit. I received my first off-scheduled medication; the staff had that information several hours before I received it.

Again, I asked why was I getting this medication when for 2½ weeks three times a day I'd been receiving medication with everyone else. Again, my questions were not answered.

When my husband told me about the accident it was very hard for me to keep connected to what he was saying. The effects were compounded with the usual three times medication and the off-schedule medication.

In my first week of being in the institution, I had a sense of really needing to be there. No one had taken the time to explain to me the effects of the drugs. I had a difficult time keeping my thoughts together—which had become fragmented because of the drugs. Even standing up was difficult. If I moved fast I would get dizzy and exhausted. I would find myself drooling and was very embarrassed about that.

I cannot emphasize enough the powerlessness of that situation in the institution.

Finally after a day-and-a-half I convinced my psychiatrist I could handle myself on a pass to see my daughter in the burn center.

My family had pretty much played down the severity of her burns and when I came back to the ward that evening * * * and for the first time considered the possibility of my daughter dying. By the way I received another off-schedule medication before I went on that leave. It was about 10 o'clock at night—I did not have the information that my daughter was undergoing gran mal seizures.

There I was in a Catch 22 situation. I wanted to go to the nursing station and inform them that I wanted to go back to the burn center. They were, of course, telling me that they could not do that. It was up to the psychiatrist and he was not there. I needed to wait until my afternoon appointment the next day.

I tried to think of every avenue of making an impact with the nursing station without getting emotional, knowing that emotionality would lessen the probability of getting a pass and moreover would probably get me injected.

I finally found myself begging the nursing staff. It did something to me. I cannot tell you. It was like a total humiliation in front of those people.

As a last attempt to do something I ran to the locked ward door. It took four staff people to hold me down and I was given an intramuscular injection, which knocked me out.

The next morning when I awoke, I was given another off-schedule medication. With the patterns of the off-schedule medication, it became apparent to me, even before speaking to my husband, my daughter had died.

Prior to her funeral, I received an off-schedule medication and began to feel like a zombie. The only thing I connected with at the funeral, was the fact that I was singing with the choir and I had family tell me that I was singing at my daughter's funeral.

It was at that point I decided, I did not want to be institutionalized. It was also at that time, my responsibility level was switched back to a suicidal status.

I had not done any acting out or voicing any ideas or notions of suicide. When my status was changed back to suicidal, I was con-

stantly supervised by a staff person. I no longer slept in the dorm, but in an isolated room with a staff person next to me.

If you can make out any rationale as to why I was awakened every 3 hours and asked if I was feeling suicidal, I have yet to figure that one out.

I want to emphasize this. I wanted to get out. This was not for myself but for my older daughter. Even though I signed in voluntarily, I did not have the right to leave.

It was also my understanding from what my psychiatrist told me, that my status was changed to involuntary. I assume that, because I never had the right to file a writ. I never had a hearing. I never had counsel.

I was institutionalized for 3 months and my daughter's death was 2½ weeks after I was there. I spent the rest of my time trying to find out how to play the game and how the system worked in getting out.

It became apparent, a way of making the responsibility level work for me. I no longer questioned the drugs. I took the drugs. I no longer tried to generate enthusiasm with the other inmates. I no longer talked about my frustration in the institution. I started taking a personal concern about my hygiene and flirted with the men or anything that I saw other people doing—to get bumped up a notch. I was also sharing this information with other patient inmates.

Interestingly enough, those people who followed me up the scale in responsibility level were all dropped back within days after my discharge. It seems I was a major significator to other patient inmates, offering them a sense of direction they were obviously not getting from the staff or the psychiatrists.

When I was discharged, I thought that my nightmarish experience was over only to find out from my psychiatrist—I was being discharged to the custody of my husband. If I showed signs of getting depressed or emotional, it was his responsibility to bring me back to the institution.

I want you to know I was the most perfect wife going for a year. I was totally terrified of being sent back. I do not know if this came under the definition of a conservatorship, since again, I never had counsel and I never had a hearing. I continued to see my psychiatrist as an outpatient because that was a stipulation of being discharged.

Whenever someone got into an emotional feeling place, the staff would freak. They refer to it as losing or getting out of control when inmates do it. It was very obvious that the patient inmates were trying to encourage the people in detox, who were very irritated and on a very high drug level and unbalanced withdrawal medication, not to upset the staff.

The other patient inmates would try to discourage their emotionality and say,

> Watch it, look at the people in the nursing station, they're absolutely freaking. If you don't sit down and cool down you will get injected.

I would like to share with you the experience of a fellow inmate at N.P.I. named Trotta Goldberg who, at a young age, was in a prison concentration camp in Germany for being a Jew. The ways in which

she was treated inside the institution were like reliving that horrible nightmare. She was questioning the drugs. She did not want to take oral medicine. She was held down and injected almost on a daily basis. This woman was in a dormitory with me. The horrible nightmares that women would have—I would often go and spend most of the evening trying to comfort her when the staff people were not in the room.

I would like to say, in closing, I have spent the last 2 years speaking on campuses and to community organizations about the abuses in the mental health and psychiatrist system. The things that go on in the name of "therapy" are punishment and torture.

In prison you know you have been sentenced and you have a right to due process. In a psychiatric institution you have psychiatrists and staff telling you "You are here for your own good and we are here to take care of you." Everything feels very crazy. It is a very crazy-making situation.

Senator BAYH. I thank you very much, Ms. Freedom and Mr. Garcia.

Ms. Freedom, as I recall you said more than once that you did not see an attorney at any time during your stay; is that right?

Ms. FREEDOM. Yes. I did not.

Senator BAYH. Mr. Garcia, how about you?

Mr. GARCIA. During my stay I did not see an attorney. I requested a writ, and I saw an attorney for about 3 minutes immediately before going to court. I was released by a court proceeding.

Senator BAYH. But you requested the writ yourself and did not see the attorney until the time came to process it; is that accurate?

Mr. GARCIA. Yes, that's right.

Senator BAYH. Did either one of you try to obtain or, to your knowledge, receive any assistance through the appropriate State or local authorities in your struggle to get out of the institutions or to receive better treatment while you were there?

Mr. GARCIA. On a number of occasions I requested some kind of treatment. I did not like being locked up. I said "Well, if I'm going to be here I want some kind of treatment. I want something done."

What I was told was "We are short on staff. We cannot provide that."

That was the most I received as far as treatment goes. I pushed farther and I said "I want to talk to someone about this." I spoke in a friendly, nonthreatening and very sheepish sort of a way a number of times. Eventually I saw a mental health counselor who was supposed to see all the involuntary patients but in fact sees only the ones who strongly assert a right to see one.

When I saw her I told her I wanted to leave. She instituted proceedings for me to go to court which I did.

Senator BAYH. Both of you, I assume, feel that this legislation would be helpful to keep this kind of thing from happening to others?

Mr. GARCIA. I think it would be extremely helpful. I believe that I have seen what has gone on in California without it. We have tried nearly every avenue available. For all practical purposes nothing has been done.

There have been a few minor changes but nothing adequate or permanent. I see this legislation as being the best possible solution that I can imagine or I can see in sight right now.

Ms. FREEDOM. My only other response to that is that having been involved in the advocacy project and the incredible amount of struggles that we have had both with the mental health county and State legislation just getting the access rights to Metropolitan Psychiatric Hospital and Fairview Developmentally Disabled—D.D.—Hospital we have run up against obstacles from the director of Metro who is not giving us any support, to particular wards who are making it difficult for advocates to visit and the difficulty in obtaining parental permission to work with D.D. clients.

I definitely feel that Federal intervention to make sure that the State level is enforcing and upholding constitutional rights is of the utmost importance as delineated in the advocacy project statement.

Senator BAYH. My thanks go to both of you. We may have some questions that we might like to ask you but I appreciate the effort that you have made to be here. You have made a significant contribution and I am hopeful that together we will be successful, so other people are not subjected to the kind of abuse that you are subjected to.

Mr. GARCIA. May I make one final comment? It did not occur to me until a few moments ago but there was a film made inside Metropolitan State Hospital by a member of NAPA which is the Network Against Psychiatric Assault. There was a doctor who was criticized for the way he was running his ward. He did not think there was anything wrong with it. In fact, he was quite proud of what he was doing. He invited the cameras to come in and to film the way things were going.

The cameras went in. They filmed it. It is possible to obtain the film. I can give your counsel information on how to obtain it. It is called "Hurry Tomorrow." People on the outside who have seen the film have been outraged. People on the inside who are in the film were very proud of what they were doing.

I think it very well illustrates how no kind of reform is going to occur inside the institution. The people doing these things perceive what they do as being very beneficial and as being very therapeutic and as being treatment. A good many of them honestly do not understand the people on the outside who do not view it the same way.

Senator BAYH. We thank you very much. We appreciate your help very much. We will recess now until 1 o'clock next Wednesday when we will have our next hearing.

[Whereupon, at 1:30 p.m., the subcommittee stood in recess.]

[The statement from the Mental Health Advocacy Project was marked "Exhibit No. 6" and is as follows:]

[EXHIBIT NO. 6]

STATEMENT FROM THE MENTAL HEALTH ADVOCACY PROJECT

The Mental Health Advocacy Project urges prompt passage of S. 1393. Legislation authorizing federal intervention to protect the physical safety and civil rights of California state hospital residents would be most welcome. The causes of the appalling conditions in California state hospitals, which provide services

to both the mentally disordered and the developmentally disabled, and the official justifications for permitting the situation to continue unabated are irrelevant when one observes first-hand the suffering of our state hospital residents.

The Mental Health Advocacy Project is jointly sponsored by the Beverly Hills and Los Angeles County Bar Associations and is one of ten projects funded by the American Bar Association's Commission on the Mentally Disabled. We are presently providing services to residents of two California state hospitals—Metropolitan and Fairview, which have a combined resident population of 2700 persons—pursuant to an access agreement with the Department of Health. Paralegals, students, volunteer professionals and former patients work under the supervision of Project attorneys to notify state hospital residents of their rights, represent them in in-hospital disputes,, and assist them in obtaining community services, including legal representation. In our first six weeks of field operation (February and March, 1977) we provided services to nearly 500 persons. Our perspective, since we have field offices at the two hospitals, is unique. We are the only independent, privately-funded advocacy group now providing services within the state hospital system.

The state hospitals are administered for the convenience of staff and administrators. State regulation and policy do not reflect the resident's need for services. Attempts to reform the service delivery system from the inside are ineffective (Fairview State Hospital's Acting Executive Director was fired in May for making public statements critical of the Department of Health and for attempting to initiate new programs beneficial to clients but inconsistent with state staffing patterns. One particularly controversial new policy was refusing to admit persons for whom Fairview could provide no services.). The Department resist external reform efforts (The recommendations of the state's Little Hoover Commission report to improve treatment services have been ignored. The Mental Health Advocacy Project was only permitted meaningful state hospital access after the legislature demanded that the Department negotiate an agreement in good faith. Criminal prosecutions of staff members who have abused or even murdered patients have been unsuccessful because evidence was concealed and treatment records falsified. Complaints of parents of the developmentally disabled have been ignored even in situations where the child's life is threatened by hospital practices). The Department of Health administers state licensing for private and public hospitals so licensing is an ineffective monitoring mechanism (Some staff members have been instructed to write treatment programs for the developmentally disabled even though no services are available. Staff members who wanted to indicate in writing those services which were not available were told not to do so in violation of federal law, 42 U.S.C. 6011 (b).). The California Department of Health is extraordinarily well-insulated even from political pressure generated by revelations in the media. From August until December, 1976 state hospitals were front page news every day in Los Angeles. While there have been some token efforts by the Department to remedy conditions in the state hospitals, serious efforts to address the real problems have been frustrated repeatedly .

Persistent efforts to encourage local prosecuting attorneys to take action to investigate the conditions in California's state hospitals and to prosecute the persons responsible for the injuries and injustices commonly suffered by the residents have been unsuccessful. The political constraints have been insurmountable. The California Attorney General's office is counsel for the Department of Health. The Los Angeles County Grand Jury views state hospitals as being outside its jurisdiction although Los Angeles County is by far the largest single user of the state hospitals. The situation in California is a classic instance of one when federal intervention would be appropriate.

The Department of Health's insensitivity to the welfare of its clients is frightening. To place the burden on patients to initiate reform would be tragic in this state where the legislature, prestigious government commissions, executive agencies, and powerful outside organizations have failed to bring about an improvement. The California Supreme Court called one California state hospital "little more than a sanitary dungeon."

While we believe that the project's interventions on behalf of our clients is helpful to them, our own limited resources and the lack of available public or private legal assistance preclude our undertaking litigation to address the systematic abuse of patients' rights in the near future.

The systematic disregard of the patients' welfare in California state hospitals is not merely the result of insufficient funding and scarcity of resources to

meet the demand for services. There is no excuse for the chronic maladministration, misallocation of scarce resources, and gross insensitivity to the needs of patients displayed by the highest officials in the Department of Health.

Federal interests are involved since there is a significant amount of federal money applied to fund California state hospital services, particularly for the developmentally disabled. For example, 42 U.S.C. 6011 required preparation of written individual habilitation programs for the developmentally disabled by September 30, 1976. California legislation implementing requirements of federal law (P.L. 94-103) became effective January 1, 1977. Under Health and Safety Code § 38215 regional centers for the developmentally disabled were permitted (not required) to develop treatment plans for their clients within 60 days. The San Gabriel Valley Regional Center, from which 40% of all community placements are made for Los Angeles County resident, contracts with an agency of the Department of Health, CCSS, to provide placement services. To date, CCSS social workers and other staff have never been trained to prepared individual habilitation plans. There have been no complete diagnoses or assessments by the Regional Center for persons living in board and care homes upon which to base such individual habilitation plans. Nor has the Department of Health yet ordered its CCSS workers to prepare such plans. In fact, Health and Safety Code § 38215.1 requires "By January 1, *1979* (emphasis added), all active cases shall have an individual program plan as specified in Section 38215." The federal legislation is quite specific. A state or an agency of the state will not qualify for federal funds unless there is an individual habilitation plan. In California, we are already one year behind the deadline and, in fact, under state law we are potentially more than 2 years behind the deadline.

July 1, 1977, a new rate schedule for reimbursing community facilities will go into effect for the developmentally disabled in California pursuant to Health and Safety Code § 38260. The new rates are pegged to the needs of the recipient as described in the individual habilitation plan. How will clients of the San Gabriel Valley Regional Center be able to "pay" for their care when their is nothing in existence to qualify them for *any* level of payment under the new rate schedule?

Area Board 10, part of the California administrative system responsible for planning for the developmentally disabled and for disbursement of federal funds under the state plan, operated illegally for at least five months. It conducted business without a quorum. Contracts were awarded to agencies with whom board members had been employed only a few months before. An accountant who contracted with the board in March became a member of the board in April. There is at best a violation of the spirit of new legislation governing appointments to Area Boards which is intended to obviate conflicts of interest between board members and providers of services. *See* Health and Safety Code §§ 38157-8. Area Board 10 is the regional planning body for all of Los Angeles County.

On February 4, 1977, William Keating, M.D., who administers all the California state hospitals for the Department of Health, testified before the State Assembly's Subcommittee on Mental Health and Developmental Disabilities. He announced new Department policy as a matter of record. Weekends would be computed in calculating the first 72 hours of involuntary hospitalization for the mentally ill. (California state law permits exclusion of weekends only when evaluation clinical staff is unavailable, Welfare and Institutions Code § 5151.) Two weeks later a Program Director at Metropolitan State Hospital informed me that he had been ordered to revise his staffing schedule so that clinical personnel would not be assigned to weekends to perform 72-hour evaluations. The hospital's Executive Director later stated that he had issued the order with concurrence of the Department of Health (and presumably Dr. Keating who is his immediate superior) on equal protection grounds. Since some program directors could not convince their clinical staff to work on weekends, he had decided that no programs should have the ability to perform evaluations on weekends. The result is that 72 hours means 4, 5 or 6 days instead of three. Dr. Keating's testimony is false. The Department now claims to be developing policy for weekends and has been doing so for four months. The cost of hospitalizing persons on a 72-hour hold is over $100 per day. A substantial percentage of them are released at the end of the 72-hour hold. Were these patients evaluated in a timely fashion, the savings would be substantial. At Metropolitan State Hospital, the federal government was the third largest

source of payments for hospitalization of the mentally ill. The amount involved several hundred thousands of dollars.

There are at least 16,000 people living in California state hospitals at any one time. There are 10,000 developmentally disabled residents. There is a high rate of turnover among mentally ill patients. At Metropolitan State Hospital, the average length of stay is 8 days. Certainly this high rate of turnover indicates that a great many persons are needlessly hospitalized. Were there adequate numbers and types of community care facilities and crisis intervention services available, far fewer persons would be subjected to the agony of involuntary hospitalization. In March, 1977, there were 1073 admissions to Metropolitan State Hospital, and nearly all of them were involuntary admissions. Both the state and the County of Los Angeles are to blame for the needless deprivation of liberty, exposure to indignities and physical danger which results when state hospitalization is the only placement alternative. Although the Lanterman-Petris-Short Act encourages community services in a number of ways, neither the state nor the county has funded community programs. In fact, in Los Angeles County community programs are being cut back and nearly all funding other than maintenance funding is being allocated to county hospitals. In so allocating funds, County Health Services abrogated its own planning process and rewarded those facilities which were inefficient.

How does the mal-, mis-- and non-feasance of government agencies impact upon the lives of state hospital residents. The following are descriptions of complaints received by the Mental Health Advocacy Project and involve real Project clients.

1. UNLAWFUL DETENTION FOR A PERIOD LONGER THAN IS THERAPEUTICALLY NECESSARY

There are over 100 conservatees being held at Metropolitan State Hospital for three to nine months longer than treatment staff feels is necessary because the Los Angeles County agency (Public Administrator/Public Guardian) which is the patient's conservator is unable to process benefit claim applications in a timely fashion. Community facilities will not accept Public Guardian conservatees on credit, thus there is nowhere for these persons to live. The Public Guardian's office refuses to communicate with the Project on any matter. The California Attorney General has refused to take any action. The County Public Defender has decided it would not be politically feasible to bring suit against another County agency. State hospital authorities refuse to discharge the conservatees. Although the state offered to place the conservatees, the Public Guardian's office declined the offer (valued at about $50,000) because its contract with CCSS had expired. A Public Defender offered to bring petitions for release if the hospital would release the conservatees' names to him in December. The hospital never did. In May, the names were finally disclosed to the Project.

2. LACK OF PROGRAMING AND TREATMENT SERVICES

The only visible mode of treatment at Metropolitan State Hospital is chemotherapy. On one unit, the staff communicates with patients from inside the nursing station via a public address system to announce "It's medication time, ladies."

Nearly all of the 1700 developmentally disabled residents of Fairview state hospital would benefit from speech therapy. There is one speech therapist for all 1700 residents.

There are too few physical therapists to serve the many Fairview residents who need physical therapy. Some residents who were ambulatory when they entered Fairview can no longer walk because of severe muscle contractures. Some residents need surgery, but the surgery cannot be scheduled because no physical therapists are available for aftercare and the surgery would be useless without it.

A substantial proportion of Fairview residents are deaf but there is no deaf program.

Behavior modification services are available on only one program at Fairview out of ten.

There are 17 teachers for 1700 Fairview residents. Under federal law, all children are entitled to a public education. Changes in federal law have been interpreted by the Department of Health to require depriving adult Fairview residents of an education. Only minors will be going to school next year.

3. LACK OF MEDICAL SERVICES

Five patients from a single unit at Metropolitan State Hospital recently sought assistance from Project advocates in securing medical treatment for burns, broken bones, infections, and adverse reactions to medications. A week later none had received medical attention even though a complaint had been registered with the chief medical officer.

In April, staff members asked Project advocates at Metropolitan to help obtain medical treatment for a patient who was slumped over a chair, apparently comatose. This 44-year old patient entered the hospital in good health in September. She is now on a geriatric unit suffering from an organic brain syndrome of unknown origin. Her treatment chart indicates that she was "oversedated by medication" shortly before the Project advocate was contacted.

4. UNSANITARY FACILITIES AND INADEQUATE NUTRITION

Infection control procedures at state hospitals are deficient. There has been one shigelosis quarantine at Fairview since January. A parent of a Pacific State Hospital resident informed us that her son contracted "shig" every year and the entire ward was quarantined for several months during which time there was no programming for residents. During one outbreak of shig, her son had two tapeworms. For two years, her son continued losing weight. She now brings high protein food supplements to the hospital and for the first time in two years of hospitalization her son's weight is in the normal range.

5. OVERMEDICATION

A statewide policy governing the administration of psychotropic medications was prepared by the Department of Health in February, withdrawn in March, and a new policy is being developed. Nearly every client of the Project at Metropolitan State Hospital complains of overmedication. Polypharmacy is not uncommon. Patients can be observed sleeping in hallways or the dayrooms.

Fairview residents are now being taken off anti-psychotic medications to the dismay of staff. Last fall, before implementation of this policy by the new Acting Executive Director, a Fairview resident was administered massive doses of thorazine and barbituates pursuant to a plan to keep him asleep for several weeks in order to modify his behavior. A physician found him aspirating and close to death the first night of the "treatment."

A parent of a Fairview resident was told by the Program Director and the ward physician who agreed with her that her son was overmedicated that retarded persons did not go through drug withdrawal. Several weeks later when the staff permitted her to return to the hospital to visit her son, she found him in withdrawal with dry heaves and the shakes.

6. UNLAWFUL RESTRAINTS AND SECLUSIONS

A staff member requested Project assistance on one acute Program at Metropolitan. Patients are restrained without justification and are left for an entire shift (8 hours) without being moved. Sometimes, they are forced to lie in their own excrement. Restraints are too tight. The staff falsely documents the two hour observation required.

7. SYSTEMATIC DENIAL OF STATUTORY AND CONSTITUTIONAL RIGHTS

In 1973, legislation was enacted establishing certain minimal rights for state hospital and community care facility residents. In June of 1976, the Department of Health created an in-house patients' rights program. (*See* Welfare and Institutions Code § 5325, *et seq.*; Title 9 California Administrative Code) A year later, the Department has not developed procedures for documenting denials of rights for state hospitals, although they have been adopted for counties in the state. No grievance procedure exists. To date, no state hospital resident has ever been officially denied any right guaranteed by law.

Although residents are guaranteed the right to make and receive confidential telephone calls, only pay phones are available for patient use and many patients have no money and the phones are often out of order.

State hospital residents are guaranteed to right to possess small amounts of money to make personal purchases. At Metropolitan State Hospital, all newly

admitted patients are deemed incompetent to manage their own funds and are denied access to their own funds until such time as the staff determines they are competent. Those patients on locked units are not able to spend their money in any event because the canteen does not send a representative to locked units. Canteen prices are excessive. The canteen is a corporation whose board of directors are 7 hospital employees, including the Executive Director. Profits from the canteen and from vending machines constitute the patient benefit fund. This year, profits were not released to the patient benefit fund because the canteen building may be relocated. Thus, patients are paying for capital improvements.

Patients in state hospitals are guaranteed the right to wear their own clothing. At Atascadero State Hospital, all patients wear uniforms.

Patients are afforded the right to receive unopened mail. At Metropolitan State Hospital, all mail is routed through the trust office where it is examined to determine whether the envelope contains a check. If so, the check is confiscated and deposited in a fund which is then applied to pay for the cost of hospitalization. If the trust officer is unsure whether or not the envelope contains a check, the envelope is opened and the contents are examined.

8. MENTALLY ILL OFFENDERS

Some 100 persons are transferred from the Los Angeles County Jail to Metropolitan State Hospital each month. It takes at least two weeks for the Sheriff's Department to approve a recommendation for transfer. No prisoner who constitutes an escape risk is eligible for transfer. Most persons charged with felonies are not eligible for transfer because Metropolitan is a minimum security facility. Money and clothing belonging to patients are left at the jail. Many of these patients are unable to telephone their relatives or their lawyers to notify them of their transfer. Often the court is not informed of the person's whereabouts and a bench warrant will issue for failure to appear. If the patient becomes a management problem at the hospital, he or she is returned precipitously to the jail regardless of treatment needs. One Project client who was returned to jail was found shivering under the bed covers at the jail hospital unit in an acutely psychotic state.

The Department of Health claims to have undertaken efforts to improve conditions and to protect patients' rightc in the state hospitals.

As part of its program, the Department assigned a Special Investigator to each state hospital to look into cases involving allegations of patient abuse or other criminal activity. At Metropolitan State Hospital, the Special Investigator will not accept a referral from the Project. All complaints must be sent to the Executive Director who screens them before sending them on to the investigator. This new policy was adopted because the investigator was receiving too many complaints from "unknown sources." The Project has never received a report from the Special Investigator concerning any of its referrals to him.

The Department also appointed a Patients' Rights Advocate for each of the state hospitals. These advocates do not have a written job description although they have begged for one for months. They do not have civil service status. They report directly to the Executive Director of each hospital. Some advocates have been told not to investigate certain cases or to stay away from certain programs.

Hospital staff with the tacit approval of the administration and with administrators in Sacramento, have consistently frustrated Project Advocates' ability to visit their clients and review their treatment records in violation of the agreement negotiated with the Department of Health. Some staff members have displayed real genius in isolating the weaknesses of the agreement and resolving issues which were not anticipated has taken as long as a month of additional negotiations with Sacramento.

> A Project advocate was sent to interview her clients in a locker room where she was attacked by a patient who was known to be assaultive. When the advocate complained to staff members, they promised to protect her and told her to return to the locker room, denying her request to interview in the day room. The patient returned to the locker room minutes later and again attacked her. The incident was reported to the Program Director and the Executive Director. No action has been taken to discipline the staff members involved.

One day, without notice, the Project was informed that we were not permitted to review patient records in the trust office. The decision was made in Sacramento and was not resolved for six weeks.

This week, Fairview State Hospital refused to release the names of parents of Project clients who are minors. Under the access agreement with the Department of Health, we have agreed to obtain consents to represent Fairview residents who are minors from their parents before proceeding. A parents group complained about their names being released to us early in the week. Without parental consent, we cannot assist our clients. Without the parent's name, we cannot ask them for permission.

Last week, a Program Director notified a parent of our involvement in her son's case and attempted to discourage her from permitting us to investigate a referral characterizing the Project as McCarthy-like and stating "You don't want to drag up all that old history do you?"

The Department of Health interprets California law governing the confidentiality of patient treatment records in such fashion as to shield itself rather than to protect the patient's right to privacy. One attorney was investigating a complaint which may have resulted in litigation against the Department of Health. When he presented a record release from his client to the records custodian at the state hospital, he was asked why he wanted the records. When he explained that he was investigating, he was told that he could not review the records until a law suit was filed. When he explained he needed the records to determine whether or not to file suit, he was asked whether the defendant would be the Department of Health. When he answered affirmatively, he was told he could not have the records.

The Department's interpretation of confidentiality results in frequent abrogations of patients' First Amendment right to association and Sixth Amendment right to counsel. The California Supreme Court unanimously held that persons who were not members of the treatment staff should be permitted to notify patients of their legal rights in 1971, *Thorne* v. *Superior Court*, 1 Cal. 3d. 666. When the Project asked to notify parents of their rights, we were told that it would violate confidentiality to permit us to visit patients during the 72-hour hold period. Although we ultimately convinced the Department, with the intervention of an Assembly committee, that this would not be a violation of the law, it was nearly a month before Metropolitan State Hospital could decide upon a procedure by which patient names could be revealed to us for rights notifications. Once the Project began performing rights notifications, the number of writs of habeas corpus filed by Metropolitan patients tripled.

We hope that the foregoing will be helpful to you in your deliberations and hope that it will do something to dispel the myth that California's mental health system is a progressive one.

CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS

WEDNESDAY, JUNE 22, 1977

U.S. SENATE,
SUBCOMMITTEE ON THE CONSTITUTION
OF THE COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met, pursuant to recess, at 1:20 p.m., in room 2228, Dirksen Senate Office Building, Senator Birch Bayh (chairman of the subcommittee) presiding.

Present: Senators Bayh, Metzenbaum, and Hatch.

Staff present: Nora Manella, counsel; Nels Ackerson, chief counsel and executive director; Theodore Humes, minority counsel; and Linda Rogers-Kingsbury, chief clerk.

Senator BAYH. The subcommittee will come to order.

I will be happy to yield to our distinguished colleague from Ohio, Senator Metzenbaum, for an opening statement.

OPENING STATEMENT OF HON. HOWARD M. METZENBAUM, A U.S. SENATOR FROM THE STATE OF OHIO

Senator METZENBAUM. I would like to commend the chairman for his leadership role in connection with the subject matter of these hearings, a subject matter which I consider to be particularly important.

For too long we have sat back while the basic rights of those who have been involuntarily confined have been violated.

S. 1393 is landmark legislation in this area. I wholeheartedly support it.

S. 1393 would grant the Attorney General statutory authority to sue and to intervene in suits against State institutions for violations of the fundamental rights secured by the Constitution and the laws of the United States.

I have read the testimony of Assistant Attorney General Drew Days and others who have preceded me in testifying before this subcommittee and I am convinced that this is an extremely important and necessary piece of legislation.

People who are involuntarily confined—the emotionally disturbed patient, the elderly, the chronically disabled, the retarded, prisoners, juveniles—are all particularly vulnerable to violations of their constitutional rights. In many cases these violations are the result of overcrowded, underfinanced, and understaffed institutions.

In these circumstances it is no wonder, shocking though it is, to learn of such things as six prisoners confined in a 4 feet by 8 feet

cell in Alabama; mentally retarded children in Willowbrook State Hospital in New York suffering from serious physical injuries that the staff was either unable or unwilling to prevent and being massively overdrugged to compensate for inadequate staff; and delinquent and dependent children in Louisiana being abused, overdrugged, and inadequately treated.

We have talked about these kinds of problems and many more over a period of many years—the deplorable conditions we know exist. Some of these deplorable conditions have actually come to light in suits that have been brought by the Justice Department or on which the Justice Department participated.

Sadly, these violations of basic constitutional rights are not uncommon. They are the rule and not the exception, and worse, there is no sign that they are occurring any less often.

The pressures of underfinancing and lack of space prevent those who run these institutions from making changes on their own. In some instances a lack of determination and an indifference and inapathy contribute to their failure to act.

The private bar does not want to take these cases for there is little or no money for the bar to do so. Public interest bars, such as the American Civil Liberties Union and others, including legal aid societies, simply cannot afford to finance them.

Testimony before the subcommittee and in the House indicates that this kind of litigation consumes an enormous amount of money as well as time.

For all of these reasons and many more, I am frankly, at a loss to understand opposition to this legislation. The bill does not invade the rights of States. It merely provides a much needed method of enforcing States' rights already protected by the Constitution, the Civil Rights Act, and other legislation.

No new obligations or rights are created. The operation of these institutions is not affected in any substantive way. The bill simply says to them that the Constitution and laws must be obeyed and, if they are violated, then you face suit not only by the particular persons involved but by the United States.

The Department will not rush in without giving officials the chance to voluntarily raise matters on their own. It is my understanding that the Department never has acted in that manner.

We would be blind to reality if we did not recognize that sometimes the pressures on State officials to leave things as they are is enormous. The authority conveyed by this legislation is not unusual. Similar authority to enforce constitutional rights in the face of a pattern or practice for widespread deprivation by the State has been given to the Attorney General.

S. 1393 will protect the rights of those persons who are most vulnerable to abuse. I am pleased, Mr. Chairman, to join you in adding my strong support to the passage of this legislation.

Senator BAYH. Thank you very much, Senator Metzenbaum. It will be very helpful to our efforts to have your support. It is not unusual that you would associate yourself with this kind of issue because you are one of the members of our body concerned about how individuals are treated and how human concerns are met.

We appreciate very much your being here, as busy as you are, as well as your support.

Senator METZENBAUM. Thank you.

Senator BAYH. Our first witness today as we begin our second day of hearings on this bill to protect the rights of institutionalized citizens are three individuals whose personal experiences make them uniquely qualified to document conditions in institutions.

Mr. Michael McGuire is the former superintendent of Farview State Hospital.

The plight of Farview was discussed in our opening session.

Wendell Rawls, Jr., and Acel Moore are two reporters. Mr. Rawls is now with the New York Times, but he and Mr. Moore collaborated on one of the most perceptive pieces of journalism to treat this problem. It was entitled "The Farview Findings," was published by their paper, the Philadelphia Inquirer, and for it they were awarded the Pulitzer Prize.

Would you three gentlemen please come forward? The subcommittee is very anxious to hear your personal experience in this field.

Gentlemen, I appreciate very much the trouble you have taken to be here. We are looking forward to hearing your firsthand experience.

We have already incorporated in our record "The Farview Findings." It certainly describes the problem as it has seldom been described.

Please proceed in any way you want to proceed.

Dr. McGuire, do you want to start?

First of all, do you have prepared testimony?

TESTIMONY OF DR. MICHAEL D. McGUIRE, LIEUTENANT COLONEL, U.S. AIR FORCE, FORMER SUPERINTENDENT, FARVIEW STATE HOSPITAL, PENNSYLVANIA

Dr. MCGUIRE. I have submitted testimony for this. I will not read it, but I will summarize a few things.

First, I would like to state that I am on active duty with the Air Force. I am not speaking as an Air Force officer but as a private citizen. The Air Force has no policy regarding this particular piece of legislation. I do not reflect any Air Force view.

I reflect instead the concern of a private citizen who has had an opportunity to work with extremely good hospitals which are well staffed with fine traditions of humane treatment. Farview Hospital is an outstanding and grotesque expression of the worst that institutions can become.

I wholeheartedly endorse this kind of legislation since I have had to live through an attempt to correct a dreadful series of problems and have run into the problems that the States have in doing the cleanup job and the conflict of interest that they run into, and the enormous difficulties that not having a third outside party cause, which the Department would constitute.

I think one has to live in a situation like this or spend a great deal of time with a hospital such as Farview to understand the enormity

of the broken promises that the State was unable to protect or defend its citizens.

Your kind of legislation is one way to get to that problem. I think, however, one has to keep in mind a model like Farview and design the legislation so that it can pierce through the series of problems that Farview constitutes and the problems that the State constitutes.

It is quite possible to be a patient in an institution such as that and to have mail torn up and destroyed, to have all telephone calls monitored, to not make contact with persons outside the institution, and to have such contact as they have not pay off. In other words, if they get out of the hospital and make contact with appropriate officials, then no action is taken.

If you happen to be unfortunate enough to be a patient, then you are oftentimes written off by the government agencies who should take responsibility for investigating. You are written off as a former crazy person who is now protesting. The letter oftentimes goes back to the very hospital about whom the letter complains. The answer is designed by that hospital and given back to the State department which received the complaint in the first place. So it is not a self-correcting device.

The political considerations and economic considerations of closing down a hospital such as this are huge. Even the staff itself is in considerable jeopardy. Staff who complain have to be willing to leave their jobs. They have to undergo a considerable threat, spoken and unspoken, so that only those people with enough flexibility and enough strength to be able to quit the job and go somewhere else and build a new life can afford to take the risk that it takes to pull the string on a place such as Farview.

In my prepared statement I give many instances of that.

The lawyers do not have funds to take up what might be a worthy case. It is very difficult for them to investigate a hospital in a State system which does not allow easy access. There are no funds to pursue what may be a very long, entangled course. This becomes very important, and your legislation will obviate that.

Let me stop at this point. Mr. Rawls and Mr. Moore can tell you something of the incidents and the tenor of that institution.

Senator BAYH. Before we do that, if you have no objection, we will put your prepared statement in the record.

[The prepared statement of Dr. Michael D. McGuire follows:]

PREPARED STATEMENT OF MICHAEL D. MCGUIRE, M.D.

Senator Bayh, Members of the Committee, I thank you for the opportunity to share with you the several reasons why your proposed legislation is absolutely necessary to protect citizens unfortunate enough to be confined in institutions.

My name is Michael D. McGuire, M.D. I am a board certified psychiatrist licensed in 4 states, and former Superintendent of Norristown State Hospital in Pennsylvania for 4 years and former Superintendent of Farview State Hospital for the criminally insane, Waymart, Pa. for 10 months in 1974. I was Chief psychiatrist at the Forensic Unit of the Colorado State Hospital in Pueblo until starting on current active duty with the NSAF as a Lt. Colonel in the Medical Corps as of September 1976. I do not speak as an official of the Air Force nor do I reflect any Air Force policy regarding the proposed legislation. I speak as a private citizen who has had the opportunity to work in 2 excellent hospitals, Norristown State Hospital, Norristown, Pa., and Colorado

State Hospital, Pueblo, Colo. Both of these hospitals had strong traditions of humane effective treatment programs, with trained staff and an active sensitivity for human and civil rights.

Farview State Hospital stands as the grotesque product of the failure of several systems allowing the most gross maltreatment, deprivation of rights and collusion to maintain secrecy. It is the best kind of reason for this legislation since not only the staff of that institution failed to protect and provide but the larger systems Dept. of Welfare, State Police, Dept. of Justice, and their political leaders, failed to protect and provide.

All institutions develop a personality, a life of their own reflecting the alleged founding purpose, plus the needs and character of their clients, staff and administrators. Added to these in either enriching ways or corrosively and destructively are the traditions both open and covert developed by the institutions.

Farview State Hospital was founded in 1916, as the mental treatment facility for those charged with a crime or serving sentence, who developed some mental aberration or were thought to be developing such. Over the years it also received patients from other hospitals in the State system—patients who repeatedly eloped or were allegedly assaultive. Thus one could be hospitalized having never been charged, or convicted, along with those serving time, transferred from the prison system. By the mid-40's it had a reputation as a "tough" hospital, with not a very well trained staff.—e.g. there was one R.N. on staff until 1958, 3 until 1968; 1st trained social worker 1968; no formally trained psychiatrist. At the time of my arrival in March 1974, the average age of the 8 man medical staff was 73. One of the elderly physicians was incontinent, 2 other showed obvious symptoms of chronic brain syndrome, a fourth was overtly schizophrenic.

Earlier the high point in patient census had been 1700—until the Dixon Class Action suit in 3rd circuit Federal District Court clearly found that patients were illegally and repeatedly recertified as "too dangerous" to be released or transferred to other institutions in the mental health system. Over 500 patients were removed to other hospitals—reevaluated, and almost all were released to the community with not one incident indicating dangerousness occurring in the subsequent 3 years.

The Farview staff continued to operate unchanged; it became quite clear during the first 3 months of my responsibility (while splitting my time between 2 institutions Farview and Norristown State Hospitals) that the personnel regarded patients as animals, and that patients were regularly subject to group assaults by "guards", and that group kicking and beatings were part of the program. This was confirmed by patients and staff who were too intimidated to report it officially but unequivocal that it had been that way for several decades. Patients and staff felt totally unprotected, that the state officials had been informed many times before and that it was common knowledge at the hospital. However complaints were cycled back to the staff resulting in more beatings for the patient camplainers—and clear threats to staff "dissidents". A number of superficial investigations never pierced the shared guilt and secrecy of the staff.

How could they have this much control? This way! The guards controlled all ingoing and outgoing mail, destroying anything they felt might lead to trouble for them—including writs to court. All telephones were monitored by a guard/operator who listened to all calls.

More subtle control system included "nice" patients who would get toilet paper; cooperative patients were given lucrative rackets, i.e., take food from the kitchen and sell it as grossly inflated prices on the ward while, illegal hours of serving meals left a 14 hour gap between evening and morning meals; patients needed a racket to be able to afford to purchase their clothes back from the laundry, but the food supplied above and purchase liquor or drugs supplied illegally by some of the staff.

Less subtle systems including group attack by guards, sexual assault by other patients or guards on patients, use of "the peanut"—a small unheated closet where one could be confined nude for days. Verbal abuse, ridicule and racial slurs against patients were commonplace. Degrading experiences were an everyday happening e.g. meals were served and eaten in 7 minutes, with a single spoon as the only utensil no matter what the menu was and with no napkins. This forced the most fastidious patient to eat like a slob and wipe his hands on his clothes, reinforcing his feeling inferior, dirty, and animal like.

In sharp contrast to staff food and service, patients were offered fruit and vegetables still caked with dirt, direct from shipping crates.

Within this system I discovered patients admitted 20 and 30 years before, who had never been reviewed at staff, never given active treatment, but were confined and exploited by daily unpaid labor with little or no hope for discharge. When I arrived there were in excess of 60 patients who were over age 65 yet retained in this maximum security, poorly staffed facility. Our 108 year old maximum security threat found the morgue as the only guaranteed exit from that place.

Attempts to correct such systematic humiliation exploitation and abuse were extremely difficult. One had to live in it to begin to get the breadth and extent of the violations. All previous superficial investigations had boiled down to "patients word vs staff word" and the staff could rightly say to a complainer "they'll never believe you, you're crazy—so complain all you want". The same administrative staff over the last 25 years could not have been ignorant of the tenor of treatment and abuse. Attempts to investigate complaints of abuse made to me by patients during performed rounds were a joke. The guards would admit a fight with a patient, claim self-defense and the complainer would be in more jeopardy since no one could be fired or suspended without proof. One Social Services employee witnesses an unprovoked assault, reported it and as the suspension papers were typed 5 minutes later, returned to state, "I didn't see anything"—"I've got to live here". Several employees gave information confirming the worst sort or arbitrary sadistic treatment, but feared for their lives and stated they would deny it if asked by investigators.

In asking for investigative aid from the state police, there was a 4 month stall, as the Dept. of Welfare and justics demonstrated again and unwillingness to pursue seriously the grave charges involved.

The administrator willing to correct the situation must also be willing to resign, and risks being identified as "the problem"—since it is cheaper fiscally and politically to discredit the complainer than risk the scandal of exposure and redress.

The voiced support of the Regional Dept. of Welfare director faltered so as no slots for hiring qualified staff were found, and failed completely when at my resignation, with a 14 page typed report to the Secretary of Welfare, Dept. of Justice and the Governor—she was fully informed of the contents, but later testified that I resigned for "personal reasons". The initial investigation prompted by the report was designed to produce minimal evidence i.e., all were allowed to testify only to things personally witnessed, with a very predictable white wash result, never published.

Other practical problems of the administrator include the fact that no insurance coverage from State or private carrier is available regarding "depreciation of civil rights" suits. The legal damages potential is huge, and real correction is beyond the effective power of an administrator in a Farview type situation. One may be obliged to ask to be sued to get evidence and testimony for correction.

The protracted testimony, i.e., preliminary investigation, grand jury and later possible trials is much more than many administrators are willing to volunteer. The pursuit of the problem through the delay tactics of the State, and one's likelihood of being a witness against your employer, produces quiet resignations instead of fights.

This legislation is needed—but design it to ensure successful contact to a federal attorney in spite of a staff and tradition of the Farview type. Where well intentioned and honest staff feel powerless and unprotected, you cannot rely on them to make the contact. Good institutions may not welcome it (they are already doing the job) but they do understand the need for review and that any institution may start to develop illegal, sadistic tactics—no one need tell this committee of the danger of power holders of shallow integrity, and the problems of cover-up.

The importance of a free press, and diligence of 2 reporters like Mr. Moore and Mr. Rawls was never so clear to me as in a situation like this. Their real pursuit and tenacity under one segment of constitutional guarantee protected citizens and laid the ground work for a genuine investigation to protect another constitutional guarantee when the government failed in its responsibilities to protect and provide.

Senator BAYH. As I recall, in your statement you say the guards run Farview.

Dr. McGuire. Yes, sir.

Senator Bayh. Do they run Farview contrary to the better judgment of the so-called administrator of the hospital?

You talk about controlling mail going in and out. You mention running rackets. Are they actually running rackets there?

Dr. McGuire. Yes, sir.

Senator Bayh. Perhaps the other gentlemen would want to elaborate on that. I would like somebody to do so.

TESTIMONY OF WENDELL RAWLS, JR., WASHINGTON CORRESPONDENT, NEW YORK TIMES, AUTHOR, "THE FARVIEW FINDINGS," AND ACEL MOORE, REPORTER, PHILADELPHIA INQUIRER, "THE FARVIEW FINDINGS

Mr. Moore. Senator, we are here, first of all, obviously to reiterate and stand by the material that was handed to the committee, the printed material, to emphasize the fact that myself and my colleague, Mr. Rawls, have no doubt that the material and the allegations that are contained within the printed matter are the absolute truth.

We believe these conditions exist and that the things which were outlined did happen. To me the Farview story represents the most sordid and brutal story that has ever been told. That comes from an individual who has heard a lot of stories in my 15 years as a journalist covering urban Philadelphia and the courts and being aware of the kinds of injustices that occur on a daily basis. Farview to me personally represents the worst.

Senator Bayh. I wish you and Mr. Rawls would pick out some of these obvious abuses and zero in on them. Tell us what you saw there. I assume you corroborate everything that Dr. McGuire said.

We put the article in the record, but I would like you to pick out what in your judgment might be the best example of these kinds of abuses and tell us personally how you observed them, how you became involved, and the kind of suffering to which the inmates were being subjected.

Senator Metzenbaum. I notice you mentioned something about human cock fights which were staged for the guards' benefit. I have never heard of that kind of thing.

Along the line of the chairman's inquiry, would you elaborate on that?

Mr. Rawls. We will run down a brief litany of the things that occurred there.

I personally want to say that I take no position for or against your legislation. It is not my job as a journalist to advise your legislation. It is not my job as a journalist to advise people on what a law should be, but it is my belief that laws already on the books should be carried out, and often are not.

Nevertheless, I would like to tell you why it is a problem for people in mental institutions, and even those who get out, to get appropriate redress.

The man who originally came to us with this story had not only been to virtually every law enforcement agency in America that could involve itself in Pennsylvania in any way, including the FBI, the State police, the Attorney General, the Governor, the Lieutenant

Governor, and the State senators, but he had also been to every newspaper in the State. In every case, because he had been a patient in a mental hospital, a hospital for the "criminally insane," he was not believed. He was considered as a person whose facts had no basis. In fact, they thought they were not facts.

He was turned away everywhere until he came to the Philadelphia Inquirer. He came to Acel Moore. Perhaps the reasons we knew, or that Acel knew, that there was some basis was because authorities were about to exhume a body because of a complaint that a family had made on behalf of a man who had died at that hospital 10 years earlier.

Even after one gets out of such an institution, nobody believes you. The poignant thing is that nobody ever believes such a person because he is automatically suspect when he begins writing letters to his Congressmen, when he begins writing letters to his Senator, when he begins writing letters to the President of the United States, or to the Attorney General. People say, "Boy, what a nut. This man is going to write to the President and thinks he is going to do something about it."

The truth of the matter is that all of these letters and complaints fall on deaf ears. They end up with some aide somewhere, and they find themselves in file 13, and the man remains in the institution.

Just the fact that he has written a letter to the President of the United States certifies him as insane in the minds of most people.

You start with that problem, and then, as Dr. McGuire said, the letters end up coming back to the institution for action.

In this hospital not only was mail censored going in and going out, but they had assigned a guard who was the mail censor. He would check every piece of mail that went out and every piece of mail that came in.

If the people made purchases, they would check every package that came in. They were allowed to order things from Sears, Roebuck and other catalog places.

The guards would take the mail as it came in, go through the boxes of material, find those things that would fit them or their friends, remove them, take them home, and use them themselves. Many times in helping the inmate—or the patient, as they prefer to call them at Farview—fill out his order form, they would fill out the sizes that would fit the guard, not the patient. When the shoes came back from Sears Roebuck, they did not fit the patient but they fit the guard. When the clothes came back, they fit the guard. This could include shirts, pants, slacks, underwear, whatever.

The patient had no legal redress there because there was no one to listen to the patient's complaint.

They are 130 miles from Philadelphia. They are probably 300 miles from Pittsburgh. The majority of the patients there came from those two urban areas. Very few, if any, attorneys are going to drive from Philadelphia—and it is a 4-hour drive over rough mountain roads; an hour away from Scranton, Pennsylvania—to interview a man for perhaps 30 minutes to an hour. Then there is a 4-hour drive back. He would have used a 9-hour day to interview his client who cannot pay him any money, nor can his family pay the attorney any

money. Consequently, you do not find attorneys driving up to Farview to interview a client.

The attorneys in that area are disinterested because this is the largest employer in that county. It is a stronghold of Republican patronage and has been for decades. It is the leading economic cornerstone of the entire community. It pours something over $11 million into the local economy. If that is closed down, since anthracite coal mines are closed down, there is virtually no other employment for many of these people.

A patient does not have the legal redress because no one can come there. They are not going to come from Pittsburgh there and fly in and fly back.

At the same time, up until the time Dr. McGuire came the only board-certified psychiatrist they had had there in at least three decades was the superintendent of the institution who involved himself not at all in the day-to-day operations or therapy in his institution.

There were men who had been there 27 years and who had not had a single psychiatric or psychological evaluation.

I would say roughly one-half of the patients there were diagnosed to have organic brain syndrome, which is a brain damage problem of some form or another. Yet none of them had been examined by a neurologist. There was not a neurologist on the staff.

The average age of the doctors when we started investigating this was something in excess of 65 years old. All of them had retired and none of them had had any training in psychiatry, much less being Board certified. They were internists.

They were performing surgery at this hospital and there was not a surgeon on the staff.

They were taking veterans and social security benefit checks and forgoing the names of the patients, the recipients, onto the check. A man would come in from outside the hospital, would give the guards so many cents to the dollar, let's say, to take the checks off their hands and give them cash. Then he would take it out and launder it, leaving them with cash.

The gambling was purely rampant. We coined the phrase "cock fight." There they call it "taking the floor."

For pure sport they would take one inmate who was a good fighter and pit him against another inmate who may or may not be a good fighter. The guards would bet on the outcome. They would bet with each other and with the patients.

The loser was a double loser because after he had lost the guards' money he was then kicked and beaten more severely and thrown into a room about 4 feet wide by 5 feet deep and allowed to sit there until he may or may not recover. Some did not recover.

There would be one window in this room. Often in the winter in the Poconos it gets very, very cold. Below zero is not uncommon in the dead of winter. They would open the window and let the snow come in. They would hose the patient down and leave him in this room in subzero temperature for a day or two.

It was common when a man came to the hospital that he was first placed in a shower that only had one faucet. It was cold. If

he complained, he was severely beaten and told that if there were no more complaints he would get along fine.

He was then sat on a bench, often strapped with leather restraints to that bench, for a day or 2 days or 3 days. He was left there until they decided he understood what he was supposed to do. Then he was placed in an open ward, something in the neighborhood of double the size of this room, to sit, sleep, or walk.

If he was interested in watching television, fine. If he was not, fine. If he could find anything to read, fine. If he could not, fine. The name of the game was not to cause trouble.

If he did cause trouble, then perhaps another patient would be assigned to fight this inmate. He learned his lesson pretty quickly.

The guards would bring pornographic literature in and rent it to inmates for $5 for 30 minutes or perhaps sell them a book for their own personal use for $20.

They would bring contraband whisky into the hospital. They would take a fifth of whisky and fill Coca-Cola bottles half full and fill the rest of it with water. They would sell a Coke bottle of such whisky for $20.

You wonder how the men have this kind of money when there is supposed to be no money on their person. It comes again back to the gambling which went on constantly in a room where they would book horse racing bets, baseball parlay cards, football parlay cards, basketball parlay cards, numbers rackets, and of course the betting on the outcome of the fights. There were dice games going on constantly in every area, even in the yard of the institution.

At the time we began investigating this hospital there were approximately 400 inmates and 500 employees of the hospital. They cannot complain, at least in this instance, that the State did not fund them properly.

At this point, right now, they have 170 patients. Over 200 inmates have been released as a result of this series. They still have something near 300 guards. There is almost a two-to-one ratio between guards and patients.

Mr. Moore. There are 272, to be exact.

Mr. Rawls. It is almost 2-to-1, guards to patients.

They never had a nurse at this hospital until I believe 1972.

Dr. McGuire. Before that they had a single male nurse until 1958. Then they got a second nurse. They had only two until the late 1960's. Only in about 1970 did they start getting what became up to a staff of 20 nurses.

These 20 nurses were very effectively controlled by the guards. They were locked in the nurses' station for their protection, which meant they were not out talking and dealing with the patients. They were locked in the nurses' station. They had to pound like hell on the door to get out to go to the bathroom.

If they were not nice nurses, they did not get to go out to go to the bathroom.

When they went on the ward, the flying wedge was surrounding them to protect them allegedly from the patients. The nursing staff that finally was recruited was rendered helpless because of this.

They were told unequivocably, "If you create too much trouble, some day you will need us and we won't be there." That very effectively stifled the nursing staff.

Mr. MOORE. There was one individual, a man by the name of Ash, who survived the ordeal. He was there aproximately 22 years. For his first 7 years he remained in a dungeon-like room with his wrists and ankles chained and he was naked. He remained 7 years in that condition, literally 24 hours a day.

Mr. RAWLS. You must understand that not only was he naked, with these leather restraints hand and foot, but the room had no bed; it had no commode; it had no sink; it had no rug; it had no sheet; it had no blanket; it had no pillow; it had no mattress—nothing. The room had six concrete walls including the floor and the ceiling. That was all that was there.

This man was there naked in that room for 7 years and 7 months. Often they would come in and he would complain about something, so they would just pick him up and drop him.

They would open the windows in the winter and let the snow come in. The heat would melt the snow. They would turn the heat off and so the floor would freeze or glaze over, and he would have to sleep on that.

You might think these are exaggerations, but this is literally the truth, for your own edification.

I guess we wrote 70,000 words in the series, but I do not know. That is our advance text to you.

Not one time did anyone ever question a single fact, date, middle initial, number, at any point by anybody in the State system.

This hospital was going to be closed in 1973 or 1974. Dr. McGuire was there. He had stated, "We cannot operate a hospital like this." The Lieutenant Governor agreed to it. The Secretary of Welfare agreed to it. The labor unions, of which the guards were members, did not agree to it. They got 40,000 signatures. They chased the Lieutenant Governor, and they chased the Secretary of Health, and they chased the Governor. The hospital continues to exist.

To this day the only people who are opposed to closing that hospital are the people who live in that area and members of the American Federation of State, County, and Municipal Employees.

Senator BAYH. Since your exposé of a year ago have there been significant changes in the day-to-day operation of Farview?

Mr. MOORE. Yes; there have been some changes. I think as long as the light is still on the situation I doubt if anyone is being brutalized to the extent they were when we began to first look into this over a year ago.

There have been a number of staff changes. They have hired their first Board-certified psychiatrist since Dr. McGuire left.

Governor Milton J. Shapp has created a statewide task force to look into the matter. The task force, a 17-member panel made up of mental health and criminal justice experts, has been instituted to determine the immediate future of Farview and to develop a statewide plan for the treatment of the mentally ill offender and defendant. They have a deadline of October 1, 1977.

The State's mental health act is being enforced, specifically in the area where men who were in prison and who were administratively transferred to Farview without being processed and without the proper psychological and psychiatric examinations. There were about 73 individuals at Farview who were there under those circumstances and in violation of the State law.

There now appears to be some attempt to implement a treatment plan. This was the plan with which we were always presented when we inquired about the kind of treatment that people were receiving.

The Federal agency that certifies hospitals to receive medicare and medicaid funds also investigated the institution about a month after our first series of articles. That investigation led to the cutting off of those funds.

Their conclusions were to the effect that even if plans of proper treatment were developed for the patients there, the physical plant prohibited the carrying out of the treatment plan.

Most professionals in the criminal health field feel that even if you got the properly trained people with a treatment plan, it could not be implemented at an institution which was built at the turn of the century. The physical plan is not conducive to the proper treatment of people who are emotionally sick.

Senator BAYH. Dr. McGuire, could you tell us how you got assigned to Farview? What steps did you take to try to remedy the conditions you found when you arrived? What results were you able to accomplish through the State process? What happened to you personally?

Dr. MCGUIRE. I started there in March of 1974. I was also superintendent of Norristown State Hospital at the same time. I was covering both institutions for the first 4 and a half months. I would spend 3 days at one and 2 days at the other during that time.

Over the first 4 months there was a gradual growing awareness of the kinds of problems that the institution had. The kinds of obvious things that were within my control to change, I could get those changed.

I sat in and ate with the patients in their dining room. They were served considerably different from what the staff had. They had no napkins. They had one large spoon with which to eat a chicken. They had no salt and pepper. They had no sense of dignity.

Within 7 minutes a whole ward of nearly a hundred men were brought in, waited in line, served their food, ate their food, and left. That was a 7-to-8 minute flat eating period.

I could change those kinds of things, insisting that the guards give up their scrambled eggs as a second entree and that the patient instead have eggs, which the dietary department claimed was impossible to do. Obviously it was not impossible to do. It simply required doing it.

Those things that I could check such as that, I could change.

The priority that I had was to try to stop beating and the assaults. I had not witnessed one personally. I got from the patients many, many of the same stories. It would always get back to the staff. The staff would say: "We were defending ourselves. He impulsively assaulted us and we were simply defending ourselves."

Senator BAYH. Did you see the evidence of the beatings, if you did not witness the beatings yourself?

Dr. MCGUIRE. The patients would show bruise marks and this kind of thing.

Other staff people would come up and say: "Hey, that is true. They do. They beat them every night. It is a regular occurrence. I will not say anything. I will deny it if you put me under oath, but

this is true." This happened on many occasions so I had many reasons to think that the patients' reported assaults were an accurate report.

The longer you stayed there and the more information you received, the deeper was the conviction that these were accurate reports.

The first few attempts of me trying to personally investigate alleged beatings resulted in a worse case for the patient than when he started out. If you start asking him what happened and then go to the ward staff and ask them what happened, then you wind up with no courtroom-type of evidence and the patient then gets threatened the next night that he had better keep his mouth shut or he is going to be in real trouble. He says to me: "Thanks a lot. You really helped me," and obviously I had not helped him at all.

I asked for State police intervention because I felt I needed a trained investigator. I got 4 and a half months of stall from the State police. It went through the Department of Welfare to the Department of Justice because the State police operate under the Department of Justice. Four months later I still had no investigator. I received answers that were irrelevant to my request. I got no trained investigator, and the beatings went on.

The problems with the beatings was No. 1. Probably No. 2 on my agenda was trying to get the medical staff so that they were not dangerous. It was an elderly medical staff. The average age when I came in March of 1974 was 73 years, I was told. I put in my report the unlikely character of this medical staff.

What was frightening to me was either the combination of drugs that were being prescribed or the amount with the age of the patient involved, and the fact that none of these men had psychiatric training.

I had personal friends from other staffs of other hospitals come up and give lectures on psychopharmacology and things of this sort, trying to get the medical staff so that they would not wind up with a body on their hands.

Those kinds of things that were under my personal control, I could do something about. I found myself unable to deal with the beatings.

The number of staff people whom I trusted, whom I felt were concerned about what was happening to patients, numbered 8 to 10 compared to a staff of over 500. The numbers simply were not there to modify what had become a corrupt hospital with their own traditions of silence and their own traditions of covering up what had happened.

I was told later that staff who departed also complained, and that nothing happened with those complaints.

I finally felt that I could not get the hiring slots to hire trained people to come in and help and I could see no end to the abuses that I knew were going on, so at that point I felt my obligation was to give as detailed a report as possible to the proper people. I resigned at that point with a very long statement to the Department of Welfare, the Lieutenant Governor, the Department of Justice, and I kept a copy for myself.

They started to have an investigation before I left, but that investigation was a very strange one. Investigators came in and asked

only what had been seen with your own eyes. They did not want to hear about anything else. They did not want to hear whom to talk as sources of more information. That investigation was never published at that time and was basically a noncommittal finding. I thought it was grossly inaccurate.

I waited for well over a year. I was promised that they would transfer patients. I was promised that they would get an ombudsman lawyer on the staff. Neither of those promises were kept.

On calling back to find out what the status of the hospital was, they were still going at almost the same number as before.

When Mr. Rawls and Mr. Moore contacted me, I cooperated very much with their investigation simply because the State clearly had too many conflicting interests in this matter. There was a great expensive correction involved. There was the high likelihood of considerable scandal involved.

The staff, who worry about their families and worry about eating next month and so on, are not in a position to blow the whistle on a place that needs that.

Have I covered what you wanted me to cover?

Senator BAYH. Yes; I think you have, very well.

Mr. RAWLS. I think the important thing to reiterate here, is that the Farview situation, at least in Pennsylvania—and I have reported in two or three States now—is not a unique example.

Prior to the happenings at Farview State Hospital, in western Pennsylvania they literally had mentally retarded children in cages, wooden-slat cages, 4-feet high and 4-feet long. They would stay in these cages every day all day long and were not allowed out. The lady who was head of the Department of Welfare discovered this was the case and moved to remove the superintendent of that hospital, but she was not allowed to remove him. In fact, she had to reinstate him because the State law did not specifically state that you could not put people in cages. Since he had not technically broken a State law, he had to be reinstated with backpay in order to correct that situation.

It did not really correct it, except that she put into her directives from her department that you could not put people in cages any more in the State of Pennsylvania' Therefore, anybody who did so was violating at least the departmental regulation, if not State law.

In the situation in Tennessee, for example, at Central State Hospital, virtually the entire staff are doctors who are foreign. They are not certified by the American Medical Association and are not members thereof. By and large, they do not have psychiatric training. They are just physicians who need jobs and they have openings for physicians so they hire physicians, many of whom cannot speak English. Therefore, they cannot communicate with the patients.

That brings you back to Farview which had many Hispanic patients there. Even at their own administrative hearings the State would not supply them with an interpreter. So you have a judge or a board there who does not speak Spanish and the patient does not speak English. They will not provide the patient with a lawyer or an interpreter or anything else so that he can understand what the panel or judge is doing or what is going on in the administrative

hearing. He cannot even get his points across to them. It is a very cavalier attitude.

He goes back to the hospital. He cannot get out. Nobody knows what he is thinking or his point of view. He does not know theirs. He just knows he is behind some locked doors and he does not know when he is going to get out or, in many cases, why he is even there.

Mr. MOORE. There was a special investigating grand jury impanelled at the close of last year. That grand jury, among other things, is investigating between 18 and 24 deaths that the coroner in the county where the institution is located has classified as suspicious. They handed down their first resentment 2 weeks ago and charged two current guards and one former guard with murder, perjury, and conspiracy in connection with the 1966 death of a Philadelphia man. In fact, it was the first case on which Wendell and I reported.

Senator BAYH. I appreciate what you have done to let the people of America know what the worst in humanity can do to some who are so unfortunate as to not to be able to be in complete control of their own faculties.

Senator Hatch, do you have any questions?

Senator HATCH. Dr. McGuire, how long were you superintendent of Farview?

Dr. MCGUIRE. Ten months, sir.

Senator HATCH. Ten months?

Dr. MCGUIRE. That is right.

Senator HATCH. Would you be kind enough to provide for our record a copy of your actual statement which you made when you resigned?

Dr. MCGUIRE. I can do that.

Senator HATCH. If you would, I think that might be helpful to us because that was closer to the fact, and it might be very helpful in this particular matter.

Dr. MCGUIRE. Yes, sir. I will do that.

Senator HATCH. You were the superintendent for what period of time?

Dr. MCGUIRE. Ten months.

Senator HATCH. When was that?

Dr. MCGUIRE. From the 1st of March until the 1st of December.

Senator HATCH. Of what year?

Dr. MCGUIRE. Of 1974.

Senator HATCH. Were you appointed?

Dr. MCGUIRE. Yes, sir.

Senator HATCH. Who appointed you?

Dr. MCGUIRE. The Secretary of Welfare.

Senator HATCH. In Pennsylvania?

Dr. MCGUIRE. In Pennsylvania.

She was a lady of some integrity in this matter, but I think her integrity was overriden.

Senator HATCH. Who is that?

Dr. MCGUIRE. Helen Wohlgemuth.

Senator HATCH. Who do you suspect overrode her integrity?

Dr. MCGUIRE. I think other political considerations, and I would only assume her political superiors.

Senator HATCH. Who would they be?

Dr. MCGUIRE. They would be the Lieutenant Governor and the Governor.

Senator HATCH. Who were they at that time?

Dr. MCGUIRE. Milton Shapp and Ernest Klein.

Senator HATCH. How would you categorize that hospital presently, or since you have resigned?

Dr. MCGUIRE. I have no personal information. All I know is the newspaper reports as to what is going on.

Senator HATCH. Do you believe the same things are still going on there?

Dr. MCGUIRE. I believe if they have the same basic guard staff, then many of the same things are going on. However, with the light of the present investigation, it must be much more subtle than before.

Senator HATCH. You saw what was going on and you tried to do something about it, but you really could not get very much support or help so it was basically futile; is that correct?

Dr. MCGUIRE. A man came to me from the Social Services Department saying, "I have just witnessed an unprovoked assault by two guards on a patient." I said, "Great. I need something to get the message across that hitting patients will not be tolerated."

He wrote up the immediate suspension pending removal orders. That took about 4 minutes flat. The man came back into the office and said, "I didn't see anything."

I said, "What do you mean you didn't see anything?"

He said, "I didn't see anything. I have to live here."

Without his testimony, I had no case. I suspended nobody.

That is the kind of situation in which you find yourself. The staff does not hesitate to threaten each other.

In some of the investigation before the Pennsylvania State Senate, one of the witnesses who was a guard, who was the only guard at that time willing to tell the truth, John Naughton, was very clearly threatened with bodily harm if he spoke up.

They use intimidation, threat, and bodily harm. They place aces, and the patients know it. The other staff members know it. That is very intimidating.

Senator HATCH. Didn't the administration do anything for that hospital up until the time you left in 1974?

Dr. MCGUIRE. They brought in the State police at the time I left because we were concerned about the fact the guards had told the patients, "Heads will roll. When McGuire leaves, you are all going back to work and heads will roll." I took that very literally. The State at that time did provide State police coverage. I think they took over the mail and I think they took over the telephones, at least temporarily.

They did start that investigation, and that investigation was a very modest effort at best.

Those are the things that I know happened because part of it was happening when I was still there.

Senator HATCH. Did you try to talk to Governor Shapp or Mr. Klein.

Dr. McGuire. I talked to Lt. Gov. Ernest Klein, who was very open and heard very clearly what we were saying. Lt. Gov. Klein and then-Attorney General Packell and the Department of Welfare lady, Helene Wohlgemuth, were present at a meeting, plus their aides and some other people. I brought down two patients with me who were very clear minded and very good witnesses. I brought down the head of the Social Service Department and my wife, both of whom had worked in the hospital and knew the hospital very well and very unequivocal in the kinds of things we told the officials.

I thought at that time, "Ah, now we are going to get something going."

Senator Hatch. Basically what you are saying is that you think there have been some superficial attempts to straighten it out, but you feel it is probably the same today as it was when you left in 1974; is that correct?

Dr. McGuire. If the same staff is there, yes, sir.

Senator Hatch. It is basically staffing that is causing the problem?

Dr. McGuire. I would suspect that within the past year with all of the investigational light that the newspaper articles brought, this would have probably toned way down at Farview. Even a very good, well-run hospital is always in danger of having this develop on the night shift, on the afternoon shift, or sometime when the activity level drops in the hospital. Any good hospital is subject to having this kind of corruption develop in one ward or in one wing. All it takes is the shift leader and two or three people to work with him.

Somebody starts bringing in booze, supplying illegal things, and allowing illegal occurrences. It is always a problem even in good hospitals.

Senator Hatch. But generally only in isolated areas rather than across the board; is that correct?

Dr. McGuire. In a good hospital the rest of the staff will finally find it out and blow the whistle and the people get fired.

However, here you had a whole staff, with some exceptions, but basically the whole hospital was run this way for 20-some years.

Senator Hatch. Mr. Rawls and Mr. Moore, as I understand it, you wrote your very penetrating and important article starting in June of 1976. These were basically the first articles written that exposed the difficulties at Farview; is that correct?

Mr. Rawls. Yes.

Mr. Moore. Yes.

Senator Hatch. At that time, which was about 3 years after Dr. McGuire left, did you find the conditions about the same as he has described them here today?

Mr. Rawls. Yes. They were no longer limiting a man to one sheet of toilet paper. They did have napkins because Dr. McGuire insisted they have napkins. He insisted that they have toilet paper and free access to it. He insisted that they have more than just a spoon with which to eat. He insisted that they have more than 7 minutes for 100 men to eat.

By and large, the rate of brutality was about the same. The rate of sodomy was about the same.

Senator Hatch. The really bad things remained unchanged; is that correct?

Mr. RAWLS. Yes. That is right.

Senator HATCH. What is your conclusion—is it the same today basically, except for some of these minor changes, as it was when you first started your investigation? Or has your investigation helped bring about some actual change?

Mr. RAWLS. I am sure there are some changes.

Senator HATCH. But you still feel it is bad?

Mr. RAWLS. There is no question about that.

Senator HATCH. Have you talked with Governor Shapp or Mr. Klein or anybody else in the State government?

Mr. RAWLS. They would never talk to us. We have made written requests. We have sent telegrams. We have sent registered letters. We have made personal phone calls. At no point would they even say "no." They would never even respond by turning us down for an interview, except one aide finally said, "He's not going to talk to you." We were never able to get an interview in 1 full year with anybody higher than the secretary of welfare.

Senator HATCH. Did Governor Shapp or any of his aides give you any explanation why they would not talk to you?

Mr. RAWLS. They did not want to talk to us.

Senator HATCH. Why?

Mr. RAWLS. For the same reason you would not talk to me if you did not want to talk to me.

Senator HATCH. But I don't know of any newspaper man I wouldn't talk to.

Mr. RAWLS. Governor Shapp knows quite a few.

Senator HATCH. I think it is abominable, frankly.

Mr. RAWLS. It is not limited to Pennsylvania.

Senator HATCH. I understood that.

I think it is abominable that he would not talk to you. I think it is abominable that he would not open up his facilities to you, especially with some of the findings that you found, and that he would not personally lead the crusade to solve this problem.

Mr. RAWLS. We could not even get through the bureau of vital statistics the age, the date of birth, or the cause of death of 20 people who had died at that institution. They died between the ages of 35 and 46 supposedly of heart attacks. There were 24, as a matter of fact.

Senator HATCH. Are these the 24 about which Dr. McGuire was talking?

Mr. RAWLS. Yes.

Senator HATCH. The ones that are suspect?

Mr. RAWLS. That is right.

The State would not even give us the date of birth of the people who had died, the cause of death, where they were from, or any information. They said it would be a violation of privacy. They would not even give it to the coroner.

Senator HATCH. I will tell you how private I think that is, Mr. Chairman. I think we ought to ask Governor Shapp to come down here and testify. I think we ought to get him in here and just have him explain some reasons why. These are not just ordinary little expositions.

Mr. RAWLS. Even the coroner could not get it without going to court. He did not get it until the special prosecutor subpenaed those records from the State within the past 6 months.

Senator HATCH. Do you think it would help you and your investigation if Governor Shapp or Mr. Klein, or both, testified here in front of this committee on this particular subject?

Mr. RAWLS. I am no longer with the Philadelphia Inquirer.

Senator HATCH. I understand, but you are still interested.

Mr. RAWLS. I am still interested or I would not be here.

It would help, I am sure, the investigation——

Senator HATCH. I would respectfully request that the chairman invite them down here. I think we ought to hear what they have to say as to why they would not open up the records to you and let you really investigate this thing. I can see why under certain circumstances a Governor may not want to cooperate if the charges are unsubstantiated or if there is some sort of rabble-rousing or something like that.

Here you fellows, as I understand your reporting and as I have read some of it in the past—and I have not read any today but I have this article here—you fellows have uncovered some things that are far beyond the ordinary.

I think we ought to look into it a little bit further and see from the perspective of the Governor what causes him to, in essence, stop a reasonable investigation that has proven and uncovered wrongful-type activities.

I would like to respectfully request the chairman to consider that.

Senator BAYH. I will respectfully consider it.

Senator HATCH. I would like you to respectfully do it.

Senator BAYH. Are criminal charges now pending as a result of the investigation of the grand jury?

Mr. MOORE. Yes.

Senator BAYH. One of our other witnesses who had just been before the grand jury testified he did not feel at liberty to tell us what he said or to whom. That is the only reservation I would have right now on bringing in political figures. It might cause justice to be denied. If somebody is on the hot burner right now in the process of being criminally prosecuted, I want him to get what he has coming to him.

Senator HATCH. I do not know that we have to go into specific details, but I would like to have answers as to why he refused to discuss this matter with these reporters after they had discovered gross violations of basic human rights.

Mr. RAWLS. Even his attorney general fought access to any information—and, in fact, fought funding of the special prosecutor. The Governor's Justice Commission at first voted against funding the special prosecutor and the special grand jury investigation.

Senator HATCH. How long has Shapp been Governor of Pennsylvania?

Dr. MCGUIRE. Eight years.

Mr. RAWLS. He is nearing the end of his second term.

Senator HATCH. I guess 1978 is the end of his second term.

Senator BAYH. Within the State hierarchy who would have the immediate responsibility for this kind of thing? You mentioned the Secretary of Welfare and the Attorney General.

Mr. MOORE. The State Welfare Department is responsible for administration of the hospital. They have the immediate and most direct responsibility.

Senator BAYH. If there are alleged wrongdoings and someone needs to be prosecuted, who would do that?

Mr. MOORE. The State attorney general has a staff that is assigned specifically to the Welfare Department to handle such things.

Dr. MCGUIRE. One patient kept saying to me, "They are tearing up my writs. They are tearing up my writs."

I said, "You send the writs to me. I will mail it."

So he sent the writs to me and I mailed it. He named me at the top of the suit. I don't mind that because the suit was being brought in his own behalf, and inevitably, because I had the administrative post, I was named with about 10 or 12 others.

The problem comes in that my defense in that suit is my report to the Governor basically. It puts me at odds with the rest of the staff. The State cannot defend me along with the other codefendants named in that suit. It gets very gummy when I wind up, basically, on the opposite side of the fence from the fellow staff members named. Basically I am siding with the patient.

If somehow you feel as though your livelihood depends on this employer and you want to remain with this employer, then you are in the very untenable position with the pressures on you and the pressures from fellow employees. It gets so gummy. I think the kind of legislation about which you are talking will obviate a great deal of that.

You get a lot of quiet resignations by people who do not want to get tangled up in the grand jury testifying and then a potential criminal investigation and the criminal trials that may proceed from that.

You may linger, as I have for over 2½ years—and it may linger on quite a bit longer than that. It is a very protracted process. A lot of people do not want to dive into that. So they just quietly resign and disappear and hope to get a job at a place that is not as crazy as this place.

Senator HATCH. Were there ever any civil or criminal actions brought up to the time that you wrote your article?

Mr. RAWLS. No; there were only civil actions brought, which is the only way before we wrote this article that anybody ever got out of the place just about.

A group of law students from the University of Pennsylvania brought a class action suit.

Senator HATCH. Was this the *Dickson* case?

Dr. MCGUIRE. Yes, sir.

Senator HATCH. Was it with regard to this particular case?

Dr. MCGUIRE. It was with regard to this hospital.

Senator HATCH. Are there any other hospitals in Pennsylvania, to your knowledge, that take this approach, this violation of human rights approach?

Mr. MOORE. In today's edition of the Philadelphia Inquirer there have been charges regarding the State school and hospital for the mentally retarded called Pennhurst.

In fact, the district attorney of the county in which this State institution is located likened the conditions there to Farview. In fact, he used those terms. He has asked the State to investigate and has apparently gotten the same kinds of answers that we and others got when we asked about the Farview allegations.

Mr. RAWLS. We waited 6 weeks just for a response. We asked the State to investigate.

Senator HATCH. Have there been any Federal actions brought?

Mr. MOORE. The most damaging Federal intervention or one that corroborates a lot of what we have said is the investigation that was conducted by the social security division, the division under HEW that deals with the certification of institutions that receive medicaid funds. An investigation of Farview was conducted in July of last year. They concluded that Farview in July of 1976 did not meet minimum standards or requirements as a hospital.

In their preamble to their technical report they ran down a litany of conditions which they found and concluded that it was no wonder that abuse of the type that was charged would occur there. The situation was right and conducive to that kind of inhumane treatment.

Senator HATCH. I have appreciated your testimony here today.

I do personally think that we ought to have Governor Shapp and Mr. Klein come down here and explain why they allowed this to occur without allowing you to look into the records and the facts and circumstances surrounding this—why you have had to do it from an investigatorial standpoint. Should I say an extremely difficult investigatorial standpoint.

I have appreciated hearing your testimony here today.

Dr. MCGUIRE. I would hope that legislation that you propose has some method of circumventing a situation—of going through and making it possible for a patient to successfully contact and get a response from a Federal attorney. I think that is one of the problems that exists.

Senator HATCH. Unfortunately, I do not think this legislation does that.

Senator BAYH. With all respect, I think it does. In fact, I think it goes right to the problem that we have here.

When you talk about the *Pennhurst* case, as I understand it, that was brought by a patient. The courts have ruled that the Justice Department has authority to enter into a case that has been brought by another plaintiff. However, when you have the kind of a police state operation described here, where you can't even go to the john without getting special dispensation as a member of the staff, it is almost impossible—if not totally impossible—for an inmate or a patient to bring a suit.

In those instances where the Justice Department has attempted to initiate suit, such as the *Solomon* and *Mattson* cases, the courts so far have ruled that the Department does not have the legal authority to do that.

I guess my colleague and I look at that a little differently.

It is just exactly this kind of thing that we are trying to deal with.

Senator HATCH. If I was looking at it practically, it is the same problem of being able to get a message across to the Attorney General that the action should be brought. You still have to prove cases, even though we all feel badly about what happens after the fact. You still have to be able to prove that it happened.

Your biggest problem and frustration, Dr. McGuire, was that you could not get people to testify.

Senator BAYH. Dr. McGuire, if instead of going to the Governor and the Lieutenant Governor, you had gone to the U.S. Attorney General, he—being bound by the *Mattson* and *Solomon* decisions—could not have initiated suit. If on the other hand you could have found somebody who could have brought the case himself, the Attorney General could have intervened in that suit.

That is what we are trying to get around. You should not have to go through that.

Mr. RAWLS. Most of these hospitals and institutions are placed away from where people are. They are placed away from communities, away from cities, away from where people do not want their properties devalued. They put them in the woods. They put them in the Pocono mountains—out of sight, out of mind.

The political considerations are such that that is where citizens want them to be. Communities fight institutions coming in and then they fight them leaving. They have become the source of economic well-being for the community.

At Farview, for example, in the nearest town the leading attorneys—and there are not many, only about seven attorneys in the entire town—four of them are members of the board of the banks in the town. The former superintendent before Dr. McGuire was also a member of the board of the bank in that town.

One is the former Republican county chairman in that area. One was a commissioner of the Turnpike Commission, who is also a member of the board of directors of the bank.

So you have them all tied in so that you cannot get a lawyer in that area, if you want to make the argument that there is legal representation in every town, you cannot get a lawyer near Farview because anything he does affects the well-being of the bank, the well-being of himself, and the well-being of the hospital. All of the deposits of the hospital are going into that bank.

It is just a cesspool of political corruption that makes it impossible, virtually politically impossible, for any action to occur at the State level because the pressure is brought at the State level.

Senator BAYH. This is a rather strange kettle of fish. I do not know what sort of a civil service system they have in Pennsylvania. I had been led to believe there was a rather heavy overtone of patronage as to the employment policies of Pennsylvania.

Yet we are talking about a situation where you had a Democratic Governor. I do not know what the politics of the State attorney general were. I know the Lieutenant Governor was a Democrat. Yet you are talking about the local people at the hospital, and you

say the hospital was subservient to members of the other party. How does that situation exist?

Mr. RAWLS. Money. That is how it exists.

Senator HATCH. How what exists?

Mr. RAWLS. How that situation exists that he is talking about.

For a long time you could not get anybody to comment and you could not get Shapp to comment because his former press secretary was running for Congress from that district. He did not want to get his former press secretary embroiled in a controversy about whether or not Farview should or should not exist, whether allegations of things that were going on there were or were not true. The candidate did not want to make any comments, so the Governor would make no comments that might place his friend who was running for Congress at the time in the position of having to embroil himself in a sticky situation.

Senator HATCH. Did his friend win?

Mr. RAWLS. His friend was beaten soundly.

We asked the same question. We said, "Why does he care?" He has never carried the county. Nobody ever votes for him up here. "Why does he care?"

He did not want the scandal. The status quo in Pennsylvania is a very strong force.

Senator BAYH. How could a Republican county chairman have the kind of influence that you say he has? Are the guards there long-term people who have been appointed and have civil service status and were there before Shapp got there?

Mr. RAWLS. They are civil service.

Senator BAYH. I am not trying to apologize. There is no excuse for his ignoring your message.

Mr. RAWLS. They are civil service and they are members of AFSCME.

Senator HATCH. As I understand Pennsylvania, it is not a straight civil service situation. People can be removed fairly easily.

Mr. RAWLS. At this hospital they were civil service.

Senator HATCH. They were civil service.

Mr. RAWLS. They were all civil service.

Senator HATCH. They are not appointed, are they? Aren't they just hired?

Mr. RAWLS. They are hired but they are civil service. They took the civil service examination.

Senator HATCH. My point is that the superintendent hires them; is that correct?

Mr. RAWLS. Yes. That is based on civil service examinations.

Senator HATCH. Maybe I am missing something. What did you mean by the Republican county chairman? What kind of influence does he have?

Senator BAYH. Do you want to repeat what you said, Mr. Rawls?

Mr. RAWLS. The Republican county chairman was the most powerful man in that area politically.

Senator HATCH. But he did not run the institution.

Mr. RAWLS. Basically he did. He had such influence over the former superintendent. He used this hospital as a place to have his friends hired.

Senator HATCH. What is his name?
Mr. RAWLS. Who?
Senator HATCH. The Republican county chairman.
Mr. MOORE. He is the former Republican county chairman. His name is——
Senator HATCH. Maybe we should be indiscriminate here and invite Governor Shapp, Mr. Klein, and the former Republican county chairman.
Mr. RAWLS. Mr. Lester Berlein was his name.
Senator HATCH. You are giving us one of the more flagrant examples.
Mr. MOORE. I questioned Mr. Berlein about the institution. He indicated, if my memory serves me correctly, that up until 1964 that Farview was a patronage situation. In 1964 the civil service took effect at the institution. In other words, men were required to pass civil service examinations. He said it was no longer a patronage situation.
Senator HATCH. Let me get this straight. You are not saying that the county chairman had such control that he hired and fired the people that worked at Farview, are you?
Mr. RAWLS. Yes.
Senator HATCH. The superintendent did not do it then?
Mr. RAWLS. He hired and fired them on the instructions of the county chairman.
Senator HATCH. The superintendent was appointed by Shapp, was he not?
Mr. RAWLS. No, he was there 30 years.
Senator HATCH. He had been there 30 years. Why didn't Shapp remove him?
Mr. RAWLS. You will have to ask Mr. Shapp that. We could never get an interview with him.
Senator HATCH. I see.
Mr. RAWLS. All the guards were members of AFSCME, and Mr. Shapp has very strong ties with labor. AFSCME was the biggest critic of this series.
Senator HATCH. Who?
Mr. RAWLS. The American Federation of State, County, and Municipal Employees.
The guards are all members of that.
Dr. McGuire went first to Lieutenant Governor Klein, where he felt as though he had gotten a good reception. It was after that meeting that Mr. Klein and Mrs. Wohlgemuth, the Secretary of Welfare, had determined they were going to phase Farview out and transfer these patients to other institutions.
Suddenly a petition of 40,000 signatures ended up on Lieutenant Governor Klein's desk. It was circulated by AFSCME. Mr. Shapp did not want to do anything to alienate the labor unions. All these guards are members of that union.
Statewide AFSCME mounted a huge campaign to be sure that these 300 to 500 employees up there were protected.
Senator HATCH. Who would you blame more—the labor union, Berlein, Shapp, or all of them together?

Mr. RAWLS. Prior to 1964, I would say Berlein. Since 1964, I would say the labor union.

Senator HATCH. So you would say prior to 1964 it was the Republican county chairman and since then the labor union. Since Governor Shapp has been there, you would say Governor Shapp, for doing nothing and stonewalling this thing and not letting anybody know what is going on and not letting you investigate it properly, and doing nothing about it since.

Senator BAYH. You shouldn't have to have the press come in and investigate something like that, with all respect and gratitude to you for what you have done. That ought to be a service performed by people who are being paid by the taxpayers to keep that kind of thing from happening.

Senator HATCH. There is no question about that.

Mr. RAWLS. With all respect, that is true, but we always do.

Senator HATCH. Unfortunately, it is the press in many cases that straightens out wrongdoing. Unfortunately, it is the press that has to do it in many cases.

Mr. RAWLS. In most cases.

Senator HATCH. In many cases.

Mr. RAWLS. In most cases. I think Watergate explained that.

Senator HATCH. I think there is some truth to that. I think the press deserves a great deal of credit in many cases—maybe in even most cases, but certainly not in all.

[Laughter.]

Mr. RAWLS. I think you will find the States that have the least problem with this are the States that have the strongest newspapers.

Senator HATCH. I just want to say we have appreciated your testimony. I do think maybe as part of these hearings we ought to go into this in a little more depth because what you have said is astounding. I think it should be astounding to anybody in America.

Pennsylvania is certainly not an uncivilized State. There are a lot of good people there who I am sure would be very upset and shocked by this.

Whether it is Shapp, or the union, or whoever—we ought to find out.

Maybe that would help us, if we are going to have this legislation, to refine it even more. I do have some question about the legislation being constitutional the way it is presently written.

We have appreciated the work you have done and the good efforts that you have made. I think it has been quite enlightening to us today with regard to this one situation.

Senator BAYH. Gentlemen, thank you very much. I have a feeling that we have not heard the last of this case as far as this committee is concerned.

We are after results. We want to try to get some legislation to help alleviate this kind of situation where it exists.

Personally, I think the record will show that Pennsylvania is not the only State where this has happened.

Thank you. You have all been very kind, gentlemen.

[The following series of articles from the "Farview Findings" submitted by Messrs. Rawls and Moore were marked "Exhibit No. 7" and are as follows:]

[EXHIBIT NO. 7]

[From the Philadelphia Inquirer, June-July, 1976]

THE FARVIEW FINDINGS

(By Wendell Rawls Jr. and Acel Moore)

Farview State Hospital is not a hospital at all.

Officially, it is Pennsylvania's institution for the criminally insane. But in fact it is a warehouse where an odd assortment of inmates—some criminal, some insane, some neither—are kept out of society's sight.

It is not a pleasant place. Troublemakers, or those who look as if they might be troublemakers, pay a high price. Sometimes the price is a beating, or two beatings, or years of beatings. Sometimes it is death.

In the spring of 1976, Inquirer reporters Acel Moore and Wendells Rawls Jr. began an investigation of conditions at Farview. The more they learned, the more clearly they saw that this was not just another penal institution with an occasional instance of brutality.

Moore and Rawls worked day and night, visiting former inmates in various prisons, at their homes and wherever else they could be found. They tracked down former guards, social workers, scholars and others who had first-hand experience at Farview. Using documents and testimony, they corroborated allegations of beatings, of bloody human cockfights staged for the guards' amusement, of patients battered again and again until they died, of such victims being certified as dead of heart attacks. They also found a nearly total absence of medical care.

What they ultimately demonstrated is a pattern of extraordinary, systematic brutality, spanning a period of decades. Farview, it turns out, is a place where troublemakers can be put away forever.

Moore and Rawls published the first of their series, "The Farview Findings," on June 27. The articles are reprinted herewith.

PART I—THE STATE TREATS PATIENTS WITH DRUGS, BRUTALITY AND DEATH

Waymant, Pa.—Farview State Hospital, in the rolling wooded countryside north of the Poconos, looks almost like what it was once intended to be—a benign circle of three-story brick buildings where the mentally ill who have committed crimes are treated and, if possible, cured.

A passerby driving through this anthracite region could almost mistake it for a small college or a resort hotel or a monastery.

It is none of those things. Over and over, those who have been patients at Farview and who have been lucky enough to get out describe it as a living hell on earth.

And there is a wealth of evidence from others—guards, administrators, scholars and even government investigators whose findings have been suppressed—that the description is chillingly accurate.

A three-month investigation by The Inquirer has revealed that:

Farview State Hospital is a place where men have died during or after beatings by guards and by patients egged on by guards.

It is a place where men who have died this way have been certified as victims of heart attacks.

It is a place where men have been pummeled bloody and senseless—for sport.

It is a place where an unwritten code requires all the guards present to hit a patient if one gaurd hits him.

It is a place where patients have been forced to commit sodomy with guards and other patients.

It is a place where men have been forced to live naked for years on end, sometimes handcuffed on icy floors.

It is a place where guards have sponsored patients in human cockfights and bet on the outcome.

It is a place where there is virtually no treatment aside from the use of mood-altering drugs, some of which other institutions abandoned a decade ago.

It is a psychiatric hospital without a board-certified psychiatrist.

It is a place where a man under a 30-day sentence for disorderly conduct can wait 30 years for his freedom.

It is a place where decades—26 years, in one case—can elapse between the time a patient is admitted and the time he gets a psychiatric evaluation.

It is a place where men have been denied such basic amenities as toilet paper.

It is a place where staff members and patients alike must like in a system based on hustles, extortion and theft.

These are some of the findings of The Inquirer's investigation—an investigation prompted by the complaint of an embittered former patient and based on score of interviews and on the study of numerous documents previously not made public. Those interviewed include former and present guards, administrators and state officials, as well as patients who have been freed or transferred to prison.

The main findings—homicide, coverup, neglect, corruption, brutality, sodomy—form a pattern that spans the last three decades and possibly longer.

The current administration at Farview, interviewed last week, says it is trying and succeeding in stamping out many past abuses.

But the pattern of crime and neglect at Farview has easily survived all past attempts at reform, and two high-level staff members interviewed in recent days say that any new attempts at reform have yet to penetrate the guard structure that runs the hospital.

State law-enforcement authorities have long known about the abuses at Farview. Their files include strong evidence of crimes, including murder, and yet nothing has been done.

The files also include admissions from investigators that their work was superficial in crucial ways.

In November 1974, State Attorney General Israel Packel ordered an investigation of "allegations of threats, beatings, illegal contraband and deaths at the institution" at the request of Helene Wohlgemuth, then secretary of the Department of Public Welfare. Most of the investigating was done by the Bureau of Investigation, but the State Police also conducted inquiries about deaths at Farview.

By the time the results came in, Packel was no longer attorney general. On April 16, 1975, his successor, Robert P. Kane, wrote his conclusions on the matter to Frank S. Beal, then the secretary of public welfare. He said, ". . . there have been a multitude of occasions where staff has used force against patients," but concluded that such force had not been "excessive or unlawful."

"There is no evidence supporting allegations of criminal violations at the hospital," Kane said, but he did conclude that "there are serious problems caused by patients' possession of money and other contraband . . . and that there has been a lack of administrative resolution of these problems . . ."

How was that conclusion reached?

By listening to guards and ignoring patients, according to an accompanyiing letter by Cecil H. Yates, director of the Bureau of Investigations.

Yates cited two predicaments that, he said, made his department's investigation "superficial." One problem, he said, was that the credibility of patients certified as both criminal and insane "must be viewed as questionable."

However, Robert Hammel, current acting superintendent at Farview, says that fully 30 percent of the 453 patients at the hospital have never been convicted of a crime. And the records at Farview are filled with accounts of patients who were admitted not because they were "insane," but because they were troublemakers elsewhere or, in some instances, because a court somewhere simply made a bureaucratic error.

Yates also noted that his investigators had perused the medical records of guards injured by patients, but not those of patients who claimed to have been injured by guards. To do the latter, he said, would be "legally questionable."

Thus it was, he said, that "no attempt was made . . . to thoroughly analyze the problem" or to recommend "corrective actions."

The narrower, simultaneous State Police investigations into three deaths did turn up strong evidence of murder in one case—the death of Robert (Stonewall) Jackson in 1966. In two other cases there was conflicting evidence. In yet another three cases not involved in the investigation, questionable circumstances surround the deaths. In none of the cases were charges lodged or reforms proposed.

To moviegoers who saw "One Flew Over the Cuckoo's Nest," the circumstances under which "Stonewall" Jackson died at age 36 may have a familiar ring.

But Jackson died, and law-enforcement officials were told how, long before the film was made. It is a death that illustrates a pattern described by many former Farview patients—beatings, murder, incorrect records at the hospital and indifference from legal authorities.

Jackson's mother, Mrs. Alma Jackson of Southwest Philadelphia, says she visited him at Farview about three months before his death on Sept. 24, 1966.

Stonewall, she told The Inquirer, had acquired the nickname because of his formidable size and strength, and but when she saw him at Farview his body was weak and twisted.

"He walked with a stick," she recalled. "He was all bent over. He told me that they were going to kill him, that he didn't have long to live."

She said she asked a doctor why her son was being mistreated. "He told me that my son wouldn't talk. He said that he was stubborn and that 'we are going to break him.'"

According to William, 57, who spent 22 years at Farview and now lives in Philadelphia, Jackson quarreled with guards on "D" Ward one evening on or about Sept. 21, 1966. It was near midnight, Ash says, when the guards "dragged" Jackson out.

Jackson ended up in a medical ward. A patient there, William James Wright, who is currently in prison at Dallas, Pa., awaiting sentencing for murder, was interviewed by State Police investigators 18 months ago.

"As a patient, I witnessed Robert Jackson beaten," he related. "He was cuffed by his hands and legs to a bed with leather restraints.

"It was later in the evening sometime between 10 p.m. and 6 a.m. Jackson was making a lot of noises. He was disturbed. The guard told a patient to stop Jackson from making noises.

"The patient then went out of the office and struck Jackson in the throat with the back edge of his right hand. He struck him only once and Jackson started to gag and about 20 minutes later he died."

Another former patient, William Franklin Sipes, 30, of Philadelphia, told the State Police he also saw a male nurse strike Jackson in the throat after Jackson knocked a tray off his bed with his knee, spilling some of the food on the nurse.

"As soon as I seen what was going on, I got away," Sipes said. "I was worried about what could happen."

Another inmate, Clayton Allen Terhune, told the investigation that he witnessed Jackson's final moments. "Jackson's arms and legs were cuffed," he said. "He was restrained to a bed . . .

"This is how it happened. The inmate working in the ward placed a pillow against Jackson's face while he was cuffed to the bed. The pillow was held against his face for a long time. In fact, the patient got on top of Jackson and put his weight on the pillow against (Jackson's) face. During this time the nurse was standing beside the bed. He was watching and did nothing about it."

The hospital's official paperwork on the death mentions none of this.

The cause of death entered on the death certificate by Dr. Joseph D. Moylan, a staff physician who is now dead, was acute coronary occlusion with myocardial infarction—a heart attack.

No autopsy was performed, and the body was embalmed by a guard who is also a registered mortician.

Jackson's mother recalls the condition of the body when she received it.

"His neck was crooked," she said, "his arm looked bent out of shape."

A year ago, Dr. Halbert E. Fillinger Jr., assistant Philadelphia Medical Examiner, concluded in a letter that was part of the State Police report:

"The police investigation involving the circumstances surrounding this man's death as substantiated by several witnesses would certainly cast doubt on this diagnosis (death by heart failure). As a matter of fact, the information supplied to the police by several witnesses would strongly suggest that this man's death is of a highly suspicious nature.

"There are certainly several allegations that the deceased may well have been suffocated with a pillow and that the cause of death given on the death certificate is a totally erroneous one.

"If the allegations of these several witnesses interviewed by the State Police have any basis in fact, the only conclusion one can draw is that a felonious death had occurred and a thorough investigation must be conducted to pin-

point the person responsible for this man's death and see that he is brought to justice."

No charges have been filed in the death and no evidence has been presented to a grand jury, as far as The Inquirer can determine. Several years after Jackson's death the male nurse was fired for allegedly smuggling a pistol to an inmate.

Since The Inquirer began looking into Jackson's death, however, the State Police have shown a renewed interest. Mrs. Jackson said she was called last week.

"They asked me questions about his death," she said. "I tried so hard to get someone to listen to me back in 1966. No one would help us. I knew that whoever killed him would never have any rest, never have any peace."

The death of Calvin Bush on Oct. 11, 1973, may or may not have been murder. In either case, it says a great deal about what passes for medical care at Farview.

Bush, 32, died of a heart attack. At the time of death he was being subdued by eight guards, one of whom weighed nearly 200 pounds and was sitting on his chest.

The incident apparently began shortly after breakfast that day when Bush returned to the minimum-security ward where he had been living for about a year. A guard, who later testified before State Police investigators, said that Bush threatened to kill him, called him a "goddam white man" and then threatened to knock his "block" off.

The guard said that Bush had frequently been abusive, but that this time it was decided to transfer him to either the "N" or "D" wards, which the guard characterized as "a little rougher than the ones I have (worked on)."

But Bush refused, saying that he wasn't "going no place," the guard recounted. Bush then picked up a chair but was persuaded to put it down. When he walked out of the day room, eight guards dragged him to the floor and began fastening his arms in a leather restraining device.

While the guard, who estimated to State Police that he weighed 197 pounds at the time, sat on Bush's chest, a doctor ordered a 100-milligram injection of Sparine, a tranquilizer, to calm Bush down.

But Bush died first.

That, however, did not prevent guards from rolling him over and pulling his trousers down to allow a male nurse to administer the injection.

An autopsy by Marvin E. Aronson, Philadelphia's medical examiner, disclosed that the dose of Sparine was indeed given but remained concentrated in the left buttock near the point of injection. It was never circulated because Bush's heart was no longer beating.

The official cause of death was "cardiac arrythmia due to hypertension aggravated by excitement."

Coroner Robert Jennings of Wayne County told The Inquirer: "I knew he died of a heart attack, but I also feel that such things are brought about by unusual stress and that struggling with and being restrained by eight men, some sitting on his chest, could cause enough anger and stress."

The indiscriminate use of drugs was also manifest in the death of John Rank, 68.

Last March 2, Rank was given a ham sandwich by a guard. In quick succession, according to a post-mortem report, Rank "developed bizarre agitated behavior, jumped up from where he was sitting, ran head lowered, smashed into a wall and fell to the floor."

He was soon dead.

An autopsy disclosed than Rank apparently had choked to death on a part of the ham sandwich—an unremarkable fact, except for the fact that he had earlier been heavily sedated with a drug that inhibits swallowing.

When John Rank died, there was no nurse on his floor and no doctor in the hospital. Dr. Bernard J. Willis, the hospital's assistant superintendent and clinical director, told The Inquirer: "The doctors got tired of being here all the time."

When a nurse from another floor arrived, she tried to give aid, then telephoned Dr. Willis at home.

According to a preliminary investigation by Coroner Jennings, Dr. Willis ordered the body removed to the hospital morgue and placed on a table.

The body remained on the table for 14 hours and was never placed in refrigeration. Eventually it was picked up by the coroner's office and an autopsy was performed.

By the end of last month—three months after his death—John Rank had yet to be officially pronounced dead by any official associated with Farview State Hospital, according to the coroner.

A toxicological report on the thin, pale elderly man was performed by National Medical Services Inc. of Willow Grove, Pa. Dr. Richard D. Cohn disclosed these findings:

"The level of chlorpromazine (Thorazine) detected in this individual's blood is more than double the usual maximum therapeutic level. It is reasonably certain that at the level of (Thorazine) found to be present in the blood, pronounced central nervous system depression was obtained and that coordinated and reflex actions were significantly impaired.

"The blood level (of Thorazine) found is not inconsistent with an acutely toxic (Thorazine) concentration which in the absence of similar or more competent causes, could be competent, independent causes of death."

Thomas L. Garrett, 37, died at Farview on March 19, 1960, according to hospital records.

The cause of death, again according to hospital records, was a sudden and unexpected pulmonary embolism which Garrett suffered after spending 17 days in the medical ward with a fever.

What killed Garrett, however, according to patients who say they witnessed it, was a sustained beating by guards that took place in a Farview dining room in February of that year.

Hospital records say that Garrett was confined to the maximum-security ward in February after "attacking guards," and was transferred to the medical ward on March 2 after he came down with a fever.

Hospital records, however, are contradictory on the subject, and an autopsy said to confirm the cause of death cannot be found.

Ward notes for the day in question say that an autopsy was performed by Dr. Harry Probst of nearby Wayne County Memorial Hospital. Dr. Willis, clinical director at Farview, also told State Police who investigated the incident in 1975 that Dr. Probst performed the autopsy determining the cause of death.

Dr. Probst, however, told police that he could not recall any such autopsy.

The director of nursing at Farview told State Police that he was present, along with a lab technician and a guard, when Dr. John Perridge, at the time Wayne County coroner, performed the autopsy confirming the cause of Garrett's death. He said that copies of the autopsy report went to the county coroner, to the Department of Public Welfare, to two undertakers and to Farview itself.

However, Dr. Perridge told police that his records indicated that he had never performed any such autopsy, and all of the supposed recipients of the autopsy report told police that they had never received it.

Dr. Willis, who signed the certificate of death attributing Garrett's death to a pulmonary embolism, told State Police on Jan. 21, 1975, that he could remember nothing of the incident. Twenty-three days later, his memory had greatly improved. He told State Police that he remembered the incident "very well" and said that Garrett had appeared to be responding well to treatment for fever when, suddenly, he died.

Patients who were there remember it differently. They say that they believe Thomas Garrett died because he was brutally beaten by guards. They told State Police that one day in February 1960, Garrett asked a guard for a job in a dining hall and was refused. Then, they said, Garrett slapped the guard, whereupon a number of guards attacked him and beat him. Heyward Speaks, a Farview inmate at the time, who currently is an inmate at the State Correctional Institution at Graterford, Pa., told The Inquirer that he witnessed the incident. "All the guards around kicked and stomped Garrett," he said. "They stomped and kicked him in the side of the head. Broke him up real good. Then they put him on "J" ward (Farview's maximum-security ward).

"I was one of the last to see him alive. I went on the ward to shave and cut the inmates' hair. When I went into Garrett's cell, I saw he was busted up. His jaw was broken. He was semi-conscious. He was trying to say something, but he couldn't open his mouth. His ribs were busted up as well. I told the guards that I couldn't shave this man . . . Ten days to two weeks after that, Garrett died. We were told that he died."

The Inquirer is not the only party to whom Speaks has told his story. In 1969, he wrote to the State Department of Public Welfare, detailing the

Garrett incident. The department handled the matter promptly. It mailed Speaks' letter back to Farview—namely to Dr. John Shovlin, the superintendent at the time. Later, Speaks said, he wrote to the state attorney general on the same subject. That letter, too, was referred back to Dr. Shovlin.

State Police did look into the Garrett incident in their 1975 investigation after another patient told them that he had heard the story of Garrett's death from many inmates.

Nothing came of the investigation.

Russell Sell was 46 when he died at Farview on Jan. 7, 1963. The cause of death was recorded as acute coronary occlusion. On the death notice, Dr. Willis wrote that the body had no wounds, no fractures and no dislocations.

However, an autopsy one day later by the Wayne County coroner reported that Sell in fact had three broken ribs. And 11 years later, Clayton Allen Terhune, a fellow inmate, testified to Pennsylvania State Police investigating the incident that Sell actually died of a severe beating administered by guards six days earlier in a hospital dining room.

Terhune said that Sell was beaten after he waved in the air a newspaper clipping reporting that Farview had purchased a large order of beef and complained that patients received little meat because the guards were stealing most of it.

Guards told State Police investigators that there was in fact a dining room fracas six days before Sell's supposed heart attack, and that he probably broke his ribs falling against a steam table.

The hospital ward notes of Jan. 7 tried to take a middle path. They noted that Sell "died this date following injuries received while being subdued during a disturbed period during a work assignment in K-3 dining room. Contributing cause of death: acute coronary occlusion."

Consider, lastly, the way Farview cared for Alfred E. Miller, 61, an epileptic who died of natural causes this year, a week before Rank.

Miller's name came up about 18 months ago in an investigation by the State Department of Justice. John M. Fiezgerald, director or social services at Fairview, told investigators that another patient had informed him about repeated mistreatment of Miller by guards.

Miller was known as "Jughead." According to the testimony, the guards on the second shift in his ward "would get Jughead to strip and they would taunt him verbally until he would scream and carry on. The guards did this as amusement."

"Jughead" died in bed during a seizure. According to Coroner Jennings, this is how Farview handled his death:

"Mr. Miller's death was reported to me by Dr. Hobart Owens, who was scheduled to have been the officer of the day and should have been on duty. But instead he called me from his home in Hawley, Pa., approximately 20 miles from the institution.

"Dr. Owens reported Mr. Miller's death to my office without examining him or determining that he was, in fact, deceased."

"Being the doctor on duty does not require my being at the hospital," Dr. Owens said in a telephone interview with The Inquirer. "Sure, I am supposed to check the body before he is pronounced dead, but when they (the hospital) called me he was already dead.

"How did I know he was dead? A nurse told me he was dead. A nurse pronounced him dead. But it's true, I am supposed to check the body."

The patient's plight is one side of the story, the guards say. The other is the attacks on guards, and indeed there is ample evidence of guards being injured.

One guard was shot and paralyzed from the waist down by a former inmate who returned seeking one of the doctors. Another guard was bitten by an inmate and lost part of a finger. There are many other instances.

It is a fact that some of the patients at Farview are among the most vicious criminals Pennsylvania has ever produced. And it is also a fact that nearly half of them are blacks from the ghetto streets of Philadelphia and Pittsburgh, while the guards who deal with them are, almost without exception, whites from the rural area around Waymart.

Those facts and others have led several officials who have studied Farview to recommend, in private reports, that the facility be closed down altogether.

But every time the suggestion has even been hinted at, both the guards' union and much of the local populace, who consider Farview a main industry, have objected.

Consequently, Farview continues—although it does shrink. Its current inmate population of 354 is down from a peak of 1,410 in 1962, largely because of court rulings on mental patients' rights. Even given those cases, however, Farview still harbors a surprising number of inmates with no evident criminal record and some with no documented classification of mental instability.

Farview officials say that as many as 100 inmates have never been convicted of a crime but are men who have proved difficult to control at other mental hospitals. And about 10 inmates have been committed voluntarily, eihter by themselves or their families.

The officials also say, as noted earlier, that they are doing their best to stamp out the worst abuses of the past, and they assert that what goes on at Farview today bears no resemblance to what went on earlier.

It is impossible to either confirm or altogether call into question that assertion, for news of conditions, abuse and even violent deaths seeps out of Farview slowly, carried by the handful of patients released each year who are brave enough and lucid enough to talk. The Inquirer, in its investigation, has been told of murders alleged to have taken place in 1946, 1950, 1954, 1958, 1960, 1962, 1963, 1967, 1968 and 1972. What goes on at Farview today cannot be accurately assessed until possibly a year or more from now.

According to the patients violent deaths tend to happen in the same basic way. The victim, sometimes baited, gets into a fight with a guard or another patient. The guards respond by forcibly subduing the patient. A short time later the patient is pronounced dead. Usually the cause is listed as a heart attack.

But this is only what former patients say, and, as noted by Cecil Yates, Farview alumni have had a hard time persuading those in positions of authority to take them seriously. The very fact that they have been at Farview means that, whether they are or not, at one time they were branded as both criminal and insane.

That is one problem in plumbing the death of the Farview swamp. Another is the shoddiness of the records.

Many records were lost, officials say, when a basement at the hospital flooded in 1968. Some former officials add that the surviving records are not to be believed. And indeed in some cases, such as that of "Stonewall" Jackson's supposed heart attack, there is every reason to suspect that the records are misleading.

But there can be no question that inmates at Farview are, and have been treated with extraordinary brutality, of which the recurring deaths are only a symptom.

In 1975, Joseph Jacoby, a criminologist working on a study sponsored by the National Institute of Mental Health, gave a committee of the State Legislature a strong indication of the widespread cruelty.

He and his fellow researchers interviewed 269 former Farview patients who had been released or transferred to other mental institutions between 1969 and 1971 as a result of a federal court suit.

The patients were asked what they liked most and least about Farview and its staff. With no prompting at all, Jacoby reported, 45 percent of those who gave "recordable responses" cited burtality ar Farview. In contrast, less than 2 percent cited brutality in the hospitals or prisons to which they had been transferred.

Here are some of the responses, each from a different former Farview patient:

"The guards would knock you down and kick you if you talked."

"The way they beat them and kill them—I seen it done."

"They once beat up a guy so bad his mother couldn't recognize him. They said a patient beat him up."

"Beatings and stomping of the patients."

"Beatings they gave to the men. They beat me up about once a month or so."

"It's a butcher house—house of no return."

"Too brutal and cruel to you at Farview. They don't beat you here (the patient's current hospital)."

"At my present hospital they have good guards who don't resort to brutality. At Farview, your life is in danger from the minute you enter to the minute you leave."

"The guards and attendants beat me up and didn't treat me like a human being."

"Sadistic guards terrorizing and beating up on patients."

"Beating guys for no reason. My friend was beaten, had his jaw broken, and was robbed. My face was busted. I been beaten up on every ward I been on."

And so on.

Jacoby said that the percentage of those citing brutality might have been even higher had not some patients still been in fear of their former guards.

"We have reason to believe," Jacoby said, "that a number of subjects refused to answer questions about Farview candidly because they feared retaliation if they complained about conditions and their identity were discovered. One patient confided, 'They, the guards, used to tell us we'd better not talk about Farview or else. But I ain't afraid.' This fear could have been a real factor in the way some patients fashioned their replies . . ."

Another view of the violence was given to The Inquirer by John Naughton, who retired as a guard and secretary of the guards' union in December 1974 after eight years at Farview.

Naughton, now the assistant manager of a restaurant in Scranton, confirms the claim of former patients that the guards had a code that compelled them to join in on the beating of inmates.

He said that there "absolutely was a mode, an unwritten but well understood rule among the guards, that when a guard hit a patient you had to jump in. If you didn't, you were pulled off that ward immediately. You were branded as a coward, or just branded, period.

"I've seen the guards come to work and start out the shift picking on a patient and put him in the 'peanut' (a tiny room) for punishment—all for no reason, except that the guard could do it.

"There are guards there that just like to kick and stomp patients. I've seen them kick and stomp patients. There were people there that I just would not work with, because I knew I would spend all night pulling them off the patients."

Those who were wicked and stomped undoubtedly have even more vivid recollections.

Rayford Smith, who was a Farview patient from 1959 to 1964 and is now a prisoner at Graterford, told The Inquirer that he was kicked so hard in the genitals "that they ruptured my scrotum and I urinated blood for three months after the beating."

"They kicked me so hard in the stomach that I actually had a bowel movement right there. My intestines hurt for five years after that . . . ."

Arthur Pitts, 49, served two terms at Farview, one from 1963 to 1964 and the other from 1966 to 1968, and is now at Western State Correctional Institution in Pittsburgh. During his second stay he attempted to escape but was caught hiding in a recreation area.

"The guards beat me and kicked me and stomped me," he said in an interview." "Then they stomped and jumped on my shin bones until they broke both of them. They kicked me in the face and kicked one tooth out."

Heyward Speaks, 55, a convicted rapist currently serving a sentence as Graterford, says he learned an important lesson in the first hour of his first term in Farview in 1956.

"The first night I got to Farview from Eastern State Penitentiary I was met by a guard who told me I had to take a shower first," Speaks recalls. "There was only one nozzle in the shower stall. I turned it on and the water was ice cold. I started to step out and complain but I could see from out the side of my eyes that about seven guards were coming towards me into the stall.

"I sensed that I had better not complain. I held my breath and stayed under the shower until I got used to the cold water. Then I was given a nightshirt and told to sit on the bench outside the shower stall.

"I watched from the bench what happened to the next inmate, a white man who came up in the same car as me. The men turned on the water and it was cold. He jumped out and complained. They beat and stomped and kicked . . . him.

"When they finished beating him, his naked body looked like a piece of raw meat. I knew that I wasn't going to give anybody any trouble here."

PART II—THE PATTERN OF THERAPY: SEDATION AND BRUTAL NEGLECT

Waymart, Pa.—When the cornerstone was laid for the construction of Farview State Hospital on July 24, 1909, Dr. Charles G. Wagner, superintendent of the State Hospital for the Insane at Binghampton, N.Y., had this comment:

"If there were places of this kind available there would be no longer any excuse for the deplorable practice of placing the insane even temporarily in common jails where, often, regardless of sex or mental disturbance they are grossly ill-treated . . . . Concentrated effort on behalf of the individual patient will be the watchword of the future.

"Your wards will be well-ventilated apartments, lighted by electricity, heated by steam, and comfortably furnished, with carpetings on the floors, pictures on the walls and draperies at the windows, for all of these things help to banish the idea of prison bars and to make an environment that tends to aid the recovery of the patient."

That isn't quite the way it has worked out at Farview, Pennsylvania's hospital for the criminally insane. To most inmates—certainly to the former inmates, staff members and officials who talked to The Inquirer—prison, any prison, looks good after "hospitalization" at Farview.

Technically, of course, Farview is a hospital. But among inmates, guards and even administrators, both at Farview and at other state institutions, Farview has another reputation—that of a concentration camp, brutally run by and for guards. By no stretch of the imagination, they say, is it a "hospital" or a place for "care" or "therapy."

For example:

To treat its 354 "insane" inmates, Farview has not a single psychiatrist certified by the American Board of Psychiatry and Neurology.

It has only five physicians, and none of them is regularly in the hospital past normal working hours.

Particularly obstreperous patients have been "treated" by being stripped naked, handcuffed hand and foot and then thrown into concrete cells without even a mat to sleep on. Sometimes, such "treatment" has lasted for years.

There are only eight psychologists at Farview, and not all of them have degrees in psychology. There are only about 30 registered nurses (until 1972, there was one) and only eight social workers (until 1969, there was one).

There are, however, 305 guards, or nearly one per inmate. They are men who were recruited—most of them decades ago—from the rural area around the hospital. They have had little or no medical training. They are called "psychiatric security aides."

Some patients at Farview have waited for decades before psychological evaluation. Then, more years passed between evaluation and the initiation of recommended treatment.

When "treatment" finally does come, it is limited to tranquilizing drug injections for those patients the guards do not want to deal with and some minimal occupational therapy (ceramics, leathercraft, art) for a very few privileged inmates.

None of this is a secret to state authorities responsible for Farview.

As The Inquirer pointed out yesterday, both the State Police and the state attorney general's office, through quiet investigations of their own, are aware of the truth about Farview. And nothing has been done.

The State Department of Public Welfare, of which Farview is a part, has been informed of conditions there by former administrators. And nothing has been done.

A committee of the State Legislature has heard testimony by a criminologist who told of the terror that former patients exhibit at the mention of Farview and of their relief at being transferred to another institution—any other institution. And nothing has been done.

The truth about Farview lies not just in the minds of those who have lived through their confinement there. It lies, in ample detail, in reports, surveys and investigations that have been filed away in offices throughout Pennsylvania's state government.

1974 survey

One such survey, made in 1974 by a "Utilization Review Committee" of Farview staff members, discovered, among other things, that a patient who had been admitted to the hospital in 1930 had waiter 26 years for his first

psychological interview and test. It was another 13 years, for a total of 39 years, before he was given a diagnostic staff evaluation.

Another patient, admitted in 1944, waited 24 years for a diagnostic staff evaluation and 30 years for the beginning of formal treatment for his mental illness.

Another had waited more than seven years for his first diagnostic staff evaluation. At the time of the survey his formal treatment had not yet begun.

For many, the diagnostic staff evaluation might as well never have been made.

In one case, according to Dr. Michael McGuire, who was superintendent at Farview for seven months until he resigned in disgust and frustration in November 1974, the staff decided that a patient's mental condition had significantly improved and his transfer out of Far view was recommended. Dr. McGuire concurred, and directed that the patient be released.

Several days later, however, the patient was still in the hospital. Dr. McGuire said he had checked the patient's file and discovered that Dr. Bernard J. Willis, the hospital's clinical director, had in effect countermanded his order by writing a report "that bore no resemblance to the actual condition of the patient, the recommendation of the staff and my own decision as superintendent."

'Humiliation'

Another former patient, Roberto Torres, now confined at the State Correctional Institution at Dallas, Pa., recalled in a recent interview that a diagnostic staff evaluation was "simply a humiliation."

"The doctor asked me if I had performed sex with my mother or sister or brother, or whether I wanted to. Then he said he had heard that I made sex with dogs. How could he say such things? I think he is the one that is crazy."

That is not the only humiliation recalled by patients sent to Farview for care and treatment.

Patients who have left Farview for other institutions recount instances in which they were required by guards to commit sodomy on other patients and to watch while patients submitted to sodomy with guards. Leon Ziegler, who spent eight years at Farview and was transferred to another hospital 18 months ago, estimates that 75 to 100 of Farview's 305 guards have had sex with patients. (Ziegler was released from institutionalization early this year and declared sane. Currently, he is a truck driver in central Pennsylvania.)

Other patients recall having to help hold patients on the floor while a guard urinated on them or another patient defecated on them.

They recall being placed naked in the "peanut," a tiny room with a window in the ceiling—there is one on each ward—and having buckets of water thrown on them while the window was open in below-freezing weather.

In April 1973, Helene Wohlgemuth, at the time secretary of the State Department of Public Welfare banned such cells as the peanut, along with cages and netting tied around some patients. And officials at Farview today say the peanuts are no longer in use.

However, in April 1974—one year after the peanuts were banned—Farview inmate Michael Marrera, in a letter smuggled to Lt. Gov. Ernest P. Kline, complained about his own recent detention in a peanut after he had balked at an order to get a haircut.

Marrera's 26-page letter to Kline, in which he referred to Farview as "God's forgotten world," vividly detailed other abuses at Farview, including brutality, racial slurs and illicit gambling. Kline mailed the letter back to Farview—to Dr. McGuire, at the time Farview's acting superintendent. Kline suggested that Marrera's letter "may be useful in his future treatment."

McGuire turned the matter over to Thomas Glacken, a Farview social worker, who responded in a handwritten note to McGuire that Marrera "does ramble on at length about the hospital not doing anything to help patient's and in fact are (sic) actually hurting patients."

"I have to acknowledge," wrote Glacken, "there is some credibility to what he states."

No one recalls Farview more vividly than William Ash, 57, who recently spoke to The Inquirer in the dining room of the West Philadelphia home he has almost finished paying for.

Ash was sent to Farview in November 1946 after he was convicted of killing a man who was assaulting his uncle during a quarrel over an automobile accident.

Today, one prosecutor said, such a crime would rate a charge of second-degree manslaughter. But it was 1946, and Ash's jury recommended death in the electric chair.

However, Ash was spared by being sent, at age 27, to Farview for "observation" while motions for a new trial were being considered.

Farview "observed" Ash until he was 50 years old. Ash says the hardest part of the "observation" for him began one year and one day after he arrived. That was when he got into a fight with a guard and was placed in "J" Ward—the ward for maximum-security, solitary-confinement patients.

'Stripped naked'

"I was stripped naked and had my hands and feet cuffed," Ash recalls. "Then they placed me in a cell that had no sink, no commode, no bed, no blanket, no sheet, no nothing. Just four concrete walls, a concrete floor and a ceiling. There was a small window and a small opening in the door."

Ash stayed in that cell for seven years and seven months. The cuffs were removed after he had been there for three years and 11 months. But still he was naked in the bare room.

"They would throw all the food together in a small metal bowl," Ash says, "but they would give you no utensils to eat with. You just held the bowl in your cuffed hands and put your mouth down into the food."

In the winter, Ash says, the guards often would open the windows during a snowstorm, allowing the snow to blow in and melt on the floor. Then at night, the cell would get cold enough to freeze the water to a light glaze on which Ash had to sleep—naked.

When Ash went into the cell on "J" Ward, he was 28. When he came out, he was 36. Fourteen years later, he was transferred to a state prison. After a few months there, he was paroled.

Other inmates at Farview were more fortunate. They recall ordeals that lasted not for years but for days—such as being strapped to hard benches while guards in cushioned rocking chairs looked on.

They recall doctors making their rounds of the wards and addressing each patient's question or request with such responses as: "You're just as crazy as a s--- house rat" or "You're a faker" or "You're a pest."

They remember that the medication prescribed for them was chosen more often by the guards than by a physician and often consisted of powerful drug injections designed to disorient and immobilize a man.

Charles Simon, who spent 30 years at Farview, says he was never given medication during all that time, and, in fact, had trouble getting an aspirin.

"But if the guards thought you were too big or strong or belligerent, or if they wanted to render you helpless so they could do something to you, they might ask the doctor to prescribe some Sparine or Thorazine as a tranquilizer that would make you a zombie," he says. Simon, who left Farview in 1970 because a court found that he had been illegally committed, lives in retirement in Bristol, Pa.

Another patient recalls that the guards themselves administered drugs, both orally and by injection, "and if you refused the shot, the guards would hold you down and give you a shot right through your trousers."

Yet the drugs are the only therapy for at least 85 percent of the patients, according to Dr. McGuire, the former superintendent.

"When I went to Farview in early 1974," he says, "there simply was no treatment going on, except bad treatment. They were using drugs as the answer to every problem.

"They actively popped Sparine into patients regardless of their mental problem or physical condition," he says. "And Sparine is a drug that most hospitals stopped using at least a decade earlier because it can have dangerous side effects and because there are better drugs available.

"The scary thng about the indiscriminate use of drugs was the easy availability of contraband alcohol. The mixture of alcohol with the very powerful drugs presents a potentially dangerous hazard to the patients, but no one seemed to even think about that."

Other aspects

No one seemed to thtink about other aspects of the patient's lives at Farview either.

A number of patients remember being deprived of toilet paper unless they performed tasks for the guards, who could then declare the patient a "good boy" and dispense to him one or two sheets of toilet paper. Many patients recall having to use scraps of newspaper—or their hands—to clean themselves.

The patients say they were allowed one shower a week, if they were "good boys." They then had to dress without toweling.

After stating that his "personal priority" had been to stop the "kicking and beatings," Dr. McGuire said in his final report to the secretary of the Department of Public Welfare that a second priority was "to attempt to stop the peculiar and dangerous and/or ineffectual use of medications."

"The race was to train enough (attendants) to avoid a death by ignorant overdose or thoughtless combination of drugs. The unauthorized use of medication by guard staff is also highly suspected, but extremely difficult to prove and highly dangerous for the patient."

Regardless, to this day guards do give patients shots as well as oral medications, according to two highly placed administrators at Farview, even though only a handful are trained to do so.

Shower policy

When Dr. McGuire came to Farview, one of the changes he implemented was the subject of the following memo:

"Effective Friday, August 16, showers on each ward are to be open and available to every patient daily."

But, aware of the atmosphere that existed between patients and guards, he apparently felt compelled to add a paragraph:

"If any patients do not wish to take a shower, they are not to be forced to do so . . ."

When the new program was announced, Dr. Maguire was told that there was not a sufficient supply of towels for daily showers by patients and that the laundry facilities were inadequate to provide enough clean ones.

Shortly thereafter, Dr. McGuire's wife found six dozen new towels in a supply closet. Then, Dr. McGuire discovered that one reason the laundry could not supply clean towels was that it was being used to launder guards' uniforms, a departure from state regulations.

He also discovered that patients working in the laundry were charging other patients money to launder their clothes, which is illegal. Hence, another memo from Dr. McGuire:

"A blackmail system for patient personal laundry has been operating for years—why was it allowed?"

But the laundry system was not the only questionable activity that had been allowed for years. Until 1974, guards were allowed eggs as an alternative course with every meal, even though the eggs had been brought for the patients. Patients were not allowed eggs—ostensibly because the kitchen facility was not large enough to cook eggs for the 475 patients as well as for the 320 guards.

The only silverware allowed patients were soup spoons, which could not cut meat. So, on the rare occasions when meat was served, patients had to eat it with their hands. Not having any napkins, they would resort to wiping greasy fingers on their clothing.

Guards' viewpoint

Tomatoes and peaches were produced on the hospital farm. However, when they were presented to the patients at mealtime, according to several sources, they were still in bushel baskets just as they had come from the fields—covered with dust, dirt or mud.

"The guards simply could not visualize the patients as human beings," Dr. McGuire told The Inquirer. "They insisted, by their words, attitudes and actions, that the patients were animals—dogs, not people."

In his final report to the secretary of public welfare upon his resignation, Dr. McGuire reiterated:

"There is a mind-set shared by the staff and community which insists that patients are not really human beings with rights, but are animals to be caged, watched and beaten if they do not conform."

For the many blacks and Puerto Ricans at Farview, verbal abuse is added to the physical and psychological abuse. Racial slurs are commonplace and minority patients (who are only barely a minority at Farview) are subjected to added derision.

Dr. McGuire and others verify the claims of black and Spanish-speaking former patients interviewed by The Inquirer. Joseph Jacoby, a criminologist who supervised interviews with 269 former Farview patients, pointed out to a committee of the State Legislature in 1975 that, while nearly half of Farview's inmates are blacks from Philadelphia and Pittsburgh, not a single member of the guard staff, recruited mostly from the rural area around Farview, is black. He called it "a duplicate of the situation at Attica," where 41 were killed in an inmate uuprising in 1972, and urged that the situation be corrected. It has not been. Currently, Farview's staff of 509 includes just two blacks.

One patient, Walter Buress, Jr., wrote in a letter to the hospital superintendent two years ago: "I am extremely tired of being treated with a prejudicial racist attitude by people here. I am not an animal, nigger or a jigaboo. I am a man!"

Patients who spent time at Farview, whether recently or long ago, tell the same story—a story not just of mistreatment, but also of the absence of beneficial therapy.

John McCullough, a patient in the early 1960s, says his days on the wards were filled with walking single-file in a circle until he chose to sit on a bench.

"The key thing in the guards' minds seemed to be that all the patients walk in the circle in the same direction," he says.

Going outdoors

Leon Ziegler, who was released from Farview in 1974 after eight years, recalls one year in which patients other than trustees were allowed less than 40 hours "outdoors." Outdoors, said Ziegler, meant this:

"We would have almost 1,000 men in a tiny mudhole of a yard, with one (bathroom) on each side, and the homosexuals would occupy them immediately. We would be outside about 45 minutes and the guards would decide that it was time for everybody to go back inside so they (the guards) could flop their butts back into those rocking chairs."

Two activities specialists from Harrisburg State Hospital made a survey of Farview's activities program two years ago and arrived at the following conclusions:

"The problem is that the program appears to be for only a very few clients and that what is done is done for the wrong reasons. Time and again we saw a small, well-equipped work-activity area with a few favored clients working with a good staff member. By 'favored,' I mean that those allowed in the program are spared the pervasive drudgery and boredom of spending their days on the wards.

"The central damning criticism of the system there, as we saw it, is this: What about the other 85 percent of the patient population who also need meaningful activities, the joy of work, and the human relationships often formed in the work-activities setting?"

Former and present patients and staff members maintain that facilities exist for more activities, but that none are offered.

Dr. McGuire says the gymnasium and the three-lane bowling alley are seldom used—because the guards do not want to bring only a ward or two at a time to use them. He said the recreation personnel also did not want to have the floors scuffed.

The Harrisburg State Hospital specialists also mentioned the gymnasium and bowling lanes in their report:

"In the therapeutic recreation area, little activity can be observed at the beginning of the afternoon session. The recreation staff gives the appearance of being poorly prepared for the arrival of the patients: as a result, activities are not prompt in starting and are slow in attracting interest from patients. A three-lane bowling alley, a large, well equipped gymnasium, and spacious outdoor recreation areas seem to be used on an irregular basis and are not always accessible to patients during scheduled recreation periods."

And in the workshop areas:

"This small number of men are placed in the workshops without prior evaluation and testing for appropriate placement. This group remains almost

stagnant, spending many hours each day repeating already familiar projects in completing the same projects over and over; there are no clear lines of progression for the men from these lower-level projects to more skilled vocational activity."

All these things are known to state authorities as well as to the administrators of other state institutions.

"Within the state system," says Dr. McGuire, "Farview has a reputation for toughness, harshness and minimal treatment. Guards basically run the institution. Everything is done for their pleasure and convenience."

When McGuire, who said he resigned once he had discovered that he was unable to make meaningful changes to improve the mental condition of the patients, speaks of Farview, he uses words like "dehumanizing" and "harsh." The institution "unquestionably gave the message to the patients that they were less than human," he says.

A final irony: For all this, patients at Farview whom the state deeems able to pay are billed, according to their ability to pay, up to $75 a day—or more than $20,000 a yeaar—for their "care and treatment." In fact, Mrs. Alma Jackson, whose son Robert (Stonewall) Jackson died under suspicious circumstances at Farview 10 years ago, was billed $860 after his death.

She paid.

'THE GUARDS STILL RUN THE PLACE'

Waymart, Pa.—"Certainly Farview is an institution with a troubled past," acknowledges its acting superintendent, Robert J. Hammel, "and there are still a few problems, but every institution like this has them."

The "troubled past" of Farview State Hospital includes frequent charges that patients have been murdered or suffered brutality, sodomy, neglect, extortion and theft at the hands of guards and other staff members.

But Dr. John P. Shovlin, 68, was was superintendent of Farview for 25 years until his retirement in 1974, said in a telephone interview that reports of wrongdoings at Farview "the always terribly exaggerated."

"I couldn't say we did nothing wrong," he added, "but a lot of witch-hunting in the past has turned up nothing wrong."

Hammel, in conceding abuses of the past, maintained:

"Nobody ever said that what they were doing to patients here in the past was wrong. There were never any complaints from the public about the way the criminally insane were treated here. The view was that the public wanted these people locked up and heavily controlled."

Hammel's acknowledgements about the past and his tempered optimism about the present and future are echoed by Dr. Bernard J. Willis, the assistant superintendent and clinical director.

"Certainly we have some sadistic brutes among the guards," Willis said last week. "Certainly some contraband is brought into the hospital by staff—the patients don't get outside to bring it in."

"Sure," he added, "guards take advantage of patients here. It is a real problem, but it is not pervasive and is not a big deal."

Both Dr. Willis, who has worked at Farview for 21 years, and Hammel, who arrived 18 months ago and was named acting superintendent last October, maintain that the institution is changing. They portray the present administration as a broom to sweep away past abuses, and they insist that those abuses have been curtailed and are, in fact, minimal.

One thing they do not point out is that the new broom still consists mostly of old straw. The guard force, which by most accounts makes Farview what it is, remains essentially unchanged. And even at high levels in the "new" administration many of the faces are the same.

Hammel and Willis point to new therapy initiated recently or being planned. They cite treatment teams—groups of guards, nurses and social workers assigned to work as a unit—and group therapy, and they show visitors to patient workshops and recreation facilities.

"Why do people always want to look at Fairview's past?" Hammell asks. "Why don't they talk about the good things we are doing now?"

Last week two Inquirer reporters and a photographer toured Farview. From the inside, the institution seems a maze of endless corridors that form guadrangles within a quadrangle. All the windows are secured with thick metal bars painted silver. Every door is locked. Guards are everywhere.

The patients address the guards as "mister" and make frequent use of the word "sir"—sometimes at both ends of a sentence.

In a dayroom, patients were asleep on the floor and on hard benches. Others watched television. Still others were walking single-file in a circle while guards watched from padded rocking chairs.

"That's therapy," one guard said later. "They walk around and begin bumping shoulders and getting uptight, and finally they start fighting. You didn't see a treatment team, did you?"

(He, like other guards and social workers interviewed in connection with the visit, asked not to be identified for fear of reprisals.)

In the afternoon, some patients were in workshops in the basement of the buildings. Some were in art shop, two were in a tailoring shop, three or four were in a hobby shop playing with electric trains, a handful were painting ceramics. At the same time, more than 100 were in a yard where some played softball as others watched. Guards lined the area.

"See?" said a social worker. "That's one of the problems with the program. The shops and the outdoor time are scheduled at the same time, always. A patient must make a choice between shop and 'yard-out.' The guards resist scheduling one activity in the morning and the other in the afternoon.

"Did you see anyone getting treatment when you went through the place? No, you did not. You didn't see anyone even faking treatment. It is hard to fake something that does not exist."

The social worker did acknowledge that plans exist for some new programs, but added:

"We have been planning new programs for years. Look, the guards still run this place. They do what they want regardless of policy—written or unwritten. The professional staff might as well be standing on its head.

Said a guard with more than 20 years' service: "Therapy at Farview. That's a joke. There is no therapy. There are fewer reports of beating because there are fewer patients here. Things are pretty much the same as they have been for years."

THE FARVIEW FINDINGSS PART III—HUSTLES, THEFTS AND BETTING ARE A WAY OF LIFE INSIDE

Waymart, Pa.—There is considerable question whether many of the patients who are confined at Farview State Hospital—Pennsylvania's hospital for the criminally insane—are either criminal or insane.

The hospital's population ranges from those who are clearly criminals and clearly mentally ill, to those who fit only one of those categories, to those who fit neither.

But if some of the patients know nothing about crime when they enter Farview, it doesn't take them long to learn a lot about it. For at Farview, crime—by guards and staff against patients—is a way of life.

Beyond the crimes of murder, assault and sodomy—which, as The Inquirer disclosed Sunday and yesterday, are all too familiar to those at Farview—there are other kinds of crime on which the hospital almost seems to run, just as an engine runs on gasoline. These are crimes of money.

Hustles.

This is the story of money at Farview.

Money comes into Farview in a variety of forms—Veterans Administration benefits and Social Security checks that are sent regularly to inmates; cash, money orders and valuables mailed to inmates by friends or relatives; and small sums paid to patients by guards and staff for odd jobs and favors.

According to numerous former patients, money goes out of Farview in different ways:

Outright theft by guards who illicitly open patients' mail or dupe slow-witted patients into endorsing over to them Social Security or Veterans Administration checks.

Bookmaking in which patients are lured or forced to gamble their money on horse racing, numbers rackets, sports parlays or human cockfights.

Guards selling or sometimes renting pornographic pictures and books to inmates.

The use of patients to help steal food and other supplies and prepare them for pickup by the wives of guards, staff members and physicians.

The use of patients as cheap or free labor at the homes or outside businesses of staff members and administrators.

And the sale to patients of drugs and water laced with whisky.

The center of much of this activity is a room at Farview called, by inmates, guards and administrators, "the horse room."

The horse room, as described by one former inmate, is lavishly furnished by Farview standards—a bed, a large table, a window with curtains and several easy chairs. It is there, he says, that guards run the bookmaking operation—placing their own and patients' bets with an outside bookie and "laundering" patients' Social Security and Veterans Administration checks by exchanging them with a local businessman for cash.

The horse room is also where pornographic pictures are clipped from magazines for sale or rent to patients—and where inmates are frequently brought for forced sex with guards, the former inmate says.

In a recent interview, Francis Truman, captain of the guards at Farview, said he did not know exactly how much money passes through the horse room's bookmaking operation. However, he said, people "in higher positions than me know it is going on and that it has been going on and (they) have never done a thing about it."

Truman maintains that at least one physician and three other staff members besides guards currently participate in what goes on in the horse room.

What goes on there, among other things, is theft. Mrs. Judy McGuire, the wife of a former superintendent at Farview and herself a social worker at the hospital until 1974, said in a recent interview at her home in Colorado Springs, Colo., that one guard once explained to her how he and others had duped patients into endorsing their Social Security checks over to the guards.

"They would show a piece of paper to the patient," said Mrs. McGuire, "and then ask the patient if he liked to go outside for fresh air or if he liked to play ball. . . . When the patient said he did like those things, the guards would say, 'OK, sign your name here.' The patient would sign his name. That was just one way of getting a signature endorsement on a check."

Mrs. McGuire's husband, Dr. Michael McGuire, who quit after seven months as superintendent of Farview in 1974, says that he was "never fully armed with proof of what was going on," but that he did "notice certain staff members spending an inordinate amount of time standing near a pay telephone in the front section of the hospital and that the guards' union got quite upset when I tried to change that particular room to some other purpose."

There was reason for the guards to get upset. Clearly, much money was at stake.

Michael Marrera, a former Farview patient who has since been transferred to Camp Hill Correctional Institute, dwelled on Farview's bookmaking operations in an account of his experiences at Farview that he smuggled to Lt. Gov. Ernest Kline in April 1974. In the letter, Marrera referred to guards and others by "code number."

"The main pastimes at the hospital," Marrera wrote, "are, clearly, without doubt, gambling. I gambled quite often; so did other people. Certain people would borrow money from guards. The guards would charge the patients a pack (of cigarets) for every 30 cents they wanted. I have placed with guards to make a bet with 041, who is a known bookie and runs his business right here at the hospital with other guards. I'll place my bet with the understanding that me and Mr. 007 would split my winnings if I won, but I never won in that bet."

Marrera's letter went for naught; Kline sent it back to Farview with the suggestion that "perhaps it may be useful in his future treatment."

What is certain, and nobody denies, is that large sums of money exchange hands inside the hospital and that has been the case for at least two decades, even though possession of cash by patients is against both state and hospital policy.

Cash and special favors for guards seem to be a patient's only avenue to a livable existence and privileges at Farview.

William Ash, 57, a former patient who spent almost 23 years at Farview, maintains that he put a $5 bill on every letter he gave to a guard to mail for him.

"You knew the odds were pretty good the guard would keep the $5 and not mail the letter, but sometimes a guard would actually mail it," Ash recalls.

"One thing was for sure, if there was no money involved, the letter damned sure wasn't going anywhere except to the trash can."

Former patients say guards at Farview routinely opened and read mail coming to and sent out by patients. In some cases, they destroyed or censored it. Farview administrators interviewed late last week said that incoming mail was opened to check for contraband and that outgoing mail was not. Others, including attorneys inmates write to, dispute that claim.

In at least one documented case—that of Charles Simon, 68, who was sentenced to 30 days for disorderly conduct, then spent 30 years at Farview—even such privileged mail as letters to attorneys was opened and read. Not only were Simon's letters to attorneys censored, but cover letters written by Dr. John Shovlin, Farview superintendent from 1949 to 1974, were attached to them, informing the attorney that the sender was a psychiatric patient. Three different times, Dr. Shovlin warned attorneys that Simon had also written to other lawyers and wrote that the hospital thought the attorneys "should know more of Simon's mental condition."

For years, Simon was unable to retain an attorney.

Dr. Shovlin confirmed all that in testimony in a 1974 court case in which Simon contended that he had received no treatment during his 30 years at Farview.

Simon's letters to family members were not allowed to be mailed and a notation was placed in his file: "Letters contents noted for paranoid aspects. Not mailed as per censor decision."

And a letter from Simon to Sen. Herman Talmadge (D., Ga.) was intercepted and never left Farview, with the reason noted in Simon's file: "Not serving any valid purpose."

Such censorship and destruction of mail ensures that allegations of events inside Farview often fail to reach the outside community. It also prevents patients from communicating with people who might help them gain legal release.

Contents taken

Attorney David Ferleger, director of the Mental Health Civil Liberties Project, says he often receives letters from Farview patients asking: "Why won't you reply to my letters? This is the third or fourth letter I've written to you. Why don't you respond?"

Says Ferleger: "I imagine that the letter I finally received is the one they smuggled out of the place after trying three times legitimately."

Leon Ziegler, a former patient who left Farview about 18 months ago after eight years there, says he has seen guards open packages and remove whatever they wanted or whatever fit them.

John McCullough, a patient at Farview from 1960 to 1962, says that was also the case as long ago as his stay at the hospital.

"The guards would open the packages and try on shoes if there was a new pair inside. They would take socks, shaving cream, radios or whatever they wanted. Then sometimes they would come around and try to sell it to the inmate who was supposed to get the package in the first place. But if you got cash or a money order in the mail, forget it, man. It's gone, and you never knew it came."

Patients also could make money at Farview, former inmates say—although not on a scale to match the guards. They shined guards' shoes for a dime a pair.

Those who worked in the kitchen sold sandwiches and coffee between meals to other inmates.

Some washed and polished guards' cars for 50 cents or $1. Those in the laundry washed and pressed guard uniforms for 25 cents or so. And all were encouraged to charge cigarets on their store accounts at 45 cents a pack and sell them to guards for 25 cents.

With the money the patients make from such chores and sales, they may rent a pornographic picture for $5 an hour or buy a pint of water with a splash of whiskey in it for $20.

According to Ziegler, some inmates who have been at Farview many years have accumulated thousands of dollars. Some of them, however, have entrusted their money to certain guards who have told the patients they have placed the funds in a bank account outside for the patient.

Sold newspapers

Ziegler himself, an enterprising patient if ever there was one, says he sent about $10,000 home during the last two years he was at Farview, much of it from a newspaper route in the hospital that he held exclusively.

The state pays for a dozen newspapers every morning and another dozen every evening for patients to read in the ward day-rooms, Ziegler says. But those newspapers are taken by guards and doctors, Ziegler says, so, on his own, he ordered additional papers and sold them to the patients.

In addition, during the last year he was at the hospital, Ziegler says, he became something of a teacher's pet among guards and administrators. He was trusted to go from Farview to Carbondale and do carpentry work on a recreation room for Dr. Shovlin, the former superintendent.

"I am sure the material alone cost $4,000 or $5,000," Ziegler says. "And I can only imagine what he would have had to pay a professional carpenter. He paid me $750."

Dr. Shovlin, in a telephone interview, acknowledged that Ziegler had worked at his home "off and on for more than a year," but that he "wouldn't want to mention how much I paid him."

"It wouldn't be unusual to have patients working outside," he added "It had been done in the past and was encouraged as good therapy."

Shovlin said he "could not estimate" how much money he saved by having Ziegler do the work.

Earlier, before Dr. Shovlin retired and moved to Carbondale, he lived in a rent-free, 14-room, Tudor-style house, where he had two maids on the state payroll.

Such free labor is not the only benefit accruing to a some Farview employes.

Former patients say that the wives of doctors and guards call in their grocery orders to the main kitchen and patients box up the items, from canned goods to meat, toilet paper to soap. The wives, they say, then drive to the back gate and patients load the boxes into the automobiles. Fruits and vegetables grown by patients on the hospital farm are also distributed to employes and, on occasion, according to Ziegler, a guard would take some produce and a patient out to Route 6 and set up a roadside stand.

But, while employes' wives take food and supplies, patients are deprived of such basics as toilet paper, former inmates say. Guards dole out a sheet at a time to inmates who are considered "good boys." And although the state supplies such items as soap to the hospital, inmates have to purchase cakes of it from the canteen, they say.

"Almost everybody in the place had a hustle going," recalls Ziegler, a New Cumberland, Pa., truck driver who got out of Farview in 1974. "You had to have cash money in order to make it and there were guys in there who could loan $100 as easy as a bank could. If you borrowed money from a guard, you owed him a favor. If you borrowed money from a patient, you had to pay 100 percent interest.

PATIENTS FORCED TO FIGHT: 'THE GUARDS WANTED BLOOD'

Waymart, Pa.—Seasoned criminals who have served time a numerous prisons have vivid memories of violence and brutality at one place in particular—Farview State Hospital.

Some tell of watching men get beaten to death by guards.

Others tell simply of being cuffed about by guards.

But one of their most searing memories is that of watching inmates, chosen and sponsored by guards, "take the floor" against one another in fistfights that ended when one man could no longer stand up. These matches, patients say, were nothing less than human cockfights.

Nowhere else, they say, have they ever seen this sort of spectacle—only at Farview.

Most of all, those who were there remember the numerous bloody fistfights, instigated and gambled upon by guards, between John McCullough and Eugene Vernon.

McCullough and Vernon are not big men. But both are muscular. Both are fast of reflex and strong of body. And both spilled a great deal of blood at the hands of the other in bare-knckle fistfights staged by guards at Farview.

McCullough came to Farview in 1960 from Camp Hill Correctional Institute, where he was serving time for assult with a knife and auto theft and

where he was considered an unmanageable troublemaker. He left Farview in 1962 and spent nearly a decade in prison thereafter. Today, he is an auto mechanic in Philadelphia.

Vernon came to Farview in 1958, at age 15. He was charged with murder, but his trial never took place. He was released in July 1973 after an attorney retained by his family successfully argued that, given the passage of 15 years, Vernon had been denied his constitutional right to a speedy trial. But he was arrested a year later and convicted of a second homicide, a case now under appeal before the Peensylvania Supreme Court.

Vernon and McCullough each remembers the other, and the human cockfights at Farview, as if they happened yesterday.

McCullough says one incident in particular stays with him. It was a fight he observed that ended when the losing inmate could no longer get up off the floor.

The man lay there, McCullough recalls, face swollen, bleeding from his nose and mouth and deep cuts above both eyes. As he gasped for air, a guard walked over to him, kicked him repeatedly in the back and sides and screamed: "Get up, you nigger. You made me lose my money. I'll teach you how to fight!"

McCullough says he fought dozens of bouts while a patient at Farview.

The loser of the fights often would be beaten by guards who lost money betting on him.

"The guards would clear an area on a ward. They would then form a ring by placing benches around the room," McCullough says.

"The match would be stopped only after one man was either knocked out or had been bloodied," McCulough says.

McCullough says he was always good with his hands. "But when I saw what happened to the loser of a fight (at Farview), I was determined not to ever lose.

"Once I beat a man until his eye fell out of the socket. The guards wanted blood, and if they didn't get it, they would beat you even if you were winning the fight."

Other former inmates say that the guards often would stage bouts between the toughest men from different wards.

The combatants in those fights usually would be about even in size and weight, though sometimes the guards would force a mismatch—a small man against a big man.

Vernon, interviewed at Western State Correctional Institution in Pittsburgh, is a nervous, bitter man who the courts say is emotionally disturbed. His memories of Farview, however, are quite vivid and match those of other inmates in nearly every detail:

"They (the guards) would take me over to the ward where McCullough lived. They would say, 'This is my coon, my nigger. He can beat your nigger.'" Vernon says he fought McCullough about 15 times.

Vernon, like McCullough, remember the fights as brutal and bloody.

"I knocked a man's teeth out of his mouth. I broke my hand," he says, pointing to disfigured knuckles on one of his hands.

"The guards would come up to me and urge me to fight. I would be beaten if I didn't, and all my visits would be cut off. If I won, I got special privileges."

McCullough, who won most of the matches, describes Vernon as a strong fighters who fought in a rage. "He always kept boring in, no matter how much or how hard you hit him," McCullough said.

Vernon, who most often lost to McCullough, describes him only as a good fighter.

Both men say that after awhile they refused to fight one another or other inmates. Vernon says he stopped because he figured "I was going to get beat either way."

"I used to be like a Tom for the guards," he say. "I didn't want to get beat, but they beat me anyway. I finally decided that they were going to kill me anyway. I was convinced that I wasn't going to leave there alive. But I was going to die as a man. I wasn't going to do what they said any more."

Farview has left both mental and physical scars on Vernon. Both of his arms, from wrist to just below the elbow, are covered with scars and slash marks, wounds that Vernon says were self-inflicted.

"I would slash my arms with pieces of glass, metal or razor blades. I hoped that maybe if I cut myself bad enough, I would be sent to another hospital. Maybe I could tell someone about this place."

Vernon escaped once during his 15-year commitment at Farview but was captured a few hours later by State Police.

During the interview, Vernon said that the fights with McCullough were bad, but that they were not the worst thing about Farview.

THE FARVIEW FINDINGS: PART IV—CLOSE FARVIEW? 40,000 CITIZENS SAID, 'NO'

Waymart, Pa.—The official reason that the Commonwealth supports Farview State Hospital is to provide a place for criminals who are mentally ill.

But that does not explain why the support continues in spite of the alleged murder, brutality, sodomy, neglect, extortion and theft which have been detailed in recent days by The Inquirer and which have long been known to state authorities.

The reason that Farview has remained a sacred cow to politicians decade after decade has nothing to do with providing care for the patients.

The real reason is that Farview State Hospital provides 500 jobs and pumps $7.6 million a year into a local economy that has been moribund ever since anthracite ceased to be black gold.

The lobby that speaks for Pennsylvania's mentally ill criminals is so small as to be nearly nonexistent; but, for state workers, the opposite is true. Through their unions and the politicians they support, they can and do generate fierce pressures in Harrisburg.

Nobody knows this better than Mrs. Helen Wohlgemuth, a former secretary of welfare in the Shapp administration who once tried to close Farview.

"People kick and scream when an institution for criminals or the insane is proposed for their area, and they fight it all the way," she said recently. "But once the institution is built, just try and take it away. The residents the the first and loudest protesters."

Two years ago, Mrs. Wohlgemuth came up with a plan to transfer Farview's patients to other state hospitals. Wayne County, where Farview is the largest single employer, was ready.

"That plan collided with 40,000 signatures on petitions protesting the closing of Farview," she recalls, "and the plan lost."

The figure represents 10,000 more persons than lived in Wayne County as of the 1970 census.

The number of patients at Farview has been declining since 1962, when there were 1,410. Today, largely because of court decisions on the rights of mental patients, the number is down to 354.

Corresponding cuts in the staff have been resisted by the American Federation of State, County and Municipal Employes (AFSCME), to which most Farview employes belong. As a consequence, Farview today has almost one guard for every patient, although it has only five physicians, about 30 registered nurses, eight social workers and no certified psychiatrist at all.

The staff, recruited mainly from the rural area around the hospital, has also been shielded by local Republican leaders, who have long used the institution as a patronage base. Consequently, Farview now has more employes (509) than patients (354).

Thus, to some extent, those who are committed to Farview are not only prisoners of the state; they are also prisoners of the Wayne County economy.

While there has been heavy pressure on the state to leave Farview as it is, shifts in population in recent decades have made its location less and less desirable. Most inmates come from the Philadelphia and Pittsburgh areas, and the distances involved make patients' contact with families and attorneys often difficult and sometimes impossible.

Perhaps in response to the challenges to its existence, Farview has generated institutional pressures against releasing its inmates.

Lawyers, psychiatrists and others who have dealt with individual patients at Farview say that the institution operates so as to keep patients there as long as possible—including patients who are neither mentally ill, nor dangerous nor even under criminal sentence. Patients are returned to society, when at all, grudgingly.

"Once a man went there, he had limited chance of leaving," says Barry Schnittman, a New York attorney who had extensive dealings with Farview while working with the Prison Research Council of the University of Pennsylvania law school. "If you don't have patients, you don't need guards."

He cites examples.

Herbert Knapp was convicted of arson in 1949. He was admitted to the hospital in September of that year.

In 1970—21 years later—students at the Prison Research Council, working with practicing attorneys, came across Knapp's case. They wrote the district attorney in the county that had sent Knapp to Farview and they asked if the charges could be dropped.

The district attorney wrote back—saying that the charges had been dropped in 1949.

Robert Briesel, charged with contributing to the delinquency of a minor, was admitted to Farview in 1950. He never stood trial. Twenty-two years later, the district attorney of the county in which he was charged was asked if the charges could be dropped.

The district attorney agreed. But, before Briesel could be released, he died.

Spurgeon Dency was charged with arson in 1948. Charges against him were dropped in 1953. But he remained in Farview until 1973.

Milton Iseman was charged with "solicitation to commit sodomy" in 1938. In 1972, the district attorney of the county where Iseman was charged was asked to drop the charge. His response, according to Schnittman, was: "Why not?"

Another example of a patient kept at Farview for no reason is described by David Ferleger, director of the Mental Patient Civil Liberties Project.

In recent negotiations to gain the release of Donald Watkins, 64, who had been in Farview for 23 years, Ferleger says, an officer in the State Department of Public Welfare openly agreed that Watkins had no legal or psychiatric problem that would require his being detained in the hospital.

The officer's admission came almost a year after Dr. Thomas S. Szasz, a nationally recognized professor of psychiatry at State University Hospital, Syracuse, N. Y., had examined Watkins' attorney's request. Dr. Szasz called Watkins "a model inmate and a valuable worker in the hospital," and went on:

"Mr. Watkins presents the tragic story of a man imprisoned (for murder), in effect, for 22 years, without trial or conviction of any crime. Ostensibly, then, he was and is incarcerated because of his mental illness and/or dangerousness.

"If he is incarcerated for his mental illness, then it is important to note that mental illness is not a sufficient justification for commitment. Moreover, Mr. Watkins is not receiving any kind of treatment.

"Finally, if his 'illness' were treatable, the hospital surely has had enough time—22 years—to treat it. If it could not cure till now, more time will not enable it to effect this miracle."

Dr. Szasz's recommendation was to "restore a legally innocent and mentally competent human being (Watkins) to the freedom that is his constitutional right."

Even with Szasz' and another psychiatrist's independent evaluations, it still took almost a year for Watkins to gain his freedom. And that came only after Ferleger continued to press the authorities for his release. Finally, Ferleger says, one official of the State Department of Public Welfare said:

"If anybody is going to push his case, we will let him go. Do you want him out? OK, we'll let him out."

Watkins was released in May.

Families of patients, too, tell of Farview's reluctance to part with its inmates.

One woman, who asked that her name be withheld because her former husband, a former Farview patient, is now leading a normal life in a suburban community near Philadelphia, says that doctors at Farview "told me my husband would never, ever come home, that he would be there the rest of his life."

"In fact," said said, at the time her husband entered Farview, "the doctors advised me to get an annulment of our marriage even though our baby was only 2 months old."

She said the hospital asked her to sign a statement giving it permission to administer electroshock therapy to her husband, "and then the doctors wanted me to sign another statement releasing them from any responsibility if my husband should die while undergoing electroshock treatments."

She refused to sign either statement and immediately went to a public defender to get help. She was able to have her husband transferred to Norristown State Hospital after three months at Farview.

Other factors

There are two other factors that encourage the staff at Farview to keep patients longer than necessary.

One is that those who are nonviolent and good workers—and therefore excellent candidates for release—are also valuable assets in the day-to-day operation of the hospital. The other, according to attorneys who have dealt with Farview, is an attitude that the only mistake the hospital can make is to release a patient who might later get into trouble.

Dr. Michael McGuire, superintendent of Farview for seven months until he resigned in November 1974 because his attempts at reform were constantly thwarted, says that when he arrived it was common to see patients who had been there 30 years fail to gain release "because they were good workers, either on the farm or in the kitchen or medical sections."

"Many patients' charts indicate that it is possible to remain at Farview State Hospital for 20 to 30 years, being termed too dangerous to be (confined) in less than maximum security but never or rarely tried on any medication likely to influence the course of the illness," Dr. McGuire wrote in a final report to then Secretary of the Department of Public Welfare Mrs. Helene Wohlgemuth.

"These same patients may have never been to (diagnostic) staff or may wait years between staffing. However, they may be regarded as safe to work for 10 to 20 years every day on the farm with minimal supervision."

Frightening

In an interview with The Inquirer Dr. McGuire said the fact that "some men could be there for decades and never get therapy, yet be confined as crazy and just be used for labor, is almost more frightening than the misuse of drugs and the inhumane treatment."

Richard Bazelon, a Philadelphia lawyer who six years ago won a lawsuit that brought about the release of about 50 patients from Farview (only 30 were returned after outside evaluation), says that "all the pressures are felt at Farview to continue to hold somebody and never let them go. Doctors there just recommitted patients as an office procedure.

"There is a high degree of self-preservation there. The state entrusted those people (hospital staff) with safe-guarding society against potentially dangerous people. In essence, the state said, 'Make sure these people never bother us.'

"The only way the people in charge can make a mistake, then, is to release somebody who may go out and do something bad. So, the doctors there, and even most outside psychiatrists occasionally called in for independent examinations, continued to maintain that the patients were not significantly enough improved for release.

"Farview became a place for forgotten individuals. For them, it was like being put in a tomb."

Stephen Walker, a lawyer from Chicago who spent one summer at Farview as part of a Prison Research Council project, agrees with Bazelon's contentions, but adds:

"Even with outside, independent psychiatrists, recommendations on whether a patient stayed or was released depended more on who the doctor was than on the condition of the patient.

"Most of the so-called independent psychiatric evaluations would last between two and five minutes. The doctors were being paid by the state on a per-patient basis. The doctors tried to see a lot of patients in a day. Very rarely did the recommendation mention release."

Far away

One of the frequently noted problems with Farview is its location: as far away as possible from populated areas—and from relatives and attorneys.

This geographical positioning has had two significant results. One is that families can rarely see their incarcerated relatives—and, in some cases, the damage inflicted on them (most inmates are from the Philadelphia and Pittsburgh area). The other is that face-to-face legal consultation between patient and attorney is difficult.

As Dr. McGuire point out to Secretary Wohlgemuth, "No matter how well motivated, it is very difficult and unlikely for counsel to travel 2½ to 4 hours one-way to interview his client, and telephone consultation cannot be considered confidential at this institution."

One of the threats to Farview's continued existence is the continuing pressure of patients-rights suits.

Dr. McGuire, in his report to Mrs. Wohlgemuth, said the state was vulnerable to "a number of highly winnable lawsuits, and if called to testify, I could have to support the basic contentions of the patients in most instances."

Among the subjects of legitimate lawsuits that he mentioned in his final report are "failure to treat, treatment inadequacy and maltreatment with ridiculous combinations and use of drugs, patient abuse, violation of peonage (work) regulations, illegal commitments."

Sources closely connected to the hospital maintain that the last item on Dr. McGuire's list is something the state is and has been aware of for some time. In fact, actual lists of patients who are being held in violation of the law have been compiled more than once by staff at Farview. Such lists have been supplied to the hospital's superintendent, who notified the Department of Public Welfare of their existence.

The most recent such listing says that almost 200 of the 354 patients now confined at Farview are being held there possibly in violation of the Mental Health Act of 1966. About 65 of those patients were committed under a section recently declared unconstitutional because they were denied due process. However, the state is appealing the ruling and the patiens are being retained at Farview pending the outcome of the appeal.

An additional 114 may already have been held longer than allowed by law, and 14 and 15 more "should be converted to a different status because they have already been held longer than the 60 days allowed for the status under which they were committed," said one source familiar with the legal situation.

In light of the legal vulnerabilities and present staff and conditions, McGuire thinks the possibilities for reform and meaningful change at Farview are limited.

"I think the only correct course would be to close down the place," he says.

Ferleger thinks the same.

"It is my strong feeling that Farview State Hospital should be closed down completely, the facilities taken down, and the property used for some non-incarcerating purposes," he wrote to Mrs. Wohlgemuth on Nov. 25, 1974.

"As you know," he wrote, "it is impossible to find qualified staff (especially nonwhite staff) for Farview, and the terrorism practiced on the inmates is so ingrained that it probably cannot be changed."

Can anything be done? Mrs. Wohlgemuth recalls that when she planned to transfer all Farview inmates to other state institutions, she got support from Lt. Gov. Ernest Kline after a meeting in his office in November 1974.

"I know I wanted to close Farview," said Mrs. Wohlgemuth in a recent interview at her home in Sewickley, Pa., "and that Ernie Kline wanted to, too, and so did Gov. Shapp.

"The reason they didn't close it is based on politics, the power of the AFL-CIO and the public employes union."

Her recollection of the meeting in Kline's office is supported by a Dec. 4, 1974, memorandum to her from Dr. James R. Harris, who was also present at the meeting. It said:

"We are beginning today a national recruiting effort for a new superintendent, as this is an urgent necessity, even if Farview is to be phased out."

The "national recruiting effort" ended with the selection of Dr. Franklyn Clarke, of Norristown State Hospital, as acting superintendent at Farview on a part-time basis. He was followed closely by Dr. Ulysses E. Watson, of Eastern Pennsylvania Psychiatric Institute, who served as part-time acting director until Robert J. Hammell became part-time acting superintendent in October 1975. Hammel remains as acting superintendent.

In fact, a state statute was enacted in 1975 to allow a person with no medical degree to be a superintendent, because, officials say, no physician would take the job at Farview.

This problem, too, is related to Farview's remote location.

'An excellent idea'

Oddly enough, one of those who think that Farview ought to be closed is Dr. Bernard J. Willis, a 21-year veteran of the hospital and now its assistant superintendent and clinical director.

In an interview last week, Dr. Willis said he ethought it was "an excellent idea" to abolish Farview as a maximum security mental hospital.

"I think the state should build two smaller hospitals, one near Pittsburgh and one near Philadelphia, and move these patients out of here," he said.

Many others—former patients brutalized at Farview, administrators, attorneys and state officials—agree with that conclusion, and have for years. But the political and economic pressure to make no changes are great.

So, the horror and the terror that is Farview, Pennsylvania's hospital for the criminally insane, goes on.

TAPES AND PHOTOS DEPICT HORRORS

(By Acel Moore and Wendell Rawls Jr.)

Los Angeles—"Them beatings takes their toll . . . a man can only take so many and then he dies."

Those are the words of a guard on duty at Farview State Hospital, recorded without his knowledge by a patient who escaped 6½ years ago.

The words are part of six hours of taped conversations with guards and other staff members as well as about 100 photographs and 150 feet of 8-mm. movie film that the former patient, William J. Thomas, covertly compiled with hidden equipment in his eight years at Farview.

Thomas has provided the material to The Inquired as part of its investigation of Pennsylvania's maximum-security mental hospital.

Thomas, who now owns a Los Angeles printing firm, has copyrighted all the material for use in a book and a motion picture he intends to produce.

There is no question about the validity of the material. It is clear to anyone who has visited the institution that the movie footage and the photographs were indeed taken at Farview. Both interior and exterior scenes are unmistakable. And on the tape recordings, voices of guards who are still at Farview are readily identifiable.

The taped conversations include:

A guard acknowledging to Thomas that two inmates, John Rankins and Robert (Stonewall) Jackson, died on Farview's medical ward after repeated beatings by guards on other wards.

A guard discussing beatings with Thomas and telling him: "If you dropped dead right here right now, I'll load you up on a f...ing wheelchair...you died on R Ward (the medical ward.)"

A guard explaining that an experienced guard can beat a patient so "there's no marks on the guy."

A guard explaining that guards kick patients with their boots rather than hitting them with a fist so as not to hurt their hands.

An account of how a guard knocked a patient to the floor of a shower stall because the patient did not stop showering when ordered to.

Another guard asserting that patients get no psychiatric treatment, and that sometimes a patient remains at Farview only because a staff member holds a grudge against him.

A dietary staff member saying that guards' meals are much superior ("roast beef and steak and ham") to the meals, supposedly the same, that patients receive.

The photographs show patients sleeping on and under hard wooden benches; patients injecting themselves with hypodermic syringes; whiskey stored in staff lockers; lighter fluid in open availability; guards sleeping in rocking chairs while supposedly dangerous patients, declared criminally insane and committed to maximum-security confinement, sit beside them; hacksaw blades smuggled into the hospital by guards; and pornographic pictures that are brought into the hospital by guards and then sold or rented to patients.

The movie footage shows a homosexual advance by one patient on another who, Thomas says, was too "out of it" to defend himself; patients drinking from bottles of whisky, which, if combined with certain drugs, can produce fatal complications; inmates shooting up with a syringe; and a dice game in progress during "yard out" (outdoor time) while guards look on with a group of kibitzers.

After a three-month investigation of Farview, The Inquirer disclosed a pattern of violent death, organized brutality, sodomy, gambling, theft, extortion, contraband, neglect and lack of treatment. The Inquirer also disclosed that the state had conducted at least two investigations into conditions at Farview, but had made neither public and had taken no further action.

Since the articles were published, a legislative committee headed by State Sen. Henry J. Cianfrani (D., Phila.) has begun an investigation of Farview and Welfare Secretary Frank Beal has advocated closing it.

On Friday, Gov. Milton J. Shapp said that Farview's remote location was "totally wrong," but he said he was not yet prepared to endorse Beal's plan to spend $50 million on two substitute hospitals at Pittsburgh and Philadelphia.

Farview's defects were evident to Bill Thomas long ago.

"I only know what I say and what I heard," Thomas said in an interview last week in his apartment in Los Angeles. "I know I lived through an eight-year nightmare. I only had cameras and tapes the last year I was there, 1969."

Thomas entered Farview in 1961, in lieu of trial on charges of assault and battery and malicious mischief. He acknowledges that he was mentally upset when admitted, having just experienced, in a brief period, the death of his father, the birth of a severely retarded child and the loss of his business in York, Pa.

"I flipped out and even admitted to crimes I didn't know anything about except what I read in the newspaper," he says now. "I wanted to be locked up, to be sent somewhere for mental relief. I thought that going to Farview would probably be a good thing for me. I knew I needed treatment."

What he saw, he says, shook him and he began to fight for sanity and a trial on his charges immediately.

One of the most disturbing things he say, he says, occurred less than two years after he was committed to Farview.

"It was sometime between Christmas and New Year's," he recalls. "In fact, it may have been New Year's Day, 1963. I was walking down the hallway near K-3 dining room when a bunch of guards, it looked like eight or ten of them, came out the door dragging a patient who was struggling with them.

"Then, right there in the hallway, the guards were kicking the patient and stomping on him, and he was moaning and trying to cover himself. Then they dragged him down the hallway leaving a trail of blood."

Thomas says he asked another patient who the beaten patient was.

"I was told that it was Russell Sell," Thomas recalls. "Then I heard about a week later that Russell had died on R Ward (the medical unit). It looked to me like he was already half dead when he left K-3 dining room."

As The Inquirer noted in its earlier series on Farview, the official cause of death for Russell Sell listed in hospital records and on the death certificate was acute coronary occlusion.

An autopsy conducted on Sell's body disclosed that he had three fractured ribs, but the official explanation, one accepted by State Police investigators who later inquired into this and other deaths at the institution, was that Sell's ribs probably were broken when he hit the corner of a steam table in the dining room during a fracas with the guards.

Witnesses questioned in the 1975 police investigation said the fracas began when Sell accused the guards of stealing meat that was intended for patients.

In a taped conversation with a guard, recorded without the guard's knowledge about six years after Sell's death, Thomas asks how the Sell death was "covered up."

"They killed him," the guard says. "He didn't die on our ward, he died on R Ward (medical unit). They never die on the ward. No, nobody dies on the ward. If you dropped dead right here, right now, I'll load you up on a f...ing wheelchair...you died on R Ward.

"I mean, so he dies of natural causes. Ninety percent of the time the family ain't gonna claim him."

At another point in the taped conversation with the same guard, the name of another patient comes up. The guard says, "We just put the boots to him.

"He'll wind up like (John) Rankins. They'll send him over to R Ward and he'll die over there. All them beatings catch..."

"Is Rankins dead?" Thomas asks in the tape recording.

"He's dying," the guard says. "All them f...ing beatings caught up with him. It was a year ago we worked him over on D Ward . . . a year and a half ago . . . Fact is some guys you got to lace them once a month."

The conversation was recorded on July 3, 1969. Rankins died, at age 45, on July 26, 1969. The cause of death was officially given as "generalized carcinomatosis, carcinoma of right lung."

The taped conversations with that guard occurred as he stood in the doorway of the room where Thomas lived in a "privilege ward." Other conversations took place in the main kitchen, in the bathroom of the kitchen, and while Thomas was cutting guards' hair in the main kitchen.

In his ward room, Thomas hid the tape recorded under the bed, with the microphone behind his arm as he lay on his side, his head propped up on an elbow. At other times, he had the recorder hidden under his clothes, with the microphone wired down his sleeve and taped to a wrist.

In his final year at Farview, the electronic challenge provided him with something to occupy his mind. Before that, he was something of a model patient, working hard at a variety of projects and trying to make the hospital a place which would provide some kind of therapy.

He started a hospital newspaper named Focus. He worked with a social worker to try to start a program for teaching automobile repair and repainting. He also tried to get the hospital to train patients in cooking.

But invariably, the hospital halted his plans.

In fact, says Thomas, one occupational therapist finally insisted that Thomas work under his direction instead of the social worker's.

"He complained that he didn't like the idea of a patient walking around with an attache case," Thomas recalls, laughing. "Then the job training guy simply stopped my working on such projects.

"So instead of training people to go outside and be productive individuals, they did nothing to help them. And if the patient got out, all he could do was something wrong that would send him back into some institution.

"It was totally frustrating."

It was also frustrating for Thomas, who worked in the main kitchen, to see the best pieces of meat go to the guards' dining room and what seemed like scraps go to the patients. In fact, in one recorded conversation with a dietary staff member, Thomas complained:

"They (the guards) seem to think that what they're getting is patients' food. Christ, they eat better than the patients."

MORE FARVIEW FINDINGS—EXCERPTS FROM THE FARVIEW TAPES

The following are excerpts from tape records made by William J. Thomas at Farview State Hospital.

July 3, 1969

THOMAS—You know that colored guy you said you put, how many inches did you say you put your foot up his behind?

GUARD A—(name deleted).

THOMAS—We didn't know that was (name deleted) boyfriend. Now we know why he was walking around in such a daze.

GUARD A—I just shined my shoes, I just shined my shoes on him. A guard took him to the (bathroom) and started walking away and he (patient) comes running after him. So that was the wrong move. We just put the boots to him.

THOMAS. Do any good?

GUARD A—Good for about a month. Three times we did it to him now.

THOMAS—Three times in one night?

GUARD A—No, about three straight times in three months. He'll wind up like (John) Rankins. They'll send him over to R Ward (medical unit) and he'll die over there. All them beatings catch——

THOMAS—Is Rankins dead?

GUARD A—He's dying. All them —— beatings caught up with him.

THOMAS—Well, this guy tells me, "They beat my kid up over on Q Ward."

GUARD A—We cuffed him to a beach and every other thing, Jesus, I found that —— dandy and he was bent over and the guard was wrestling with him on the floor and I caught him tight in the (behind), that bone there. Boy, don't think that ain't a sore son-of-a-bitch.

THOMAS—Did you kick him?

GUARD A—I put my —— foot about that far up his (behind). This other stupid —— guard, the new guard who came off the night shift, he's there palming him (the patient). After it was all over, I dusted my shoes off and

he's heading toward R Ward to get his hand taped up. I said, "You'll learn, you stupid ——— ——— especially on niggers." I ain't used my hand in here in seven years.

THOMAS—It doesn't pay to hurt your hands.

GUARD A—You can always buy a new pair of shoes. You can't buy another knuckle. Once you ——— them up you're done.

GUARD A—You know that big fat (patient) that works in the Recreation Department, that big tub of lard? He was in the shower, tying up the shower. I said, "Hey, (patient) come on out." He says, "I ain't done yet." I says, "Hey, lookit, I ain't going to repeat it to you any more. Out." He says, "I ain't done yet." In I go. I get in there and this other guard he sees me and he comes over and I saw him and I swung and when I hit him on the button and down he goes and he slipped on the ——— floor and down he came. So we put the shoes to him in there. On a job like this you come to be a sadist to a certain extent. This place ain't no Sunday School affair.

THOMAS—What happened to (Robert) Stonewall Jackson?

GUARD A—He got the hell beat out of him.

THOMAS—Did he die as the result of the beating or did he die as a result of all the other ones he got?

GUARD A—Well, it builds up on you. You take a beating today and you get one tomorrow and you get one the next day. Eventually they take their toll. You can't trace it down to just one beating.

This conversation with Guard B occurred April 20, 1969, in the bathroom of the dietary department of the hospital.

THOMAS—This man that I'm seeing every week to get therapy off of——

GUARD B—A waste of time, a waste of time.

THOMAS—Nobody has any respect for him, yet I'm supposed to——

GUARD B—Waste of time, Bill. That man is sick. He knows you're smart, that you know the laws upside down. He won't give in. He tries to keep you down as much as he could.

July 1969

THOMAS—What is your reaction to the deaths of Russell Sell (in 1963) and Robert (Stonewall) Jackson (in 1966)?

GUARD C—This is pure sadism, has been, was, and still goes on. Let me put it this way. This is a farce, this hospital. It is an absolute farce. They bring men here to rehabilitate them. As far as hospital care is concerned, that's nil. They're bringing men in here as prisoners. This is just a place to lock men up. That's all it is. There's no rehabilitation. There's no therapy. There's no nothing.

July 6, 1969

THOMAS—You remember sometime ago you were sitting out here and were telling me about how you and some other guards caught two guys in the (bathroom) over there and beat their ———?

GUARD D—Q Ward. Yeah.

THOMAS—Somebody wrote a letter to Harrisburg about what happened over there on Q Ward and some other things, but I couldn't pick it all up because I wasn't listening until I heard your name mentioned.

GUARD D—Oh, we didn't beat them up, we didn't beat them up. We just gave them a couple of open handers. They can write all the letters they want. I don't know how they're supposed to prove it. And their word is no good.

THOMAS—I don't know if that was the incident or not. The only thing I heard was about the letter that either was or was not going to be smuggled out during a visit.

GUARD D—You know, what the hell good is it going to do a patient to send a letter to Harrisburg? I mean, after all, let's face it. They're locked up here and they're (Harrisburg) gonna take a guard's word for it. So what the ——— if a guard does cuff a guy up a bit? He's not marked. They (Harrisburg) come up and investigate, even if they did come up and investigate, Jesus, there's no marks on the guy.

When we work a guy over, we work him over very carefully. Now we don't mark them up too bad, not like we used to.

July 6, 1969

THOMAS—Do you see anything that I could do in here to better myself, to convince these people I'm ready to get out of here? I don't have any criminal charges anymore.

GUARD E—Jesus Christ, since you been here you never give no trouble to anyone. You do your work. I can't understand. Unless it's a personal thing. They will sometimes pick on a guy personal, like (patient name deleted).

THOMAS—Do you think they're really unethical in the way they handle certain cases, like I mean you just mentioned (name deleted).

GUARD E—Well, naturally, naturally. They're unethical. There's a lot of guys that don't belong in here. Send 'em back to the pen where they belong. This is for insane people.

THOMAS—It's hard to believe that these professional men are so unethical in the way . . .

GUARD E—Aw, Jesus Christ! What's ethical mean? What the ——— professional men do you got in here? In the courtroom, psychiatrists or doctors from the institution is fighting and it's going to go against you. They'll say that you're stone buggy and conduct in improper ways, but in different ways they'll use some legal term or some medical term. The judge is ———ed. He's gotta stay with the doctor, the professional men. They got a million ways of ———ing patients. A million ways.

CORONER SCHEDULES INQUEST

Honesdale, Pa.—The investigation into the deaths of several patients at the Farview State Hospital for the criminally insane developed on several fronts yesterday.

Wayne County Coroner Robert Jennings said he planned to subpoena Welfare Secretary Frank Beal and his regional deputy secretary, Kathryn S. McKenna, to appear at a hearing on the death of former Farview patient John Rank. The inquest is scheduled for July 21 at the Honesdale courthouse.

Jennings said he was investigating the possibility of neglect in the death of Rank, who choked to death last March 2 on a ham sandwich while heavily sedated.

Jennings also announced that he had exhumed the body of former Farview patient Thomas L. Garrett, who died at the hospital on March 19, 1960.

Hospital records show that Garrett died as a result of a sudden and unexpected pulmonary embolism. He was 37 at the time of his death.

But patients who say they witnessed it have told State Police investigators that Garrett was killed when he received a sustained beating by guards. The exhumation was done Friday.

In a third development, Jennings said he expected to release the results soon of an autopsy on the body of another Farview patient, Robert (Stonewall) Jackson. Jackson's badly decomposed body was exhumed in May from a cemetery in Sharon Hill, Delaware County, as part of Jennings probe.

Jackson's death at age 36, on Sept. 24, 1966, was attributed to a heart attack in hospital records. But witnesses have told State Police that Jackson was beaten by guards and then smothered to death with a pillow.

Gov. Milton J. Shapp announced Friday that he planned to meet with Beal within the next 10 days to discuss the possibility of closing Farview.

Farview, which has 354 patients, is operated by the State Department of Public Welfare. Beal had said earlier this week that Farview should be closed and he proposed spending $50 million to build two new facilities near Philadelphia and Pittsburgh.

The institution is the only facility in the state for treatment of the criminally insane.

In Wayne County, Jennings said yesterday that he planned to subpoena Beal and McKenna in order to determine whether there was neglect by hospital personnel contributing to Rank's death.

"I intend to identify the person or persons responsible if neglect is proven," Jennings said.

In the probe into Garrett's death, Jennings supervised the exhumation, which took place in the Pittsburgh area last week.

Jennings said that a complete autopsy, which will include X-rays and a toxicological reports, was being done by Allegheny County Medical Examiner Cyril H. Wecht.

30-DAY TERM LASTED 32 YEARS

(By Acel Moore and Wendell Rawls Jr.)

Today he sits in a shabbily furnished Bristol apartment decorated with cheap curios and knick-knacks on the tables and pictures of his children and grandchildren on the walls.

Seemingly in an effort to display some of the dignity he lost at the hands of the state over three decades, he is dressed in a white shirt and a tie that went in and out of style a couple of times without his even knowing it.

In this setting, Charles Simon, 68, quietly, self-consciously reflects upon a lost life.

It was the summer of 1938, as he vividly recalls it. The Depression was still weighing heavily on the average American, especially in the cities of the Northeast.

Simon had begun working 13 years before that, continued to work his way through the University of Pennsylvania night school and earned a degree in accounting, just at the time that the Depression left little for a young accountant to account for.

He had a series of jobs and lost each one as businesses folded. But he had a wife and two small children, so he continued to look. He had started a new job, this time with the state government, when his long nightmare began.

It was June and Simon was quarreling with a brother who had given up even looking for a job. They were in the front yard of Simon's house. The quarrel became more bitter. Voices grew louder and fists were raised. Simon's mother began to intercede and was warned to keep out of the way.

Neighbors called police and Simon was taken to the local precinct house.

"I thought the policeman just wanted me to walk to the station house with him to give things a chance to cool down," Simon recalls. "But he put me in a cell." For this—a quarrel in the front yard on a hot summer day in the Depression—Charles Simon was to spend the next 32 years in cells, most of them at Farview State Hospital, Pennsylvania's facility for the criminally insane.

The next day, without a jury present and without an attorney, because he could not imagine why he needed one, Simon was sentenced by a magistrate to 30 days for disorderly conduct and was sent to Moyamensing Prison.

Simon got angry. And the longer he was held in jail, the angrier he got. But the unhappier he became in jail, the longer he was held. Instead of being released on July 8, 1938, the maximum expiration date, he remained jailed through September and October.

Then, on Nov. 1, 1938, Simon was advised that he would be taking a ride. He did—to Norristown State Hospital. Nobody ever told him why. His family was told that he needed treatment and that he was too dangerous to be released. His family was poor, could not afford an attorney, and took the doctors at their word.

So Charles Simon became angrier still.

He so often claimed persecution that the hospital decided he was paranoid.

A notation in his Norristown record says: "Patient's condition is unchanged. He continues to be friendly, talkative and smiling, and at times becomes very insistent about the injustice of being committed here."

After the hospital had induced 31 comas in Simon by pre-insulin therapy, a March 8, 1939, notation was made in his file. It says:

"He repeats continually that there is nothing wrong with him, that he is being tortured by the treatment and held here for no reason."

By the beginning of 1940, the hospital record say, Simon was guilty of "progressive irritableness, insistence upon his rights and . . . illogical thinking."

On April 6, 1940—nearly two years after the quarrel with his brother—Simon was transferred to Farview State Hospital after threatening a physi-

cian. Except for a brief return to Norristown State Hospital in 1949, Charles Simon was to spend the next 30 years of his life at Farview.

"There didn't seem to be many insane people there," Simon recalls. "I found out that most of them had come there from penitentiaries. They were criminals with time to serve. They seemed to be perfectly normal as far as sensibilities were concerned. Maybe they were criminals, but they were not insane. At least they didn't get lost on the way to breakfast and dinner and that was better than at Norristown."

Simon says he knew he was in for a long stretch when he asked a doctor "to speak to someone who might be interested in my welfare."

"The doctor told me I was crazier than a bedbug," Simon says. "Then another doctor, now dead, told me that the longer I was there the worse I would get."

Simon did, however, escape most of the brutal treatment that many other former patients detailed for The Inquirer during a three-month investigation of Farview. To this day, he does not know why he was so fortunate—unless it was because he was white, he was quiet and kept to himself, and he was not a criminal and the guards knew it.

"There was a lot of agitating and making it uncomfortable for you if you got angry or bitter," he says, "and the guards were always setting off firecrackers under a patient's chair or bed, or giving a patient a hot-foot with matches while the patient was sleeping on a bench. Often a guard would throw a pillow at a man and knock his head into a wall."

But other than being beaten for taking the side of a new patient one time, Simon says he was never severely injured. But he never forgot, he says, that "the guards were boss."

"It definitely is a prison, even the guards call it a prison. The only treatment I got was no treatment," Simon says: "I received two psychiatric evaluations in recent years, none until 1964 or 1965. And the only medication I got was an occasional aspirin."

But he remained in the state's only maximum security mental hospital "working like a slave" polishing floors and working in the kitchens, upholstery shop and dining rooms.

Sometimes he played chess, or read books, mostly the Bible.

"It got to the place I figures Farview was home, I had been there so long," he says. "I never saw my children grow up, nor any of my seven grandchildren.

"The world outside had changed quite a bit by the time I came out, styles had changed, it seemed like there were cars everywhere and it was hard to realize that I was free . . . that I could do something without permission."

Finally, in 1970, Charles Simon was released from Farview, one of several hundred patients set free by a court ruling declaring unconstitutional a state mental health statute by which he had been committed three decades earlier.

But for Charles Simon it was too late. He was 30 years old on that summer day that he began quarreling with his brother in his mother's front yard. He was 62 years old when he walked out of Farview and into the free world and a "grand meeting" with a son he had not seen in three decades and grandchildren who had never hugged their grandfather's legs. His wife died while he was at Farview.

Throughout the social workers' reports of Charles Simon's life at Farview there are frequent notations that the patient "is resentful."

"I guess I was," Simon says. "My life was wasted. But I think I held my bearings pretty well. I didn't cry at all."

Senator BAYH. Our next witness is Charles R. Halpern, the director of the Council for Public Interest Law, and a member of the American Bar Association Commission on the Mentally Disabled.

Mr. Halpern, I appreciate your willingness to testify. I understand you are testifying on your own behalf and also on behalf of the American Bar Association. Is that accurate?

CONTINUED

2 OF 12

TESTIMONY OF CHARLES R. HALPERN, DIRECTOR, COUNCIL FOR PUBLIC INTEREST LAW, MEMBER, AMERICAN BAR ASSOCIATION COMMISSION ON THE MENTALLY DISABLED

Mr. HALPERN. In fact, Senator Bayh, I am testifying only on behalf of the American Bar Association and not on my own behalf.

Senator BAYH. Please tell us where what you say in behalf of the American Bar Association is inconsistent with your own feelings.

Mr. HALPERN. I shall, Senator Bayh.

Senator BAYH. Fine.

Mr. HALPERN. I have just heard the preceding testimony, and I regret to say that I did not find the description of that institution in Pennsylvania astounding at all. It was precisely the sort of situation I have seen in numerous other States.

I would suggest that the conditions described there are far from astounding, but quite predictable when you consider that mental institutions in this country for so many years have been outside the law.

As you know, up until about 1966 there was a doctrine widely accepted in the court system called the "hands off" doctrine, which explicitly held that courts and judges had no business inquiring into the conditions that existed in prisons and mental hospitals and institutions for the mentally retarded.

It was only with the case of *Rouse* v. *Cameron*, decided by the Court of Appeals for the Washington, D.C., circuit in 1966, that major breaches in those walls of secrecy and insulation from judicial scrutiny were made.

It is because the years since 1966 have seen some growth in the development of law regarding the mentally ill and mentally retarded that these hearings are so timely.

The American Bar Association strongly endorses S. 1393.

I would like to submit for the record the formal statement which we have prepared on behalf of the Association. I should like to summarize a few of the highlights, if I may.

Senator BAYH. Yes, sir. We will put that in the record following your testimony.

Mr. HALPERN. Thank you.

Until 1966 there was no body of mental health law. The situation was more striking with regard to the mentally retarded than with the mentally ill. There was quite literally no case law on the rights of mentally retarded people in institutions.

The Constitution which extends its protections and guarantees to virtually all American citizens did not apply as a practical matter in institutions for the mentally retarded.

The only case that ever tried to delineate the legal rights of mentally retarded people was the case giving authorities virtually unlimited opportunities to sterilize the mentally retarded.

Senator BAYH. Have you compared that with the case law on the rights of penal inmates? I bring that up because I am struggling with a hazy memory here. When I was a law student I wrote a Law Journal article on the rights of penal inmates. I assume one of the

problems of mental inmates was the old "king can do no wrong" theory.

However, there were cases where for certain types of activity or actions penal inmates could bring suits. It was difficult, however, because of the old philosophy.

Were mental inmates treated differently than penal inmates?

Mr. HALPERN. I believe they were treated somewhat worse, Senator. I am really not famiilar in detail with the case law as it applies to penal inmates.

May I suggest that you address that question to the American Bar Association witness who will appear before you tomorrow—to address the penal side of this legislation?

Senator BAYH. In the meantime, I will have a chance to go back and read my Law Journal article.

Mr. HALPERN. So will tomorrow's witness.

Senator BAYH. I am sure there are more exciting things for both of us to do, as I recall that article.

[Laughter.]

Mr. HALPERN. The focus of my testimony today is on this legislation insofar as it has an impact on mentally ill and mentally retarded people in public institutions.

As to those people, this legislation is urgently needed. Some have suggested that those people who end up in State institutions for the mentally ill and mentally retarded can protect their own rights and, if there are constitutional violations, we can rely on these people to go to court. Just stating that proposition suggests to me a shortcoming.

These are people usually who have serious mental handicaps. Typically they are people in remote places where their personal mobility is extremely limited and where their access to legal service is very limited.

The default of the legal profession has to be noted in this context. Until the American Bar Association began a number of programs to bring legal services to the mentally impaired within the past 3 years, the default of the profession was something I think we were all properly embarrassed about.

There were no lawyers practicing mental health law, and there were no lawyers specializing in the particular problems of the mentally retarded as recently as 5 years ago.

If you look at the situation today, it is slightly better but not much. There are probably fewer than 50 lawyers in this country who have a specialized knowledge of the legal rights of the mentally ill and mentally retarded. In many States there are no lawyers who have this kind of expertise.

The kinds of problems we are talking about are the ones which require a very particular kind of legal skill and legal expertise.

Because the inmates in these institutions have special handicaps and because there are not lawyers to serve them, it is particularly urgent that enforcement of their constitutional rights not be left to the inmates' own resources.

It has also been suggested that the protection of these inmates can be left to the legal officers of the State. History has proven that

State legal officers are not a reliable source of protection for these rights, and it really is not proper to even expect them to be. The plain fact is that State Attorneys General are often defending these lawsuits and are defending the institutions against the charge that they are involved in the violation of constitutional rights.

The need, I believe, for Justice Department participation in the protection of the constitutional rights of this vulnerable population is particularly urgent.

Within the past several years the Justice Department has played an extremely creative and constructive role both as *amicus curiae* and as intervener in a number of cases challenging constitutional violations in State systems.

However, even that limited role of the Justice Department has been challenged in two recent decisions in the Mattson and Solomon cases. These have indicated that the Justice Department does not have the authority to institute cases on its own behalf. It is that problem to which this legislation is addressed.

In the future, if this legislation is passed, I think we should expect the Justice Department to approach the problem outlined by the previous witnesses in a systematic fashion.

One of the virtues of this bill as drafted is that it requires the Justice Department to find a pattern or practice of abuse of constitutional rights before action is brought. The Justice Department will not be in the business of piecemeal litigation of individual inmate complaints.

Another strength of the legislation in this respect is its requirement that adequate attention be given to federalism, and so there is a requirement that the Attorney General notify the authorities in the State. He doesn't just go into Federal court.

This is intended, I am sure, to give an opportunity for negotiation, settlement, and correction by State officials of abuses within State institutions.

Senator BAYH. Excuse me.

The Attorney General said as much in a speech he made to the State attorneys general in Indianapolis a week or two ago. The negotiation process would be pursued vigorously and only when that had failed would a court suit be pursued. I assume that is the way you think it should go.

Mr. HALPERN. Yes, sir.

It also confirms my impression of the way the Justice Department has functioned in the past in dealing with these kinds of problems. There has always been a process of negotiation first and then litigation.

Senator BAYH. Mr. Halpern, while you are on that subject, I have a couple of questions.

You are one of the founding fathers here of the whole mental health legal movement. You were involved in the *Wyatt* case, which was one of the most significant cases in the field and which really helped start the legal movement on behalf of the mentally ill.

I bring this up now because one of the concerns expressed by State Attorneys General, and I assume some of our colleagues here, is that the measure before us is unconstitutional.

As one with so much experience in the area of mental health law, and as an outstanding attorney, do you think that is a problem? What does the American Bar Association say about the constitutionality of this bill? They are hardly the kind of organization that takes constitutionality of legislation lightly.

Mr. HALPERN. I think it is fair to assume, Senator, that the American Bar Association would not have endorsed this legislative approach if they thought it were unconstitutional or even if they were troubled by a major constitutional reservation.

It seems to me that the analog between this legislation and the legislation authorizing the Justice Department to bring suit on behalf of racial minorities to protect them from unconstitutional deprivations of their rights by State authorities is very persuasive on this point. Of course, the constitutionality of that legislation has always been upheld.

Senator BAYH. Then the American Bar Association had considered the constitutionality before it passed a resolution of support for this measure; is that correct?

Mr. HALPERN. That is right, Senator.

Senator BAYH. The last thing we need to do is to hold out some hope and then have it quashed on constitutional grounds.

You mentioned just a moment ago that the situation in Pennsylvania was not an isolated example. You may want to reiterate that and let us know whether we are actually going to get relief that is not now available.

Mr. HALPERN. I think this legislation would provide a very important kind of relief that is not now available. It is not legislation which substantively redefines the rights of the mentally ill and the mentally retarded. That would be left to the court, as I think it should be, through continuing litigation to determine what the precise standards of acceptable conduct are.

However, the situation in Pennsylvania is not atypical. It is the kind of situation that occurs in mental institutions all around the country.

The people who are suffering in those institutions are not in a position to protect their own constitutional rights. Indeed, they are not in a position to recognize violation of their constitutional rights.

Therefore, having an institution such as the Justice Department which can investigate and determine patterns and practices, so that a whole pattern of violation of constitutional rights must exist before action is initiated is precisely the kind of approach which will bring the most economical, efficient, and effective relief to the situation.

Senator BAYH. I appreciate the very way you phrase it there.

I think it would be efficient and effective and would permit the Justice Department to get the maximum amount of benefit to the most people with the least amount of involvement and interference with States' rights.

Mr. HALPERN. I think it is a terribly important point. At a time when court congestion is a legitimate concern, it is important to note that this kind of legislative approach is a way of dealing with broad problems in a way which uses the least court time, and assures

maximum benefit for those who are suffering violations of their constitutional rights with the least burden on the courts.

Let me just summarize and make one more point.

I have suggested that there are too few private lawyers with the necessary expertise and commitment to provide representation to mentally ill and mentally retarded people. There are less than 50 countrywide.

Those lawyers who do practice in this field—sometimes with foundation subsidies, sometimes in Federal programs, and sometimes in private practice—are invariably hampered by a lack of adequate financial resources and a lack of adequate expertise in the mental health field. A great deal of technical expertise is needed to attempt to do something about the constitutional violations that were described earlier today.

The Justice Department is uniquely equipped to help bridge that gap. They have experienced lawyers trained in handling these kinds of cases. Perhaps just as important, they have the resources of the Department of Health, Education and Welfare—the psychiatrists, the psychologists, the systems analysts, the budget experts, who are needed to really find those cases of systematic discrimination and find effective judicial remedies.

I started, Senator Bayh, by describing the neglect of legal rights in this area up to the last decade. Providing the Justice Department the legislative authority to move forward in the area of protecting the rights of the mentally ill and mentally retarded could, I think, be a really decisive turning point in the recent evolution of the protections of legal rights of mentally ill and mentally retarded persons.

Senator BAYH. Thank you, Mr. Halpern.

You said it as well as I have heard anybody say it. You pretty well answered the questions I had in advance.

Senator Hatch, do you have questions?

Senator HATCH. Mr. Halpern, unfortunately, I was not here for all of your testimony. I am sure it was very enlightening, as was what I have heard since I have been here.

I have a couple questions about the bill itself. There are no particular standards or guidelines given within the bill. Do you have any idea or does the American Bar Association have any idea who is going to provide these guidelines or standards?

Mr. HALPERN. What is a violation of a constitutional right?

Senator HATCH. Well, that is partially it. What are the violations, period, under the bill? In other words, some psychiatrists may have differing approaches from other psychiatrists.

It is easy to point out the flagrant examples, such as we have heard today. It is easy for everybody to say that is wrong. We say that is good and that is bad. Basically today all of that was bad. I think we can all agree on that.

However, when we get down to splitting hairs on what is good psychiatrically and what is not, who is going to make that determination?

Mr. HALPERN. I have been in this field now for 10 years. The litigation in which I have been involved has never gotten down to splitting hairs. I do not think it ever will.

Senator HATCH. Who determines whether to bring an action to begin with? According to the bill, the Attorney General is going to, but upon what is he going to base bringing that action? Does it have to be a flagrant violation or does it have to be something that is repugnant to him? Who is going to set those standards and guidelines?

Mr. HALPERN. There would have to be, as the bill says, a pattern and practice of abuse. There has to be an opportunity for negotiation first.

I opened my testimony with the observation that the conditions described in Pennsylvania are not unique. They are quite common. They can be found throughout the country.

As I have seen the Justice Department operate over the past 5 years, its attention has been drawn exclusively to conditions of the type described by the previous witnesses. As I read this bill and put this together with my knowledge of the situation of mentally ill and mentally retarded inmates, I am confident that the Justice Department is not going to get into the business of splitting hairs.

Senator HATCH. I am not saying they are getting into the business of splitting hairs, but they sometimes have to get into the business of value judging whether or not to bring a lawsuit to begin with.

Mr. HALPERN. That is right.

Senator HATCH. This bill does not provide for that. For instance, they either join the head of the institution, as I read the bill, as a party defendant or they join the State. The State may not have standing in the particular matter. It may be the wrong person. It may be the county. It may be the city. From that standpoint, I see a defect in the bill.

I am concerned about this. Let's assume we reach a point where we have resolved most of the major flagrant difficulties in our society. That is a big assumption; I admit that. Let's assume we do that and it comes down to determining where we go from here. Suppose you have an Assistant Attorney General over here who wants to bring a lawsuit because he doesn't agree with this particular type of psychiatric approach that is being used. Yet maybe we have a psychiatrist on the other side who says that this is a perfectly normal, reasonable, and valid psychiatric approach.

Mr. HALPERN. That was a problem which I confronted in a very concrete case in the District of Columbia where there was a patient at St. Elizabeth's Hospital who argued that he was being denied his constitutional rights, specifically the right to treatment. It was one of the first cases I handled.

I was confronted with the question of how you prove what is adequate treatment or what is not adequate treatment. Are you just going to put on two psychiatrists who disagree with each other?

I suggested at that time and would suggest in response here that neither the Justice Department nor the court should get into the business of weighing competing claims of adequate psychiatric treatment. If one psychiatrist says group therapy and another says no, drug therapy is right in this case, the courts and the legal system have no business intervening in that question.

The real issue is the courts and the Justice Department under this legislation insisting that the mental institutions have conditions which are compatible with adequate treatment.

I think that if this legislation moves forward, the report of the committee might well reflect that approach, specifically that the Justice Department should not ever get into the process of choosing among competing therapies.

Senator HATCH. But it is going to do so because the question of "what is adequate treatment" is a difficult one to answer.

For instance, some psychiatrists believe in isolation treatment. Some of them believe in drug therapy, sometimes gross drug therapy.

We have had testimony here that there is imprisonment with drugs, and that this is one of the abuses that needs to be corrected. Yet I would gainsay that there are many, many psychiatrists who would say, "Hey, that is the only way you can handle these problems. You have the hyperactive mentally disturbed or emotionally disturbed young person and the only way you can control him is with drugs."

Another will say, "He will never have a chance if you keep using drugs, tranquilizers and other forms of medication on this young man."

What I am saying is that you get into these situations where if you get an Assistant Attorney General in charge of this who thinks that drugs are bad, the next thing you know you have all kinds of anti-drug suits.

There are value judgments that are going to have to be made if this legislation is passed. They are going to have to be made, I presume, by the Attorney General. I am not sure he is in the business of making these.

Mr. HALPERN. These kinds of problems that you are describing are not new.

Senator HATCH. I agree. That is my point.

Mr. HALPERN. The courts have been handling them for the past 10 years.

Senator HATCH. Not very well.

Mr. HALPERN. I would respectfully disagree, Senator. I think the body of case law emerging in the area of the protection of the mentally ill and mentally retarded is one of the finest products of the judiciary——

Senator HATCH. I will agree with you on that, but what about the thousands of cases that never get determined?

Mr. HALPERN. That is a great tragedy, and one that I think is being addressed by this legislation.

Senator HATCH. That is what I mean. The courts are not handling them very well. Now you are saying if we pass this legislation, this suddenly is going to solve all of the problems. I am not so sure that it is.

Mr. HALPERN. No; Senator, I don't think it will solve all the problems.

Under the present state of existing case law, a mental patient who believes his constitutional rights are being violated in a State institution has a right to go into Federal court and protest. Courts

have to make a decision about whether there is adequate treatment.

If the institution has 5,000 patients and one psychiatrist, it gets to be pretty easy judgment for the court to make. Those cases are legion.

But the courts have been in this business and they will continue to be because each patient has a right to a hearing in Federal court. If a patient is not being fed adequately, if he is being kept in isolation for years on end without ever seeing a professionally trained person, that person can go into court. and I am happy to say they are going into court. Unfortunately, that leads to an unsystematic assessment of the problem with consideration of individual cases, and with courts making decisions absent the kind of expertise that the Justice Department could bring if this legislation passed.

Senator HATCH. I guess what I am saying is that I am not sure the Justice Department will have any more expertise. I think your main point is, and correct me if I am wrong, that the Justice Department will have to acquire that expertise, if this bill is passed, and at least there will be a source of prosecution that we do not presently have today, except through attorneys such as yourself.

Mr. HALPERN. Your point on the source of prosecution is absolutely right.

Let me say I have been in cases with the Justice Department in a number of instances. The Civil Rights Division already has an impressive body of expertise.

More importantly, the Justice Department can draw on all of the expertise of the Federal Government.

If you contrast that with the situation of the private lawyer in Tuscaloosa, Ala., who is in Federal District Court in the Middle District of Alabama trying to make out the case, the Justice Department is obviously in a much better situation.

I would suggest that in order to have effective protection of the constitutional rights of this neglected minority, the Justice Department is necessary. It has the expertise and that expertise will be needed by the courts, and appreciated.

Senator HATCH. I think these are enlightening comments. I appreciate them. I am somewhat provoking you to make them.

The thing about which I am concerned, and I think maybe we have belabored it too long, and that is this. Once the flagrant cases are gone, assuming that that ever occurs, you do reach a value judgment stage where we could have all kinds of differing value judgments on which are violations of civil rights and which are not.

You seem to be saying that that is fine. Maybe that is what we do need because then we will delineate what proper care and treatment is in these institutions. In the end all society will benefit from that type of an approach.

I think basically that is what I am gleaning from what you are saying here today, among other things.

Mr. HALPERN. That is a fair restatement.

Let me add just one other point to it, though. We have a backup safeguard. The Justice Department has to present its case to an independent Federal district judge. It is the Federal district judge who is ultimately going to be making a decision full of value judgments,

just as any litigation over violation of constitutional rights involves many value judgments.

Senator HATCH. Thank you.

Senator BAYH. Thank you very much, Mr. Halpern.

You have certainly brought a wealth of firsthand experience to us. The bar association was well represented in your interpretation of their opinions.

Thank you very much.

I hope we can keep in touch with you because there will be other questions, I think, that may be raised by those on the other side. It would be nice to have a chance to communicate with somebody who has been in the arena for a long period of time.

Mr. HALPERN. Thank you. I would welcome the opportunity.

[The prepared statement of Charles R. Halpern, on behalf of the American Bar Association follows:]

PREPARED STATEMENT OF CHARLES R. HALPERN, ON BEHALF OF THE AMERICAN BAR ASSOCIATION

Mr. Chairman and members of the subcommittee, I am Charles R. Halpern, a member of the American Bar Association's Commission on the Mentally Disabled. Justin A. Stanley, the President of the Association, has asked that I appear before you today to express the Association's views on S. 1393, legislation to authorize actions by the Attorney General to redress violations of constitutional and other federally protected rights of institutionalized persons.

In addiion to being a member of the Commission on the Mentally Disabled, I am currently serving as Director of the Council for Public Interest Law. I was a co-founder of the Center for Law and Social Policy and the Mental Health Law Project, and for the past ten years have served as counsel in a number of cases in the mental health law field. I have also served as a consultant to the National Institute of Mental Health, and to the President's Committee on Mental Retardation. This fall, I will be teaching a course, Law and the Mentally Disabled, at Stanford Law School.

In late 1973, the American Bar Association established an interdisciplinary Commission to mount an action program on behalf of the mentally disabled. Since its creation, the Commission, through support from private foundations and governmental grants, has commenced publication of the Mental Disability Law Reporter; has launched, in cooperation with the Commonwealth of Pennsylvania, a pilot advocacy program for patients at Norristown State Hospital; has helped stimulate the formation of special bar committees across the nation to undertake projects in the mental disability area; has funded a grant-in-aid program to help ten bar associations develop and implement legal service programs for the mentally disabled; and is developing model state legislation for the developmentally disabled.

The landmark case of *Wyatt* v. *Stickney*,[1] and its progeny, leave no doubt that mentally disabled persons confined in state institutions have a private right of action under Section 1 of the Civil Rights Act of 1871, 42 U.S.C. § 1983, to redress violations of their constitutional rights. This private right of action, however, essentially exists in a vacuum because institutionalized mentally disabled persons are frequently incapable of asserting their constitutional rights. The legislation being considered by the Subcommittee would provide crucial augmentation to that private right of action by allowing the Attorney General, under appropriate circumstances, to initiate litigation, or to intervene in pending litigation, which seeks to secure the full enjoyment of constitutional rights, privileges, or immunities to institutionalized mentally disabled persons.

The American Bar Association supports this legislation. In August, 1976, our House of Delegates, the Association's policy making body, adopted the following resolution:

[1] 325 F. Supp. 781 (M.D. Ala. 1971); 334 F. Supp. 1341 (1971); 344 F. Supp. 373 (1972); 344 F. Supp. 387 (1972); *aff'd. sub nom. Wyatt* v. *Aderholt*, 503 F. 2d 1305 (5th Cir. 1974).

[*Be it*] . . . *resolved*, That the American Bar Association endorses legislation designed to allow the Attorney General of the United States to institute suit, or intervene in pending litigation, to secure to prisoners, the mentally disabled, and others involuntarily confined the full enjoyment of rights, privileges, or immunities secured or protected by the Constitution or laws of the United States, provided, however, that any such legislation should continue existing law and not require involuntarily confined persons to exhaust state administrative remedies as a condition precedent to securing relief under Section 1979 of the Revised Statutes, 42 U.S.C. § 1983.

My remarks will examine S. 1393 from the perspective of institutionalized mentally disabled persons and attorneys representing them.

NEED FOR JUSTICE DEPARTMENT INVOLVEMENT

The special nature of the institutionalized mentally disabled makes such legislation particularly important. By definition, the term "mentally disabled" includes the mentally ill and the mentally retarded. For obvious reasons, in many instances these groups are unlikely to have the capacity to protect their constitutional rights adequately, or even to recognize many violations of those rights.

Confinement compounds the problem. Sometimes attempts by residents of institutions to redress recognized violations of their constitutional rights produce staff retaliation. Even more often, the mentally disabled person whose rights are being ignored is so "programmed" to follow institutional regimen, even when that regimen is questionable, that he is incapable of challenging deprivations of his rights. Institutionalized mentally disabled persons having the capacity to recognize deprivations of civil rights have little or no access to law libraries or to lawyers because of their confinement. Even with access to a lawyer, the institutionalized usually are indigent, and have no resources to pay for counsel. In the exceptional case of an institutionalized mentally disabled person with the capacity to recognize constitutional deprivations and act upon them, the law frequently considers such a person incompetent to bring suit in his own name.

As a result, most deprivations of institutionalized mentally disabled persons' constitutional rights, even the most widespread and pervasive, go unnoticed and unresolved. On those occasions when deprivations are noticed, the private bar, even when augmented by legal services and public interest firms, usually does not possess the resources or expertise required to undertake the complex litigation necessary to redress those deprivations. There are at present fewer than fifty lawyers in the country practicing full time on behalf of the mentally ill and mentally retarded. In many states, not a single lawyer devotes his full attention to the problems of this group. Legal service lawyers, chronically faced with heavy caseloads and slim budgets, can rarely undertake such litigation. Nor can the public interest law projects offer much assistance. As a study released by the Council for Public Interest Law indicates, the 1975 budget of all tax-exempt public interest law centers in the United States was less than the combined income of two Well Street firms.[2] It is little wonder, then, that the Justice Department's vast expertise and resources have been crucial in the success of past litigation on behalf of the institutionalized mentally disabled, and will continue to be equally crucial in the foreseeable future. In contrast to the prison lawsuit arena, it has been consistently important for the Justice Department to participate in these cases, as is evidenced by he Justice Department presence in almost every major decision dealing with the rights of the mentally disabled.

With the assistance of the Justice Department, suits alleging unconstitutional conditions and inadequate treatment are being, and have been, successfully litigated, and thousands of institutionalized mentally disabled persons' constitutional rights have been vindicated. These successes have occurred in spite of dispute over the Justice Department's status in these suits. As developed in the Justice Department's June 17, 1977 testimony on S. 1393, the Department's successful role in litigation redressing deprivations of institutionalized mentally disabled persons' constitutional rights has been through participation as plaintiff-intervenor or litigating amicus curiae in privately

[2] Council for Public Interest Law, "Balancing the Scales of Justice: Financing Public Interest Law in America" (1976).

initiated litigation at the request of the court. Because the Justice Department has been dependent on privately initiated suits, the Department's ability to comprehensively redress institutional deprivations of mentally disabled persons' constitutional rights has been severely hampered. Even Justice Department participation in this capacity has been challenged in several suits.[3]

Legislation such as S. 1393 would clarify the Justice Department's heretofore ambiguous role. Granting the Justice Department authority to initiate actions under the circumstances specified in this bill would allow the Justice Department to consider the national scope of the problem. This legislation is especially important in light of the decisions in *United States* v. *Solomon*[4] and *United States* v. *Mattson*.[5] In these cases, the Department of Justice initiated actions against state institutions after conducting investigations which indicated widespread deprivations of mentally retarded residents' constitutional rights. No private suits had been instituted to challenge these conditions and the Department's complaints in both cases have been dismissed on the basis that the executive branch of the federal government lacks the power to bring such actions absent an authorizing statute. Both decisions have been appealed.

The *Solomon* and *Mattson* decisions, if upheld, will severely limit, if not eliminate, the federal government's ability to redress widespread and systematic violations of basic constitutional rights. Such a loss would be a tragedy to those unfortunate people who are mentally disabled and who reside in this country's mental institutions. It is clear that the states have broad discretion in the operation of their institutions for the mentally disabled. It is equally clear that the federal government has an interest and a duty to protect the constitutional rights of persons confined in these institutions where such rights are being denied because of the manner in which these institutions are operated. The Department of Justice, based on its litigation concerning the rights of confined persons, has found that these persons' basic constitutional rights are being violated on such a systematic and widespread basis as to warrant the attention of the federal government. Unfortunately, history has not demonstrated the states' willingness or ability to remedy these violations without outside impetus.

The American Bar Association, of course, recognizes that state courts and law enforcement officers have a protective role to play in safeguarding the interests of disadvantaged citizens in general and the mentally handicapped in particular. For this reason, we are pleased by the requirement in S. 1393 that before the Justice Department can proceed, as an original plaintiff, there must be a finding of "a pattern or practice" of violation of institutionalized persons' rights. This is as it should be and will stand as a safeguard against unwarranted federal intrusion in the processes of state justice systems.

In considering this legislation, it is important for this Subcommittee to appreciate the resources the Department of Justice can supply in institutional litigation. Attorneys in the Office of Special Litigation, who deal with complex litigation on a daily basis, possess unusual skill and sophistication. By virtue of their sophistication and expertise, Justice Department attorneys can often enhance planning and strategy as a case moves toward trial. Further, in cases where adequate resources are not available to plaintiffs, Justice Department intervention can bring financial resources to bear which compensate for the far greater financial resources on the state's Attorneys General who usually defend actions alleging deprivation of institutionalized mentally disabled persons' constitutional rights. With its ability to tap the expertise and resources of HEW and the FBI, Justice Department participation in such litigation ensures full and fair development of factual and legal issues.

Ideally, legislation such as S. 1393, if passed, will foster cooperation between the private bar representing the mentally disabled and the Justice

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[3] E.g. *Ruiz* v. *Estelle*, CA No. 5523 (E.D. Tex.), cert. denied, 426 U.S. 925 (1976). In *Ruiz*, the district court had granted the United States leave to intervene, and the court of appeals denied a petition for writ of mandamus to require the district court to dismiss the United States from the case. The Supreme Court of the United States denied certiorari (*In Re Estelle*, 426 U.S. 925 (1976)), but three of the Supreme Court Justices expressed doubts about the authority of the United States to assert a claim, by way of intervention, against the State correctional officials where there was no allegation that the State was denying the equal protection of the laws to inmates "on account of race, color, religion, sex, or national origin . . .", 42 U.S.C. 2000h–2 (426 U.S. at 928, Rehnquist, J., with whom The Chief Justice, and Mr. Justice Powell joined, dissenting).

[4] 419 F. Supp. 358 (D. Md. 1976) (appeal pending, No. 76–2184 (4th Cir.)).

[5] Appeal pending, No. 76–3568 (9th Cir.). See also *United States* v. *Elrod*, CA No. 76C4768 (N.D. Ill.) (motion to dismiss pending—no ruling is expected by the Department of Justice until the Fourth Circuit decides *Solomon*.)

Department. Although the American Bar Association has done much to encourage involvement of the private bar in the mental disability law area, much more needs to be done, and passage of this type of legislation will go toward alleviating the plight of the mentally disabled. The availability of the Justice Department would provide a necessary complement to the work of the Commission on the Mentally Disabled, and to the private attorneys who at long last are becoming more active in the field.

EXHAUSTION OF STATE ADMINISTRATIVE REMEDIES

Exhaustion of administrative remeides has traditionally not been required in cases brought under 42 U.S.C. § 1983,[6] and accordingly, institutional residents alleging deprivation of constitutional rights have not been required to exhaust state administrative remedies prior to instituting suit under 42 U.S.C. § 1983. Although S. 1393 does not have an exhaustion requirement, such a requirement has been proposed in this context.[7]

The American Bar Association resolution quoted earlier in my testimony opposes an exhaustion requirement. The report accompanying the resolution which was submitted to the House of Delegates stated that:

"[An exhaustion requirement] would diminish rather than expand existing avenues for peacefully resolving important grievances.

* * *

[C]reating an exhaustion requirement applicable to prisoners would make them in essence second class citizens, since other Americans face no similar obstacles to bringing federal suits to secure federally protected rights. . . . The extension of an exhaustion requirement to involuntarily confined mentally disabled persons exacerbates the harm of such provisions by applying them to persons who have done nothing voluntary to set themselves apart from the population at large.

"In addition to being legally infirm, legislation [requiring exhaustion]... would represent too high a price for the welcome involvement of the Attorney General in relatively few suits.

* * *

"It should not be necessary to take away an individual's right to access to federal courts in order for him to secure enjoyment of other constitutional protected rights." [8] [emphasis added.]

Requiring institutionalized mentally disabled persons to exhaust state administrative remedies, we believe, is entirely inappropriate. Assuming that one purpose of the exhaustion requirement is to reduce federal court congestion, applying the requirement to the institutionalized mentally disabled will not achieve that purpose. Indeed, Mr. Justice Blackmun, in his opinion in *Jackson* v. *Indiana*[9] found it "remarkable" that so few constituttional challenges had

The institutionalized mentally disabled rarely have the capacity or ability to get into court on their own, and consequently, *pro se* federal court filings by the institutionalized mentally disabled are relatively rare. In spite of major federal court litigation establishing substantial rights on behalf of the institutionalized mentally disabled, *pro se* petitions from mentally disabled patients are a tiny fraction of those filed by the smaller institutional population under correctional custody.[10]

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[6] *McNeese* v. *Board of Education*, 373 U.S. 668 (1963); *Damico* v. *California*, 389 U.S. 416 (1967).

[7] E.g. H.R. 5791, 95th Cong., 1st Sess. (Mar. 30, 1977).

[8] Report No. 121A to the House of Delegates, by the Commission on Correctional Facilities and Services, and the Commission on the Mentally Disabled, "Grievance Mechanisms for the Mentally Disabled and Prisoners," August 1976.

[9] 406 U.S. 715 (1972).

been brought considering the number of persons confined in state mental institutions.

[10] A March 1977 advance report of the National Prisoner Statistics Bulletin places the number of inmates held at Federal and State institutions on Dec. 31, 1976 at 282,000, of which 10 percent were held in Federal institutions. (National Prisoner Statistics Bulletin, Prisoners in State and Federal Institutions in December 1976.) On any given day, it is estimated that 200,000 persons reside in State and county mental hospitals. In addition, 154,000 mentally retarded persons are estimated to reside on any given day in various types of public institutions. (Scheerenberger, "Public Residential Services for the Mentally Retarded," 1976.) The National Institute of Mental Health estimated in 1972 that 1.6 million persons were confined at some time in in-patient psychiatric facilities. (Data calculated by Division of Biometry, NIMH, Apr. 25, 1975.)

Nor is there any ignoring of state judicial apparatus in claims on behalf of the mentally ill and the mentally retarded. It is noteworthy that despite important federal court leadership, there is a growing trend toward using state courts as forums for asserting institutionalized mentally disabled persons' rights.[11]

CONCLUSION

In conclusion, the American Bar Association hopes the Subcommittee will appreciate, as it deliberates, the vast potential contained in S. 1393 for protecting the constitutional rights and improving the lives of this country's institutionalized mentally disabled. We think it is needed, judicious, and consistent both with federal principles and our tradition of constitutional protection of the rights and freedoms of all citizens—the meek and handicapped as well as the strong and capable. Thank you for your attention and consideration of these views.

Senator BAYH. The next witness is Dr. Philip Roos, who is the executive director of the National Association for Retarded Citizens. He has been an expert witness in many cases. He is the former chief of Clinical Psychology Services, Texas Department of Mental Health and Mental Retardation. He is the former superintendent of the Austin State School for the Mentally Retarded.

Dr. Roos, it is good to have a man with your expertise and national reputation to give us your opinion of this legislation.

TESTIMONY OF DR. PHILIP ROOS, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION FOR RETARDED CITIZENS

Dr. ROOS. Thank you, Senator.

Our association has submitted formal testimony. I am requesting that you incorporate it into the record of this hearing.

Senator BAYH. We will put the entire statement into the record.

Dr. ROOS. Thank you, sir.

I am, indeed, pleased to represent the National Association for Retarded Citizens here this afternoon. Established in 1950, this is the voluntary organization in the United States dedicated to the welfare of mentally retarded persons of all ages.

It consists today of 1,900 State and local affiliates and a membership of approximately 250,000. Approximately 60 percent of these members are family members of mentally retarded persons. Approximately 25 percent are professionals in the field of mental retardation.

Our organization wholeheartedly supports your bill, S. 1393.

As you have indicated, my professional experience has been dedicated entirely to working in the field of the mentally handicapped. In addition to representing this consumer organization, I have served as a superintendent and associate commissioner and the director of psychological services dealing with mentally retarded as well as mentally ill individuals.

I am also the parent of a mentally retarded daughter, 16 years of age. She is severely retarded and has spent most of her life in a State institution for mentally retarded persons.

When we speak of institutionalized mentally retarded people today, we are referring to approximately 155,000 individuals residing

[11] 1 Mental Disability Law Reporter 181 (1976).

in 237 public institutions. In addition, there are approximately 30,000 such individuals residing in private facilities and an estimated 30,000 residing in so-called State mental hospitals.

Of this group, 74 percent are severely and profoundly retarded. Many of these individuals have no language. Many of them are multiply handicapped—blind, deaf, epileptic, cerebral palsied. In short, we are dealing with the most vulnerable segment of our population.

The vast majority of these individuals are totally unable to speak for themselves.

Institutions for the mentally retarded in this Nation unfortunately have been a blight on our society. We are not dealing with isolated instances of abuse and of cruelty but with massive violations of basic human rights of masses of people.

I have long pondered how this Nation which cherishes individual freedom tolerates this situation. I have reached the conclusion that we make the assumption that there are degrees of humanity and that some of us are less human than others and, therefore, we can condone such conditions.

When I first became superintendent of a large State institution in Texas, I was so overwhelmed with the horror of the situation that I commissioned a local television station to make a 12-minute documentary of the institution, which I subsequently presented to the Appropriations Joint Conference Committee of the State legislature in an attempt to justify a budget increment. I was surprised and amazed to find that a number of members of this august body later congratulated me on doing such a superb job at the institution.

To give you an idea of the nature of this film, Mr. Chairman, the first shot was a shot of a 70-bed dormitory housing the young retarded girls, three quarters of whom were tied to their beds in spread eagle fashion during the entire night.

In general, I find that there are basically four problems with State institutions for mentally retarded persons. These are problems which are recurrent and which I have witnessed throughout the Nation.

The first deals with dehumanizing conditions. These have been well documented. They include seclusion, the use of physical restraints, mass nudity, mass showering, toilets without toilet paper or toilet seats, the use of cattle prods for aversive conditioning, forcing individuals to masturbate publicly and to engage in various other types of totally dehumanizing practices allegedly in the name of treatment or behavior modification.

Second, we are repeatedly confronted with unsanitary and hazardous conditions. There are documented instances of injury and death, abuse, filth, human beings living in human excrement, overmedication, fire and health hazards, and conditions of this nature.

Third, many of our institutions are replete with conditions which foster regression and deterioration. Rather than fostering human growth and development, the conditions tend to lead to deterioration and to deviancy. In many of our institutions a large number of individuals still undergo what I call "enforced idleness." They spent countless hours day after day in total inactivity. This sort of sensory deprivation is likely to lead in normal individuals to the development of serious pathological behavior. This is no less true with retarded persons.

Finally, institutions are still often characterized by self-containment and isolation, confinement, separation from the mainstream of society which fosters rather than mitigates against deviancy.

The reasons for these problems include the following:

First, there is the problem of timing. Timing is critical. I suspect that in every State of our Nation top program administrators and superintendents would concur with the best professional opinions today as to what is desirable for retarded individuals. The problem is in implementation.

State administrators have become bogged down in rhetoric and planning ad infinitum.

In the mid-1960's superb plans were developed for the mentally retarded in the State of Texas. When I was with the State of New York in the late 1960's superb plans were developed for deinstitutionalization. Yet to this day these plans have not been implemented.

The timing problem is related to the problem of priorities. Over and over again priorities are arranged in such a way as to be politically appealing.

I recall as superintendent, for example, when $50,000 extra money was generated through budget savings and I requested the building of several additional toilets within one of my training units so that the individuals living therein could be toilet trained, I was told that, instead, the money would be used to paint the facade of the buildings facing the main thoroughfare so that the facility would look more attractive to the passersby.

Another major problem which has already been alluded to relates to shortages of staff, training of staff, and difficulty in discharging staff. This may be true at the direct care level but it is at times equally true of professionals and even of superintendents.

I know of instances where superintendents have been patently psychotic but the State has been either unwilling or unable to discharge these individuals and has instead periodically sent these individuals to a psychiatric treatment facility for courses of electric shock therapy.

The physical plants of many of our institutions were designed for economy of operation and as security facilities which are totally unsuited to rehabilitation and treatment.

I should also point out that the logistics of managing large numbers of humanity are complex and that in large self-contained institutions there are serious problems of supervision, particularly in terms of the three shifts. There are grave problems of monitoring and program implementation.

There are some instances in which there are obvious conflicts between the interests of the State agency operating the facilities, the administrators of the operating facilities, and the individuals being served. It is not unusual for agencies to investigate their own facilities and subsequently to cover up these investigations.

We of the National Association for Retarded Citizens feel that there is a critical need, Mr. Chairman, for your proposed legislation. Mentally retarded people and their advocates are particularly at a disadvantage to appeal violations of their own civil and constitutional rights. They lack the necessary resources, the time, the funds, the expertise, and in some cases they frankly fear reprisal.

Successful litigation in this area requires an extensive data base which can be obtained only through detailed investigation. It requires legal expertise in specialized areas and it requires access to expert witnesses.

The Justice Department, with which I have worked personally as an expert witness in a number of key cases, has demonstrated this expertise and the ability to access expert witnesses.

We feel there is considerable urgency. Time does not stand still for the thousands of individuals who are still currently in jeopardy.

I should like to share with you some very brief specific comments regarding S. 1393. Our association strongly endorses the provision of intervention without exhaustion of administrative or other remedies.

We feel that such remedies could well prove to be insurmountable obstacles leading to indefinite delays. People could easily bog down in the bureaucratic quagmire which characterizes so many of our State bureaucracies.

We have two comments with regard to the definition of institution. We would urge you to drop the term "treatment" as a qualifier since the very basis of much of the litigation is that the institution in question in point of fact does not deliver treatment.

We also would hope that language would be introduced which would clarify the inclusion of community-based residential services. There is no guarantee that these community-based facilities cannot be as bad, or perhaps even worse, as some of our institutions.

Finally, we would urge the inclusion of language which would clarify that the bill refers both to voluntary and to involuntary admission. There is serious question that there is such a thing as a valid voluntary admission of a mentally retarded person, particularly a severely retarded individual.

Once in the institution there is grave danger of coercive components which would mitigate against any semblance of voluntariness.

To conclude, Mr. Chairman, our association is grateful to Congress for the very significant gains that have been made on behalf of mentally retarded and other handicapped individuals in the past years.

We are grateful to you, sir, for this bill which is designed as a remedy for the continuing violations of human and constitutional rights of thousands of our fellow citizens.

We strongly urge the passage of this legislation as soon as possible.

Senator BAYH. Thank you very much, Dr. Roos, for your very thoughtful presentation and for the support of your association and yourself, personally and professionally.

Yesterday Assistant Attorney General Drew Days had some rather graphic testimony relating to a young woman in an Alabama facility who had been kept in a straitjacket for 9 years.

At that time my colleague, Senator Scott, suggested that this was certainly an isolated occurrence.

I notice in your document you say "numerous deaths due to negligent and hazardous practices exist in the State institution."

Apparently this kind of thing is not isolated? Is it prevalent everywhere?

Dr. Roos. Unfortunately, Senator, this is not isolated. It is prevalent.

I have now testified in, as I recall, five major right to treatment cases in five different States. I have found these conditions present in all instances. In addition, I have traveled extensively and visited many of the institutions of this country. The kinds of conditions described in Partlow and in Willowbrook are, unfortunately, common in many of our institutions.

Senator BAYH. Are you personally aware of any institutions where wide-scale deprivations of residents' constitutional rights are going on right now?

Dr. Roos. Yes; I am, Senator.

I testified in the current litigation at Pennhurst in Pennsylvania. I visited that facility shortly before giving testimony and found those types of conditions existing there at the time. That is the most recent of my visits.

I am alerted, however, by some of our affiliates that similar conditions are current in other States.

Senator BAYH. Would it be possible to get an enunciation from other members of your association that could detail some of the grievances and the institutions where the abuses have occurred?

I think that almost all of our colleagues have great compassion in their hearts. We should make every effort to prove to them that these abuses are not isolated but are, as you have said, pervasive; and, also that the remedy we suggest is going to deal with these specific problems.

If you could help to chronicle those abuses for us, it would be very helpful.

Dr. Roos. We will be glad to gather that information and forward it to the committee.

Senator BAYH. I notice, sir, that you make a suggestion for change so that it would be possible to deal with smaller facilities where persons are often placed and can be abused perhaps even more easily than in large institutions.

Dr. Roos Yes.

Senator BAYH. It is easier to hide the offenses against a few people who are closeted.

I just want to say from my standpoint that we are anxious to find out all types of institutions where you have large-scale abuse—large-scale not being the size of the institution but the number of instances that exist and where one suit by the Justice Department can bring substantial relief.

I appreciate your suggestion there.

Are you familiar with the Rosewood and Boulder River situations in Maryland and Montana?

Dr. Roos. I am familiar with them, sir. I did not visit either facility myself in recent years, although a member of my staff did visit and make a study of the Rosewood facility.

Senator BAYH. The conditions there were such that you feel this kind of legislation would be helpful?

Dr. Roos. Very definitely. The conditions described to me there were abominable.

Senator BAYH. I would appreciate it if you could include those two institutions in the enumeration that you submit.

Dr. ROOS. We will be sure to do that.

Senator BAYH. Thank you very much, Dr. Roos. You have been very helpful. I appreciate not only your assistance here, but the kind of assistance that you and your colleagues are rendering to a lot of people who are really unable to assist themselves.

Dr. ROOS. Thank you, Senator.

[The prepared statement of Dr. Philip Roos follows:]

PREPARED STATEMENT OF DR. PHILIP ROOS

Mr. Chairman, my name is Dr. Philip Roos. I am the Executive Director of the National Association for Retarded Citizens, the organization that represents our nation's six million mentally retarded citizens. I have spent practically all of my professional life serving mentally disabled people. I have served in such positions as:

Superintendent of a 2,400 bed state institution for the mentally retarded in Texas;

Associate Commissioner of Mental Retardation—New York State Department of Mental Hygiene;

Director of Psychology—Texas Department of Mental Health and Mental Retardation; and

Practicing Clinician—Texas Federal Hospitals.

In addittion, I have served as an expert witness, in some instances at the request of the Justice Department, in right to treatment litigation in Alabama, Pennsylvania, New York, Nebraska and North Carolina. I would also like to mention that I am the parent of a sixteen year old severely mentally retarded daughter who resides in a public institution in Texas.

My present employer, the National Association for Retarded Citizens, is greatly concerned about the active role to be played by the United States Justice Department in seeking redress for violations of constitutional rights of institutionalized mentally retarded persons. Our organization, made up of almost 250,000 members and 1,900 local Associations throughout the country, formally a legislative goal to "seek legislation giving the Department of Justice standing to bring suit to protect the rights of mentally retarded citizens." Therefore, Mr. Chairman, I am pleased to convey to this Committee NARC's wholehearted support for your bill, S. 1393.

Our organization has sought to improve the plight of our institutionalized mentally retarded citizens for many years. By fostering Federal and State legislation, monitoring programs, cooperating with State officials and other such endeavors, we have been somewhat successful in raising the level of care in some institutions.

When these efforts have failed, some of our State units have actively particiрted in litigation in right to treatment and protection from harm. The Pennsylvania Association for Retarded Citizens in the Pennhurst case and the New York Association for Retarded Citizens in the Willowbrook case are examples of such efforts. Our units have entered cases as amici and in others have provided back-up support such as expert witnesses and background information. Our national leaders such as NARC President Dr. Frank Menolascino and Dr. Brian McCann, Director of NARC's Research and Demonstration Institute, have served as expert witnesses in New York, Mississippi, Maryland and Nebraska.

In spite of these continuing efforts, the present life status of most institutionalized mentally retarded persons is still incredibly dismal. Who are we talking about when we speak of the institutionalized mental retarded citizen? According to recent (1976) statistics published by the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded, approximately 155,000 mentally retarded persons reside in 237 public institutions. Seventy-four percent of these individuals are severely and profoundly retarded. Less than 10 percent are mildly retarded.

Many of these institutions are located in rural areas, making it very difficult for the families of the residents to visit periodically. Quite frankly, a

large number of these individuals have been abandoned by their families from the day they were placed in the institution. I know of many cases where institutionalized mentally retarded persons have never received a visitor in twenty, thirty or more years.

A great many severely and profoundly retarded persons are multiply handicapped. Many have no speech, cannot make their needs known and are generally totally dependent upon the level of care afforded them by the institution. This population then, in the opinion of many, is clearly among the most vulnerable in our society.

Let me take this opportunity to briefly describe some of the conditions that can be found today in some of our public institutions. I am sure all of you have read about the terrible conditions at Forest Haven, the District of Columbia institution for the mentally retarded. Let me assure you that it is not alone in providing care in inadequate, many times unsafe, facilities. Can you imagine sleeping in a room with fifty or more other persons? How about taking a shower by being hosed down with cold water in groups of ten or twenty! Toilets with no seats and no separating partitions for privacy are common. But this is not the worst. We can document numerous deaths due to negligent and hazardous practices in these institutions. Residents physically abusing other residents to the point of death is not uncommon. Horrible aversive behavior modification practices such as isolation for long periods of time, withdrawal of meals, electric shock and chemical and physical restraint are still common practice.

Children who could talk and walk a few years ago are now unable to do so because they have been deprived of any opportunity to utilize these skills. These cases of regression and deterioration are too common. Too many States have just not been willing to change these human warehouses into facilities which provide appropriate treatment and care. There is simply no excuse for this. We are too rich a society to allow this to happen. Yet, it continues.

We must not only blame the States for allowing these practices to continue. The Department of Health, Education and Welfare, just this month, bowed to great pressure from the National Governors' Conference and extended for up to five more years the time period for States to comply with important Life Safety Code standards for Intermediate Care Facilities (ICF/MR) funded under the Medicaid program. HEW is also allowing the States to waive the standards which calls for no more than four persons to a bedroom. This surely will lead to the continued warehousing of many persons sleeping in the same room. This was done after some States had purposefully not moved to comply with the standards since 1974. Even though this was done only two weeks ago, we have heard reports that States are already cutting back on funds for mental retardation institutions since they have until 1980, and in some cases until 1982, to meet the standards. How long must our totally dependent institutionalized population suffer? Hopefully, not too much longer.

The Congress has been very helpful in attempting to improve the lives of mentally retarded persons. The passage of the ICF/MR Medicaid program, the Developmentally Disabled Assistance and Bill of Rights Act and the Education for All Handicapped Children Act are just some of the examples of the strong commitment the Congress has had toward these citizens. We come to you again for help. Mentally retarded persons, their parents and advocates and organizations such as the National Association for Retarded Citizens cannot do it alone, particularly when litigation is required.

We are here today primarily due to two suits, one in Maryland, the other in Montana, which were dismissed because the Justice Department apparently has no power to bring such suits. Ironically, both suits had been filed on behalf of residents of public institutions for mentally retarded persons. Needless to say, our organization is greatly disheartened by these decisions. We are pleased that the Justice Department has appealed, and we have joined in the appeal as amicus. In the meantime, the residents of Rosewood in Maryland and Boulder River in Montana continue to live under dehumanizing conditions. We urge this Committee to give top priority to giving the Attorney General the power to intervene on behalf of our vulnerable citizenry.

A major reason for the need for the United States Government to have this power is the lack of resources by institutionalized residents and private groups to litigate. Such class action litigation is time consuming, costly and requires extensive expertise. Public interest law centers are too few and most lack the

expertise necessary to successfully litigate cases on behalf of institutionalized mentally retarded persons. Organizations such as the National Association for Retarded Citizens depend upon membership dues and donations to finance their services. In most cases, our Association for Retarded Citizens units are reluctant or totally unable to participate in such litigation only due to the lack of fiscal resources.

With little outside help, no government assistance and since institutionalized mentally retarded persons cannot help themselves, how are we to provide such basic protection as the right to be free from harm for such vulnerable people? One major answer is—Give the Justice Department the authority to intervene.

I would now like to comment specifically on your bill, Mr. Chairman, S. 1393. As I stated earlier, the National Association for Retarded Citizens strongly endorses this bill. We have three specific comments on the bill itself:

First, we strongly endorse the provision of intervention without exhaustion of administrative or other remedies. There is simply no way mentally retarded residents can be expected to undertake such exhaustion procedures. Of all the individuals protected by this bill, the mentally retarded would clearly be the most jeopardized by such a provision. We urge the Committee to retain its language in this area.

Secondly, the National Association for Retarded Citizens wishes to comment on the definition of "institution." We wish to make two points:

1. The word "treatment" in Section 4(1) implies that there is treatment going on. The very basis for many suits on behalf of mentally retarded citizens addresses the notion that there is no treatment going on. We suggest dropping the term "treatment" from this Section.

2. To most citizens, the term "institution" for the mentally retarded indicates a facility or facilities where hundreds and some times thousands of residents reside. This is true of many of our facilities. However, more and more mentally retarded persons are being placed in nursing homes, hostels, group homes, halfway houses and other such community-based residences. These facilities usually house from six to twenty residents, but some can house as many as fifty to a hundred residents and some as few as four. The Federal Government (HEW) considers an institution to be "four or more unrelated persons living together and receiving service beyond room and board." While the National Association for Retarded Citizens welcomes such placements when made to better suit the needs of the individual, we are aware that some such facilities are as bad, if not worse, than some of our larger institutions. We suggest the bill be amended to assure equal protection for residents of such community-based residences.

Lastly, we wish to bring to your attention the need to protect all residents of such institutions, whether they were confined voluntarily or involuntarily. Any mentally retarded resident of an institution must be protected, regardless of how he entered the institution. Once voluntarily admitted to an institution, all persons should be entitled to the same protections as persons who are required by legal process to reside in the institution. We urge the Committee to consider the inclusion of such language.

In summary, our organization wishes to call your attention to the urgency of this legislation. Also six years ago, in 1971, President Nixon, in extending the President's Committee on Mental Retardation by Executive Order, directed "that the Department of Justice take steps to strengthen the assurance of full legal rights for the retarded." This effort is in serious jeopardy today. Mentally retarded people are also in serious jeopardy today.

The Justice Department is asking for the authority to intervene on behalf of the institutionalized mentally retarded citizen. This is a critical need. On behalf of the 155,000 mentally retarded citizens currently residing in public institutions, their parents and the hundreds of thousands of our members, I, again, urge you to enact this legislation as soon as possible.

Senator BAYH. Our next witness is Prof. Gunnar Dybwad. He is professor of human development at the Florence Heller Graduate School for Advanced Studies in Human Development at Brandeis University, Massachusetts.

He is a member of the ABA Commission on the Mentally Disabled. He is a Life Fellow of the American Association on Mental Defi-

ciency and a consultant to the President's Committee on Mental Retardation of the U.S. Public Health Service; also the U.S. Office of Education, and other State agencies.

Please proceed, sir.

TESTIMONY OF GUNNAR DYBWAD, GINGOLD PROFESSOR OF HUMAN DEVELOPMENT, FLORENCE HELLER GRADUATE SCHOOL FOR ADVANCED STUDIES IN HUMAN DEVELOPMENT, BRANDEIS UNIVERSITY, MASSACHUSETTS

Mr. DYBWAD. I have been concerned with the problem of institutionalization throughout my professional career for almost half a century—first in the field of prisons and reformatories; later in training schools for juvenile delinquents; and during the most recent decades, in the field of mental retardation.

I have served as consultant to President Kennedy's Special Assistant on Mental Retardation, to the U.S. Public Health Service, the U.S. Office of Education, the President's Committee on Mental Retardation, and numerous State governmental agencies.

I have visited mental retardation institutions in 49 of the 50 States, many of them repeatedly and for long periods during the day and night, as well as in some 35 countries around the globe.

From 1967 to 1977, I served without compensation as consultant to Dr. Hugo Moser, superintendent of the Fernald School in Waverly, Mass., and he recently estimated that these consultations added up to over 1,000 hours.

Many of my visits to institutions extended over several days, and I frequently visited also during the early evening and late at night to get a more complete picture of what was transpiring.

Thus, when I was requested to testify in *Wyatt* v. *Stickney*,[1] I felt I could speak with confidence of my knowledge of the widespread abuse suffered by persons confined in our mental retardation institutions; of the incredibly substandard health practices; of the flagrant denial of the most basic rights to privacy, property, and personal integrity; and of the brutal and inhuman disciplinary measures to which they were subjected.

However, as the hearings in the *Wyatt* case proceeded before Judge Johnson, I began to realize how difficult it was to bring before the court competent, cogent, factual testimony which addressed itself with sufficient specificity to the various allegations of constitutional provisions. Some of the people who have testified here have made reference to this. It is difficult to get witnesses to these situations.

While some of the conditions are easily demonstrated it is in the nature of the large closed institutions with numerous locked buildings and locked wards in those buildings, with staff numbering thousands and more—many more in some of the institutions such as in New York or Pennhurst; with complicated hierarchical layers; with frequent animosity and buckpassing between the professional and

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[1] 325 F. Supp. 781 (M.D. Ala. 1971); 334 F. Supp. 1341 (1971); 344 F. Supp. 373 (1972); 344 F. Supp. 387 (1972); aff'd. sub nom. *Wyatt* v. *Aderholt*, 503 F. 2d 1305 (5th Cir. 1974).

the usually very low paid nonprofessional staff; with longstanding and quite accomplished techniques for concealing physical abuse or other inappropriate practices—for instance, you throttle a patient with a towel and it does not leave any marks and this kind of thing; and, most distressingly, with ficticious record entries in daily logs, on nursing notes, and disciplinary reports—with all of these things, truth is hard to come by.

Therefore, my colleagues and I were very much impressed during the *Wyatt* hearings with the superior performance of the attorneys from the Justice Department who had entered the case upon invitation by Judge Johnson. Backed up by investigators from the FBI and by the resources of the Department of Health, Education, and Welfare and other Federal agencies, the attorneys from the Justice Department's Office of Special Litigation assembled factual data and developed testimony by expert witnesses in a most skillful and sophisticated manner.

This favorable impression of the key contribution of the Department of Justice was reinforced for me in subsequent right-to-treatment cases in which I was requested to appear as expert witness in Nebraska,[2] New York,[3] and Pennsylvania.[4] Each time the Department of Justice demonstrated—as a matter of fact, with each successive trial they demonstrated more and more—how valuable it was to have a national agency with such competency.

It came as a shock to my colleagues and me when in 1976 Federal courts, as I already have mentioned here, in Maryland [5] and in Montana [6] ruled that in the absence of specific statutory authority an executive agency such as the Department of Justice lacked standing to sue on behalf of institutionalized citizens.

The legislation now before your committee, S. 1393, authorizing actions by the Attorney General to redress deprivations of constitutional and other federally-protected rights of institutionalized persons provides a suitable remedy in this situation, and I am appearing before you to give this legislation my strongest endorsement.

The question might be raised, and of course has been raised very loudly, why it should be so important for the Department of Justice to be authorized to intervene in cases involving residents of institutions. The answer is compelling.

The record will show that residents of institutions for mentally ill, disabled, or retarded persons; of facilities for the chronically physically ill or handicapped; of nursing homes; of correctional institutions whether for adults or for juveniles are in particular danger of being deprived of rights guaranteed under the Constitution.

In many cases they either do not have the capacity to express their grievances actively or are being hindered from doing so, such as when they are not allowed to go to the telephone.

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[2] *Horacek, et al.* v. *Exon, et al.,* Civil Action No. CV72–L–299 Preliminary order, 357 F. Supp. 71 (D.Ct., Feb. 1973).

[3] *New York State Association for Retarded Children* v. *Carey,* 393 F. Supp. 715 (E.D. N.Y. 1975), 357 F. Supp. 752 (E.D. N.Y. 1973).

[4] *Halderman* v. *Penhurst State School and Hospital,* No. 75–1345 (U.S. D. Ct., E.D., Pa.), filed May 30, 1974.

[5] *United States* v. *Solomon,* 419 F. Supp. 358 (D. Md. 1976) (appeal pending No. 76–2184 (4th Cir.)).

[6] *United States* v. *Mattson,* Appeal pending, No. 76–3568 (9th Cir.). See also *United States* v. *Elrod,* CA. No. 76C4768 (N.D. Ill.) (motion to dismiss pending—no ruling is expected by the Department of Justice until the Fourth Circuit decides *Solomon.*

A woman who is held for years in isolation can hardly communicate. A person whose teeth have been extracted, every single one, because she had been involved in some aggressive behavior is hardly in a position to communicate.

In the case of residents of institutions for the mentally retarded, there is an additional cruel twist. When they have been victims of physical violence or sexual abuse, their testimony is usually discounted because they are presumed to be incompetent.

It does not matter if they are three young men who very clearly state what has happened to them, how the supervisor of the building in which they are confined has sexually abused them. The attorney defending the employee simply will have to bring to the court's attention that their IQ is such and such and their testimony will be discounted.

Furthermore, and this is a very important point, Mr. Chairman, from my many years of close contact with individual parents of institutionalized retarded sons and daughters, and with parent associations, I know that such families are afraid to complain about mistreatment suffered by their children. They may have been told that their complaints may cause institutional employees to quit their jobs which would result in even less care being given at the institution. Or parents may have been told that if they are so dissatisfied, they should take their children home. They are being told: "We have plenty on the waiting list. We do not need your child here. If you do not like it, take him out."

Of course, the point is that the parent never wanted to place the child in the institution. The parent has the child in the institution because there is nothing else in the whole wide world for him, no community services.

Obviously this reluctance of parents to come forward greatly complicates the job of assembling evidence for presentation to the court, and this underlines the importance of having the benefit of the skill and resources of the Justice Department,[7] which over the years has been accumulating knowledge, ways of persuading parents, and ways of finding out truths.

It has been suggested that class action suits have resulted only in negligible improvements in the institution. That is not so. For the resident better food, better furnishings, improved medical care, increased availability of therapeutic services, more adequate educational programs do constitute a significant improvement. But in most instances it is not enough.

Moreover, because of the basic deficiencies in our institutions, new problems will arise or old ones will reoccur. Having a successful legal action with regard to one institution in no way assures us that from then on we will have no more trouble.

Within the past 2 weeks the following matters have come to my attention: In New York City an institution was using methods of so-called aversive conditioning, including the use of electro-shock by cattle prods, the squirting of foul-tasting liquids into the resi-

[7] See also Elkin's Reaction Comment to Kindred's chapter Guardianship and Limitations Upon Capacity, in: Kindred, Cohen, Penrod, Shafter, The Mentally Retarded Citizen and the Law (1976) at 89.

dent's mouth, and similar cruel and abusive practices. These are techniques which are questionable in the first place and which easily deteriorate into gross abuse if misapplied by an employee.

Mr. Chairman, I would like to pass on to the committee a copy of an official document entitled "Manual of Standard Procedures for Aversive Therapy" for use in institutions under the New York State Department of Hygiene in Queens, N.Y., at the present time.

It sets forth in detail rules for applying these medieval tortures: How to squirt foul-tasting liquids into people's mouths, how you apply a cattle prod shock, and so on.

Senator BAYH. Without objection, that will be made a part of the record.

Mr. DYBWAD. In a Texas State institution for the retarded a "no nonsense approach" is introduced including a new physical method called "take down" in which the staff puts the unruly resident off balance, places him prone on the floor, and straddles him. Again, the serious abuse that can result from this kind of questionable practice is obvious.

In California the Little Hoover Commission has just come out with a report on questionable deaths in institutions, in which you might be interested. They investigated a series, I think, of 200 deaths in institutions.

I remember a case in Pennsylvania where a child had died in the institution and the coroner refused to have a postmortem. We had to go to court to order one.

In California the State authorities could see nothing wrong with placing into a mental retardation institution a physician who had just served a sentence for sexually abusing a patient.

Mr. Chairman, I have worked in the correctional field. Certainly such a man is entitled to rehabilitation and entitled to work placement, but placing such a person in a facility serving retarded persons creates a high risk situation for the intellectually limited residents who, due to their handicap, are less able to cope. A California resident who wrote to me said,

> Why can't an M.D. with this history be placed with patients who can report accurately what happens to them and who have unimpaired communication?

It is insensitivity and ignoring the rights of people which causes a placement of a man with this history in an institution for the retarded.

I hope that these examples suffice to indicate that we must expect continued institutional abuse and, correspondingly, continued need for judicial intervention.

One final point: There has been complaints about the judicial intervention and now fear has been voiced from some quarters that legislation such as is represented by S. 1393 will encourage lawsuits disruptive of State governmental processes.

I have been involved in recent years as expert witness before Federal courts in 12 cases across the country dealing with the right to treatment, the right to education, the right to be free from abuse, et cetera. In all these cases, Mr. Chairman, the Federal judges tried to persuade the parties to settle the matter out of court, gave the

State ample time to remedy the faulty situation and in every way avoided precipitous action.

For instance, in the *Wyatt* case referred to here frequently Judge Johnson originally gave the State Commission of Mental Health 6 months to come forth with a remedial plan. He refused to hold any hearings. He said, "I will give the commissioner 6 full months." Unfortunately, nothing was forthcoming that satisfied the judge.

On the other hand, it has become quite clear to me that the judges were keenly aware of the extreme harm that had accrued to the plaintiffs and were eager to have adequate documentation of the prevailing conditions as well as adequate legal representations.

In each case the judge at first was very cautious. He was really not ready to accept the seriousness of the situation. As witness after witness appeared and pointed out what was happening to individuals, then the judges recognized how serious the situation is.

The U.S. Department of Justice with its extensive resources and its ready access to other Federal agencies can help materially in this task. Its activities would in no way interfere with the involvement of the private bar and the various public interest law centers. To the contrary, in all cases I have had the opportunity to observe, there was fullest cooperation and effective complementation of resources.

Since I do not represent any particular agency, permit me to make myself spokesman of a group in whose interest I have been privileged to work for so many years, the mentally handicapped. I urge you on their behalf to give this bill your fullest support.

Senator BAYH. Professor Dybwad, I had heard your services to the mentally retarded described as a combination of Mahatma Gandhi and Santa Claus. Perhaps we could add Clarence Darrow and some other defenders of legal rights.

I really do not think there is any need to ask any questions because you answered them all in advance. You gave very perceptive testimony.

I hope we can call on you again if things come to mind on which we need some additional information.

Again, I thank you, sir, for helping us and for helping all those whom you have been helping over half a century.

Mr. DYBWAD. Thank you.

[Material submitted for the record by Mr. Dybwad follows:]

[EXHIBIT NO. 8]

MANUAL OF STANDARD PROCEDURES FOR AVERSIVE THERAPY[1]

Whenever aversive stimuli are part of a therapeutic program, it is essential that carefully delineated and controlled procedures be utilized. In order to protect the client from misuse of the procedures, and to insure consistency of application by all staff, the following standard procedures will be used:

Any aversive procedures not specified in the present manual must be made available in written form to all treatment staff. As with all aversive procedures, these may only be used after completing the standard review procedure and

[1] This "Manual" was in use by the Fineson Developmental Center, a New York State Department of Mental Hygiene facility located in Queens, N.Y. It was in actual use as late as May 1977.

must be in conformity with the Guidelines on Aversive Procedures of the Queens Regional Council.

AUDITORY STIMULI

Tokbak.—When the client emits maladaptive screaming, a standard plastic "Tokbak" headpiece will be placed on the client's head for the duration of the screaming, plus 30 seconds of acceptable vocalization. When the client is either quiet or vocalizing at a normal intensity for 30 seconds, the Tokbak will be removed.

Amplified feedback.—When the client emits maladaptive screaming, a head-set, consisting of a battery-operated microphone/amplifier connected to an ear-phone, will be placed on the client's head. The headset will be removed when the client has ceased screaming and is either quiet or vocalizing at a normal intensity for 30 seconds. The volume setting shall be decided in consultation with the speech therapist/audiologist.

GUSTATORY STIMULI

Foul-tasting liquids.—Contingent upon the clients maladaptive behavior, a small amount (1–3 teaspoons) of FTL will be administered by plastic squeeze bottle into the client's mouth. Care must be taken to insure that the nozzle of the bottle is in the client's mouth so that there is no danger of the FTL reaching the client's eyes. An alternative method of presentation is to place a ¼ of a standard washcloth soaked in the FTL in the client's mouth for 20 seconds. Use of any particular FTL must be in consultation with a physician to insure that no physical harm can result from ingesting the FTL. Possible FTL include: lemon juice, vinegar, hot sauce (e.g. chili, tobasco), listerine, yeast/water solution.

Food additives.—In the case of ingestion of dangerous non-food substances (e.g. feces, garbage, vomitus), a small amount (1–3 teaspoons) of FTL may be added to the substance rather than being applied directly into the client's mouth. Consultation with a physician is required to insure that no harm can result from ingestion of the FTL.

OLFACTORY STIMULI

Aromatic ammonia.—Contingent upon the client's maladaptive behavior, a standard capsul of aromatic ammonia (smelling salts) will be broken and held one inch from the client's nose for 15 seconds. Alternatively a bottle of ammonia saturated cotton may be held open one inch from the client's nose for 15 seconds. Care must be taken to insure that the capsul or bottle does not come in contact with the client's skin.

Vinegar.—Contingent upon the client's maladaptive behavior, a standard wash-cloth soaked in vinegar will be held loosely covering the client's mouth for 30 seconds. The client's mouth and nose area will then be wiped with a water-soaked cloth to remove remaining vinegar from the skin.

TACTILE STIMULI

Bataka.—Contingent upon the client's maladaptive behavior, a single sharp slap with the Bataka bat will be applied to the client's upper arm or buttocks.

Faradic stimulator.—Contingent upon the client's maladaptive behavior, a single shock of ½ to 1 second duration will be applied to the client's arm or leg. The client should be wearing a short-sleeved shirt or short pants. Under no circumstances should shock be applied to the chest or head area. A standard low amperage stimulator must be used (e.g. Sears Hot Shock), with electrode contacts no more than 1 inch apart.

Cool shower.—In the case of soiling/feces smearing, the client may be washed with cool water (no colder than 60°) in order to clean away feces. Water will only be applied to those areas of the body which are soiled. The "shower" will last no longer than is necessary to adequately cleanse the client.

Finger flick.—Contingent upon the client's maladaptive behavior, he will receive a single flick across his lips. The flick should be done with one finger, either vertically or horizontally, tangent to the mouth. The flick should not be applied perpendicularly, to avoid forcing the lip against the teeth.

[Exhibit No. 9]

[From "Impact," Vol. VI, No. 6, Texas Department of Mental Health and Mental Retardation, March–April 1977]

What is Behavior Modification?

Behavior modification is neither new nor sinister, as some accounts have led many to believe. Actually, it is little more than the systematic application of learning principles to everyday problems.

The basic assumption is that a person's behavior is influenced by the consequence of the behavior. Ideas about ways in which reward and punishment influence behavior have existed for centuries.

In TDMHMR facilities, the techniques of behavior modification generally develop self-control by expanding an individual's abilities and independence. The results range from a retarded child's acquiring toileting skills to a disturbed person's refraining from self-destructive behavior.

An important feature of behavior modification is its attempt to influence behavior by changing the environment and the way people interact—instead of intervening directly with medical procedures, such as drugs.

The first step in any behavior modification procedure is to obtain detailed descriptions of what the client does and does not do. Generally, positive reinforcement—in such forms as money or food, praise or attention—is used to develop and maintain new behavior, and its removal helps decrease undesired behavior.

Few would deny there is a need for ethical safeguards for behavior modification programs. Guidelines mandated by the Rules of the Commissioner help prevent abuse of this valuable treatment strategy in helping restore many clients to productive lives.

Shaping Behavior ... In a School

(By June Bilsborough)

Denton—Ask any staff member about the success of the new Intensive Training Unit (ITU) at Denton State School.

The answer probably will testify that consistency and staff communication are the key elements in programs to help self-abusive and aggressive residents decrease their inappropriate behaviors.

"Success is accomplished by direct communication with our unit administrators," explains direct care worker John Hardy. "We have staff meetings during our shift overlaps in which every resident's treatment plan is reviewed. Direct care staff members are involved in programming, and everyone is trained in all procedures. Such training and involvement make for more consistency."

Placement on the ITU is temporary. Once the resident reaches the goals set for him, he is slowly returned to programs on his home dormitory.

Since December, 18 severely and profundly mentally retarded residents have been involved in individualized treatment programs designed to reinfroce appropriate behaviors using tokens and close attention from staff. Expansion of the program is planned this spring to include 18 more residents, who are moderately and midly retarded.

Each resident has a training folder which contains a detailed description of his or her individual treatment programs, as well as data including the resident's response to the program procedures. Data is recorded daily on those behaviors for which the resident originally was referred and is used in evaluating and, if necessary, revising his/her program.

"Identifying those procedures which are or are not effective is essential to a successful program," says psychologist H. S. Colvin, who directs the unit.

An important part of the unit is the Itinerant Training Team, which is composed of four trainers assigned to small groups of residents.

"The trainers assist in writing programs and providing quality control by observing and checking programs for consistency and needed revisions," explains psychology assistant Jim Gardner, who coordinates treatment plans. The team also provides inservice training to direct care staff on the principles of behavior modification and plays a major role in helping residents gradually return to their home dormitories.

Tailored programming is scheduled every hour during the day in language training, token conditioning, prevocational training and recreation. Group field trips also are planned to sporting events, zoos and picnic areas.

"We are interested mainly in training the residents to complete individual tasks in a group setting," says ITU building coordinator Cathy Melsheimer.

"If a resident is disruptive, he is taken from his group and provided with one-to-one therapy so he can learn to obey simple commands and to increase his attention span. When behavioral control is achieved, the resident is then gradually involved in group activities again."

The ratio of staff to residents is approximately 1:1 during the day and 1:4 at night. Twenty-four direct care employees assist a special education teacher, adaptive physical education therapist, recreation therapist and speech and language therapist in all areas of programming.

"It's definitely encouraging to work on this unit because of the involvement," says direct care worker Harvey Stephens. "We're all working toward the same goal—to help the resident lower his frequency of inappropriate behaviors."

"Most of the residents at this level of functioning have little verbalization," explains social worker Carol Perry. "If we can work together to teach them how to express themselves properly, such as using the words 'I want,' perhaps they will be able to return to their dorms and express themselves without becoming frustrated and regressing to inappropriate behaviors."

Shaping Behavior . . . in a Hospital

(By Thelma Ledger)

San Antonio—The way to deal wtih a mentally retarded person who is emotionally ill is through tight control. Right?

Wrong.

The way to seek good behavior with the mentally retarded who are emotionally ill is through meaningful discussions. Right?

Wrong.

The way to make progress with the mentally retarded who are emotionally ill is to behave as any loving parent would. Right?

Right.

The Multiple Disabilities Unit at San Antonio State Hospital is finding systematized common sense effective in dealing with 40 patients who are learning how to behave in more acceptable ways. The no-nonsense approach, which includes a new physical method called "take down," is laying important groundwork for valid treatment of this type of patient.

Larry J. Aniol, Ph.D., director of the unit, says the main conclusions drawn from the three-year-old program are that (1) sophisticated therapeutic measures can be extremely simplified and (2) the key to effectiveness is the delivery of services by firstline staff.

The dilemma of how to promote choices in a person with aggressive and assaultive behavior and at the same time protect the rights and property of others is being met successfully in Dr. Aniol's treatment plan.

In the past, two major methods were used to cope with objectionable behavior. Chemotherapy, electric shock and restraint were the main medical intervention methods. Detention and isolation were the main judicial methods.

Neither method achieved the best results, maintains Dr. Aniol. They are not employed by Dr. Aniol's unit. Instead, the learning and behavioral approaches at San Antonio State Hospital utilize social skills and modification of reactions.

The "take down" process is seldom used and then only in cases of extremely destructive behavior.

The idea is to take the arm of the patient, put him slightly off balance and place him prone on the floor, without injury to either person. Straddling the patient carefully, the attendant uses a minimum amount of pressure to keep him down. The patient is immediately told that as soon as he can be calm for 10 seconds to a minute, the hold will be relaxed. At that time, the patient and the attendant make a contract, discussing alternate ways of handling the undesirable behavior. For nonverbal patients, the attendant models and physically directs the desirable behavior.

Dr. Aniol says the emphasis is on voluntary action. The patient can terminate the situation at any time by nonaggressive responses. The total sequence takes one to two minutes.

The "take down" process is only one segment of the overall program for the unit. Wanted behavior is instilled in many ways, particularly through a rewards system. In addition, patients are involved in a variety of rehabilitation and recreation activities. Art, sewing, gardening, dancing, music, singing, movies, camping trips—all are a regular part of the routine.

To maintain the program at the highest level possible, staff members are reinforced positively in three ways: by supervisors, by peers and, often, through the employee's own eyes as he sees himself succeed with a patient.

Reinforcement also is accomplished by making the staff member totally responsible for his charge, thus promoting continuity and consistency; by making the staff member responsible for writing progress notes, giving valuable information to the treatment team; and by daily inservice training sessions that review, update and implement other treatment programs. The patient's attendant also works wih families to insure continuation of proper treatment when the patient visits or returns to his home.

Prime objective of treatment is for the patient to behave as normally as possible under any given circumstances, adjusted to each patient's particular case, says Dr. Aniol.

What does a loving parent do? When you answer that question, says Dr. Aniol, you often have the answer to the problems presented by these very special patients.

A loving parent doesn't accept improper behavior from his child. A loving parent doesn't come running always when his child throws a tantrum. A loving parent doesn't try to control every movement of his child. A loving parent disciplines his child with words and deeds. Tender loving care, says Dr. Aniol, is not distributed indiscriminately by intelligent parents.

Is the common sense approach working?

Dr. Aniol points to Tommy. Until recently, every woman in sight was Tommy's "mother." With behavior modification, Tommy has learned that only one woman is his mother; the others are his friends.

Dr. Aniol points to Mary. When she first came on the unit, she was unable to make her needs known properly. With behavior modification, she now expresses herself correctly to gain the attention she wants.

"With our common sense approach, we think we are really getting somewhere," says the director.

Senator BAYH. Our next witness is Profesor Ivan Bodensteiner, professor of law, Valparaiso University, Ind. He is director of litigation of the Project Justice and Equality, Inc.

Professor, it is good to have you here, sir. We are anxious to have the advantage of your special personal attention out in the field with projects that include the Lake County Detention Home, the Gary City Jail, the Porter County Jail, the Lake County Jail, the Allen County Jail, and the Norman Beatty State Mental Institution.

You have the kind of working experience that can be very helpful to us here. We appreciate your taking the time to be with us.

TESTIMONY OF IVAN BODENSTEINER, PROFESSOR OF LAW, VALPARAISO UNIVERSITY, INDIANA

Mr. BODENSTEINER. Thank you.

I have submitted a statement. I will try to summarize that.

Senator BAYH. Without objection, your statement will be included in the record in its entirety.

Mr. BODENSTEINER. First of all, as you indicate, my perspective is that of an attorney who has been involved in this type of litigation on behalf of institutionalized persons. I have been associated with one

of the privately funded organizations that has been involved in this area. I am very familiar with the funding problems and so forth and the cost of this type of litigation.

I will try to stress some of the problems and indicate why I think this legislation is needed.

First of all, what I have to say is going to presume the need for litigation in this area. I think the conditions that exist in institutions have been well documented by previous testimony and will probably continue to be documented by other testimony.

Assuming that Federal court litigation is needed, assuming that the States themselves are not dealing with these problems, why do we need to add the Justice Department as a tool of this litigation? I think there are several compelling reasons.

The first reason has to do with the difficulty of confined persons asserting their own rights. This has been referred to previously. The problems include their limited access to the outside world, their limited capabilities, their mental capacity, et cetera. This does not need further elaboration.

A second problem that has been alluded to concerns the lack of resources to finance this type of complex, complicated, expensive litigation. There are several aspects to this lack of resources.

The first and very obvious one is the cost of discovery in cases such as this. It is no secret that depositions and other types of discovery cost a lot of money. Discovery in these cases is extremely important because of the great reliance on institutional records and institutional officials to prove the case.

Institutionalized persons are not the most credible witnesses simply because of their plight, where they are. They are confined so society tends not to believe what they have to say.

In order to successfully litigate this type of case, there must be very extensive discovery going through a lot of public records, dealing with a lot of public officials, and so forth.

A second related cost is the cost of investigation. There is a great need to informally gather facts to educate yourself on what is going on in the institution, to educate yourself on technical aspects of the institution, and to gather statistical-type data to help convince the court of the seriousness of the problem.

A third type of cost is something that has also been mentioned. That is the fees of expert witnesses. Expert witnesses in this type of litigation are extremely crucial to prove the allegations, particularly where the nature of the case concerns the adequacy of care or the adequacy of staffing and so forth.

It is absolutely imperative that the plaintiffs be able to present experts to counter the testimony of the institutional officials who, because of their job and because of their position, are almost automatically seen as experts by the court.

A fourth obvious cost is the cost of attorneys. This remains a very serious problem even after the passage of the civil rights attorney's fee act last October. This is true for several reasons.

First of all, even under this act the fees are discretionary with the court. The fees awarded by courts in the past under similar

statutes have often been much less than attorneys would normally charge privately paying clients.

A second reason has to do with the fact that it is very unpopular to represent institutionalized persons. It is not popular for an attorney to take on a State institution. For that very reason, even with the availability of fees if successful, private attorneys generally speaking do not get involved in this type of litigation.

Third, even if the fees and costs are ultimately awarded, it is often years down the road—3, 4, 5, 6 years before the litigation is completed. It takes a substantial investment by the attorneys over that number of years before they might realize their fee.

Generally speaking, the litigation in this area is now being carried by both privately funded and publicly funded legal services organizations. Neither of these types of organizations are at all equipped to carry the entire burden in this area.

First of all, there are simply too many cases of abuse for the limited number of attorneys to take on. These organizations all have other priorities. They have very limited funds. They are often geographically remote from the institution. This makes litigation in the institution even more difficult.

As has been mentioned earlier, there is a limited amount of expertise in this type of complex civil rights litigation. That, I think, is something that the Justice Department could bring to this. It was mentioned earlier about the limited number of attorneys who are expert in mental health law. I think that limitation is not at all unique to attorneys expert in mental health matters. The same can be said for prison matters and all of the areas relating to institutionalized persons.

In many respects it is almost better to have no litigation than to have someone who is not expert in the area and who is not prepared to really dig into the area to bring the litigation.

Another reason why the Justice Department could be very helpful in this is to assure a continuity of effort in this type of litigation. I think there are two significant aspects to this.

First of all, in litigation where you are relying on private plaintiffs or private institutionalized persons, there is a real problem of continuity because it is very easy for the institutional officials to transfer such persons. It is not uncommon for a plaintiff in a lawsuit suddenly to find himself in another institution or to find himself otherwise harassed to the point where he suddenly wants to drop the litigation.

A second aspect of this has to do with the counsel itself—continuity in the effort of the counsel. This is a problem because the privately funded organizations that bring such lawsuits have year-to-year funding. There is always the question when they bring an action of whether they will be around to finish it 2 or 3 years later.

Even with the government-funded organizations which have more stability in terms of their funding, there is a very high turnover of attorneys. The turnover is something like every 2 or 3 years. So you lack continuity in that respect.

Finally, because of this lack of continuity, even if the parties are successful in the litigation, there is a real problem in enforcing the court order and there is a problem in implementation.

Another reason to bring the Justice Department into this type of litigation is brought about by several recent adverse decisions of the Supreme Court which have seriously limited the access of private parties to the Federal courts in civil rights-type of litigation.

These same decisions and other decisions have also seriously limited the remedies available. The expansion of doctrines known as comity and abstention have resulted in a serious limitation on the access of private parties to the courts. This does not mean they do not have meritorious claims. It does not mean there are not substantive rights to be enforced. It simply means that the Supreme Court is saying the Federal courts are not going to hear these claims.

There have also been limitations on the scope of the Civil Rights Act, section 1983, to the extent that suits against various types of governmental entities have been excluded.

A final and I think very important reason to bring the Justice Department into this type of litigation is simply because of its prestige and its credibility. I think it is no secret that individual institutionalized persons lack credibility.

I think adding the weight of the Justice Department to this type of litigation is very significant. I do not think that can be emphasized enough.

While I generally support this legislation, I think there are a few areas that might be considered as ways of improving it.

First of all, I think it should be made very clear, as was mentioned earlier, that all children are included whether they are voluntarily placed in an institution or involuntarily. Obviously, if they are in the institution and they are being abused, it does not really matter how they got there.

Second, it should be made clear that not only States, but also local units of government can be defendants in this type of action. Many of our institutions, particularly local jails, some mental health facilities, and so forth, are run by local units of government and not by the State. Many of them house as many people as some State institutions, and the abuses obviously can be just as great or greater.

Third, I think it should be made clear, probably in the legislative history accompanying this act, that Congress intends to eliminate the possibility of judicial interpretation which would limit or restrict existing private remedies.

There is absolutely no reason to in any way limit the private remedies that are now available. I think it would be entirely inconsistent with the purpose of this act, which is to expand the protection of the people institutionalized, to somehow see this legislation as a limitation or restriction on the private remedies that are now available.

Finally, I think we should eliminate the possibility of judicial application of principles of comity and abstention to lawsuits brought by the Justice Department. Again, it would be contrary to the congressional purpose here, which is to expand the protection, to have the courts interpret or continue to apply comity and abstention doctrines that would limit the access or eliminate the access of the Justice Department to the Federal courts.

A very favorable aspect of the act on which I want to comment is that it does not require exhaustion of administrative remedy. This

is absolutely crucial that such exhaustion not be required either as a condition of Justice Department actions or private actions that now exist.

Why is this the case? I think history demonstrates to us that exhaustion of administrative remedies in this area serves absolutely no purpose.

The officials in charge of these institutions generally know of the conditions. They are, in fact, generally the cause of these conditions. To require the individuals or the Justice Department to first go through some administrative remedy I think serves absolutely no purpose.

In many instances the decisionmakers in these types of administrative proceedings are the same Government officials who are connected with the institution. So you are appearing before and asking relief from the same people who are the cause of the problem.

The remedy is simply not effective in these administrative proceedings because what is really needed is a change, a very serious change, in the institution itself. While administrative remedies may be of some value in minor individual grievances, I think they have no place in actions such as this where you are really challenging what is going on in the institution as a whole.

Another reason not to require exhaustion is that it can often cause very harmful delay prejudicial to the rights of the individuals involved. If nothing else, it often increases the opportunity of the officials to cover up and destroy the harmful evidence.

Another reason concerns the type of proof in these cases. It is very often complex, requiring a lot of discovery, requiring experts at a substantial cost, and the informal administrative proceedings are simply not adequate to deal with this.

Finally, I think experience with institutionalized persons demonstrates that there justifiably exists a complete lack of confidence in this type of administrative proceeding. It can only further frustrate and discourage them.

A couple matters came up earlier on which I would like to briefly comment.

There was some question about whether the act as written is constitutional. I assume that what was being raised is the question of whether Congress can, in fact, grant such standing to the Justice Department. The standing requirement, to the extent that it exists in article III of the Constitution, requires only that here be a case or controversy.

Clearly, in this situation where abuses and violations of constitutional rights in institutions are being alleged, there is a controversy. There is a case. In the past both Congress and the Supreme Court have recognized that in certain situations there can be so-called third party standing. That is one party suing or acting on behalf of another. That would be precisely what would be involved here.

Another question that was raised has to do with the discretion vested in the Justice Department by this act, and whether the Justice Department would in fact be exercising value judgments in determining when to bring the cases.

Obviously the act gives the Justice Department discretion. However, this discretion is really no different than that given the Justice

Department in every individual criminal proceeding that is filed. It is no different than the discretion they have in deciding whether to bring or not to bring antitrust cases. It is no different than the discretion they have in deciding whether or not to bring title VII cases claiming racial discrimination in employment.

I think the act implies a certain amount of confidence that the Justice Department will not use this act to bring frivolous lawsuits.

Thank you.

Senator BAYH. Mr. Bodensteiner, you have made an exceptionally good case, I think, by pointing out the strengths that are included in the bill and pitfalls to which we should be alerted. I also think that your enumeration of the reasons why the Justice Department is in a uniquely good position to bring its expertise, continuity, and credibility to bear in these cases will be helpful.

I think you have pointed out a consistent problem that exists with many of the people we are trying to help: That is, they are isolated to the point that they are totally unable to help themselves.

We appreciate very much your taking the time to be with us. I hope we can keep in touch with you as our hearings go along if we run into problems on which we would like your expertise.

Mr. BODENSTEINER. Thank you.

Senator BAYH. We are proud that Valparaiso is so well represented here.

[The prepared statement of Ivan E. Bodensteiner follows:]

PREPARED STATEMENT OF IVAN E. BODENSTEINER

Mr. Chairman and members of the committee, before beginning I want to testify today concerning S. 1393 which would authorize the Attorney General to bring civil actions in the name of the United States on behalf of institutionalized persons when there is reason to believe that conditions in the institution are depriving persons confined there of rights, privileges or immunity secured by the Constitution or laws of the United States.

During the past five years, both as director of a clinical program at the Valparaiso University School of Law and as the director of litigation for Project Justice & Equality, Inc., a privately funded not-for-profit organization concentrating on reform litigation, I have been involved in numerous lawsuits on behalf of institutionalized persons in Indiana. These cases represent only a very small percentage of the complaints we receive weekly from persons incarcerated in the state prisons, state mental institutions, local jails, and local detention facilities for children. There have also been numerous other lawsuits in Indiana brought on behalf of state prisoners, primarily by Legal Services Organization attorneys. In addition, due to the lack of resources, there are other areas of institutionalized care in Indiana where alleged abuses have not been seriously investigated. Examples would be nursing home facilities for the elderly, homes for abused and neglected children, and homes for children with special health problems.

Without giving a detailed listing of the alleged abuses, I will briefly summarize some of the litigation I am currently involved in on behalf of institutionalized persons. In the case *Doe* v. *County of Lake*, children detained in the Lake County Detention Home and the Gary City Jail challenge various conditions, including lack of proper supervision, lack of trained staff, lack of treatment and education programs, and excessive punishment without procedural due process protections. Approximately one week before trial was to begin earlier this month, the matter was successfully resolved with a negotiated settlement. Prior to that, the attorneys representing he plaintiffs had devoted in access of 450 hours to the case in addition to an even greater number of law student hours. Costs of expert witness fees, depositions and investigation were in the thousands of dollars. Another case, *DiMuro* v. *Porter County, Indiana*, resulted from the suicidal death of the plaintiff, a 16 year

old boy, who was detained in the Porter County Jail without proper supervision. A common practice in Indiana is to detain juvenile offenders in county jails along with adult offenders.

Several of our cases involve the plight of persons incarcerated in local jails in Indiana. *Dommer* v. *Hatcher* concerns conditions in the Gary City Jail and the plaintiffs allege inadequate food, lack of proper heating and ventilation, lack of recreation and reading materials, and first amendment issues relating to inmate contact with persons on the outside. *Jensen* v. *County of Lake* challenges conditions in the new, multi-million dollar Lake County Jail facility and emphasizes the lack of proper medical treatment, guard brutality and inmate brutality resulting from the lack of supervision. *Parsley* v. *Bender*, which was recently resolved by settlement, involved a general attack on conditions in the Allen County Jail. In the case of *Mudd* v. *Busse*, the plaintiffs, pretrial detainees in the Allen County Jail, challenge the inequities of the Indiana Bail System which result in the pretrial incarceration of numerous indigent persons while others charged with the same offenses are able to purchase their pretrial freedom. This case is an example of another type of expense incurred in such litigation, i.e. thousands of dollars were spent to gather the data and design a computer program for a study/survey needed to demonstrate to the court the adverse effects of pretrial detention on the outcome of the criminal case.

We are also involved in litigation, *Crouse* v. *Murray*, alleging a general lack of treatment in the Maximum Security Division of the Norman Beatty State Mental Institution. This institution houses between 150 and 200 mental patients in a prison-like atmosphere because they are considered dangerous. Without a doubt, the emphasis at this institution is on security rather than medical treatment.

Finally, we are involved in numerous lawsuits alleging infringement of prisoners' constitutional rights in the Indiana State Prison at Michigan City. The alleged deprivations include the entire range of prisoners' constitutional rights, including over-crowding, brutality, disciplinary procedures and the correspondence rights of inmates. As I said earlier, Legal Services Organization attorneys in Indiana have filed several other lawsuits on behalf of prisoners incarcerated in state penal institutions.

While the number of lawsuits pending in the federal courts in Indiana might make it appear that there is no need for the involvement of the Attorney General, this is clearly not the case. As I will attempt to demonstrate below, there are compelling reasons to make available the resources of the U.S. Attorney General to assist in efforts to eliminate the pervasive deprivation of federal constitutional and statutory rights of institutionalized persons who, as a class, are least able to protect themselves. Their limited access to family, relatives, friends and media makes it extremely difficult for them to make their complaints heard. By their very nature, many confined persons are relatively incompetent, because of age, mental condition or intelligence, and thus unable to even know their rights, much less enforce them. The next most obvious deterrent to an institutionalized person bringing an action to redress deprivation of rights is the lack of resources. It is no secret that most institutionalized persons in Indiana, and the country in general, do not have the extensive resources required to finance complex litigation. This includes not only the cost of attorneys but also the substantial discovery and investigation costs and fees for expert witnesses.

While the recently enacted Civil Rights Attorney Fee Act, Public Law No. 94–559 (Oct. 19, 1976), does allow the court in its discretion to award a prevailing plaintiff reasonable costs and attorney fees, this does not eliminate the need for the Department of Justice involvement for several reasons. First, even with the availability of fees, most private attorneys are unwilling to represent institutionalized persons against government officials because it is unpopular and as a reesult can have an adverse effect on their private practice. Second, because of crowded federal court dockets, a problem which is particularly acute in the Northern District of Indiana, complex cases such as these may not be resolved for several years and the possibility of an award of fees and costs several years in the future is not sufficient to attract private attorneys. This is particularly true when one considers the fact that most cases such as this result in one or more appeals. Third, because of the lack of involvement of private attorneys, the burden of representing institutionalized persons falls almost entirely upon privately funded public interest organiza-

tions or government funded legal services programs. While both of these types of organizations have been doing more than their share on behalf of institutionalized persons in the past, they have very definite limitations. Government funded legal services programs have not been given sufficient funds to cover the costs of expensive, complex litigation. In addition, the caseloads of these organizations are already excessive without getting into the representation of institutionalized persons. Therefore, such representation is often a very low priority. Concerning the privately funded organizations, funding for this type of representation is not easy to obtain. Our society has a tendency to forget about people who are institutionalized and this prevailing attitude often makes funding for the representation of institutionalized persons a very low priority. A further problem with both private and government funded organizations is the fact that they are often located a substantial distance from the institutions. Many of our institutions, particularly prisons, are located in remote areas of the state thus making representation more time consuming and costly. In addition, the government funded organizations often have geographic limitations on their services. Thus, it is apparent that there is a dire need for the resources of the Justicee Department in this relatively neglected area of representation.

Another reason to bring the Justice Department into this area of representation is to better assure continuity of effort. The first aspect of this concerns the party to the litigation. Under S. 1393 the Attorney General could institute a civil action in the name of the United States without naming individual plaintiffs. This is good not only because it takes the pressure off of one or more individuals who are particularly vulnerable to retaliatory action by the institution officials, but also because it solves a serious problem created by the transfer of individuals after they become plaintiffs in litigation. It is not uncommon for institution officials to transfer individuals as soon as they become plaintiffs in a lawsuit challenging conditions in the institution, thereby immediately creating mootness problems in court. In addition, many of the institutions, particularly local jails, are by their very nature short-term facilities, thus making it unlikely that any person would remain in the facility throughout the course of the litigation. Even though the U.S. Supreme Court has held that under some circumstances the litigation can continue on behalf of a class even after the named plaintiffs are no longer in the institution, this does not eliminate the mootness problem.

The second aspect of continuity concerns the organization providing the representation. Without a doubt, the Justice Department is here to stay. In contrast, many privately funded organizations providing representation have a year-to-year existence because of the uncertainty of their funding. While the government funded legal services organizations appear somewhat more stable in terms of funding, they have a serious staff turn-over problem; this is particularly acute with institutional litigation which is very complex and spans over the course of several years. The problems caused by a switch in counsel in the middle of a complex case are too obvious to need further explanation. Lack of continuity of representation too often results in ineffective implementation even after a favorable remedy has been ordered by the court.

Another problem with private litigation by institutionalized persons has been created by several recent decisions of the U.S. Supreme Court generally restricting the access of such persons to the federal courts. These decisions expand the doctrines of comity and abstention which require the federal courts to refuse to hear the federal constitutional and statutory claims when there are available proceedings in the state courts or reason to believe that the federal issues might be avoided by requiring the plaintiffs to seek redress in the state courts.

Finally, there is a very important, somewhat intangible, reason for involving the Department of Justice in litigation on behalf of institutionalized persons. Involvement by the Department of Justice can bring credibility and a sense of national commitment to particular lawsuits, as well as to an overriding national problem. There is no doubt that the credibility of a lawsuit is enhanced when the United States is a plaintiff and the Department of Justice is involved in litigating the case. While this is very unfortunate, it is true that one of the primary reasons for the horrible conditions in our institutions is the fact that institutionalized persons have historically lacked a credible advocate on their behalf. Involvement by the Department of Justice can

change this. Additionally, attorneys representing institutionalized persons are often viewed as "radical," thus detracting from their credibility with the court. Again, the presence of Department of Justice attorneys would change this. From the viewpoint of institutionalized persons, the knowledge that the United States Government is interested in their well-being and willing to pursue public officials who violate the law, as well as individuals who violate our criminal statutes, would be an immeasurable source of hope and confidence in our system of justice.

While I am obviously in favor of S. 1393 and the result it attempts to achieve, I think there are a couple of ways of improving it. First, in the definition of institution in section 4, it should be made clear that children voluntarily placed in institutions are covered as well as those involuntarily placed. Certainly the type of commitment does not lessen the evils of inhumane conditions. Second, in section 1 it should be made clear that not only a state but also any local unit of government can be a defendant in such an action. Many public institutions are operated by local units of government.

Other matters should also be clarified, probably as part of the legislative history. First, there should be no room for judicial interpretation that this act in any way limits or restricts any existing remedies available through private civil rights actions. It would indeed be anomalous if this act, intended to expand protection for institutionalized persons, resulted in a restriction of their remedies. Second, it should be made clear that principles of comimty and abstention do not apply to any such action where the Department of Justice is involved on behalf of the United States as a plaintiff. This should include any action where the United States is a plaintiff regardless of whether it was initiated by private parties with United States intervention or initiated by the United States with private party intervention. Application of comity principles would be inappropriate because the United States would not be a party to any state court proceedings and the very purpose of this act is to provide a federal forum for the vindication of federal rights. Given the trend of Supreme Court decisions generally limiting access of civil rights plaintiffs to the federal courts, it is extremely critical that the intent of this act not be subject to future erosion by court decisions. Third, while the eleventh amendment does not apply to actions brought by the United States, it should be indicated that, since this act is passed pursuant to section 5 of the fourteenth amendment, the eleventh amendment does not apply even where private parties are involved in the litigation.

One very favorable and important aspect of the act should also be mentioned, i.e., it does not impose any new exhaustion requirement on private litigants. Such a requirement is part of one bill, H.R. 5791, presently being considered in the House. Such a requirement would be disastrous. The Supreme Court has consistently declined to incorporate such a requirement into section 1983. By their very nature such suits challenge existing situations in state institutions and lawsuits are necessary only because the state officials fail to remedy the situations. Thus exhaustion of administrative remedies would be futile because the decision-makers would be the very officials whose action is challenged. In addition, the administrative process is generally not equipped to deal with the complex pattern and practices issues raised by such cases. Also, exhaustion always results in delay and additional expense while seldom remedying the problem.

In closing I want to express my appreciation to the Committee for giving me this opportunity to express my views concerning this important piece of legislation, S. 1393.

Senator BAYH. Our next witness is Dr. Terry B. Brelje, superintendent of the Chester Mental Health Center in Chester, Ill. He is a former administrator of the Illinois Department of Corrections. He is a former director of programs for the Illinois Security Hospital and a former chief psychologist for the Illinois Security Hospital.

At this time I have to go to the floor to vote but Ms. Manella will carry on in my absence. I hope to be able to return in time to hear as much of the remainder of the testimony as is possible.

Your prepared statement in its entirety will be made part of the record.

TESTIMONY OF DR. TERRY B. BRELJE, SUPERINTENDENT, CHESTER MENTAL HEALTH CENTER, CHESTER, ILL.

Mr. HUMES. I have some questions I would like to ask you, Dr. Brelje.

Are you still with the Chester Mental Health Center in Illinois?

Dr. BRELJE. Yes.

Mr. HUMES. I have more than a perfunctory interest in this subject because I happen to have a member of my family who is institutionalized, a retarded son who is 22 years old. He has been in a State institution for 8 years. We have been visiting him off and on for that period. He is up at Selinsgrove State School in Pennsylvania. I feel as though I have more than an average layman's conception of the problems involved here.

I can truthfully state, Dr. Brelje, that in that entire period I cannot consciously state that I have ever witnessed a single excess on the part of the administration of the Selinsgrove State School against any of the patients.

I notice that Mr. Halpern referred to them as inmates. I think we have to make the distinction between persons incarcerated in prisons and patients. I think we would consider them patients, would we not, Doctor?

Dr. BRELJE. Yes.

Mr. HUMES. As I said before, I came here with an open mind because he has been there 8 years. I am an attorney myself. If I thought for one moment that I had ever witnessed what I regarded as an excess against my own son or anybody there, I certainly would have been the first one to raise hell.

I must confess at the same time, when I go there, at one stage or another I have seen what would be regarded here among the average layman as an excess. I have seen boys rolling all over the floor. You know the type about which I am talking. I have seen boys butting their heads against the wall. Some of them have football helmets. I have seen them in various stages of disrepair and dissolution, standing in their own urine, so to speak. Some are physically restrained.

I understand that because, as you well know, Dr. Brelje, they have various stages of mental deficiency. The fact of the matter is that some of them do get obstreperous and some must be restrained. Is that not true?

Dr. BRELJE. Yes.

Mr. HUMES. If a reporter happened to go to a State school and he comes upon a scene whereby a young man or a young woman is being physically restrained and perhaps placed in what would be regarded as sort of a cage, he might get the wrong impression that that is the modus operandi when, in fact, you and I agree that certain patients, because of their very obstreperous nature, do in fact require restraint. Some become quite violent, I believe. My son is a case in point. At one point he was given to breaking clocks and kicking out the windows. I am happy to say that that conduct has abated a great deal. But the fact remains that he has been subjected to what some people might call excessive drugging. They have had

to administer certain drugs to abate his condition because he was hyperactive.

I do not personally regard that as an abridgement of his constitutional rights.

What impressed me about the testimony that I have heard here today and the previous day, Dr. Brelje, is that the assumption is being gotten, I think, by the people who are listening here and by Senator Bayh, I believe, that these institutionalized people, mentally deficient people, have absolutely nobody to speak for them. To a certain extent that is true.

However, is it not also true, Dr. Brelje, that a great many of them have parents and legal guardians such as myself who visit them frequently and who know about their condition and who would be the first ones to become aroused and to take action in the event that they felt loved ones were being abused?

How do you account for the fact, then, that the parents and legal guardians—have they been accomplices in this abridgement of their rights? Have they just stood by?

Dr. BRELJE. No, I think not at all.

In fact, I was going to start out my comments by saying that I have a great deal of respect for Mr. Halpern, Dr. Roos, and Professor Dybwad. I have been familiar with their work. I believe they do speak most articulately about a number of abuses that do occur.

However, I would also feel negligent if I did not say that I do not believe that all institutions are bad. There are some that are good. Over the past number of years one could point to many, many advances, improvements, and many outstanding institutions.

I would not want the impression of those who have been listening to the previous witnesses to be what in my view would be an erroneous one. That is that every single institution across the country——

Mr. HUMES. Dr. Brelje, sitting here as you have been today, wouldn't you get a general conception from just listening here—not as a professional such as yourself but, say, the average layman sitting in this room who does not understand the complexities of the average State institution—wouldn't they get the impression that these things are widespread and very prevalent and all pervasive in all institutions?

Dr. BRELJE. I think it would certainly be easy to form that impression from what we have heard today. I think the problems and abuses are widespread in terms of their not being simply isolated in a State or an institution or a program. They do occur across the country. It is possible that every single State has an institution or a program that does have problems with it.

My point would be that it is not correct that every institution that exists throughout the country is that way. I have said there is much that is good. There are many institutions that are good.

I would also have to submit, though, that there are many institutions which are bad. In just the past couple of years I have observed a facility which kept a man in segregation for almost 2 years because he threatened to harm someone.

There was one institution in which I was concerned about what diseases I might catch as I picked my way among the urine puddles on the floor.

I visited an institution that did not, for all practical purposes, permit the residents to speak to one another except with permission of the attendants in the day room.

There are, in fact, abuses which are occurring and they are pervasive but not in every situation.

Mr. HUMES. In your own experience when you have a violent patient, how do you handle him? I am talking about a person who is given to maybe assaulting somebody or who becomes overly destructive. How do you handle such a person?

Dr. BRELJE. That is very difficult for me to answer in the abstract because I think each individual gets handled differently. At times that individual has to be restrained.

Mr. HUMES. Right.

Dr. BRELJE. At times they are medicated. At times they are isolated.

Mr. HUMES. You say isolation. You have separate quarters where you might keep him for a limited period of time until he cools off, so to speak; is that correct?

Dr. BRELJE. In my particular institution every patient has a private room.

Mr. HUMES. You mean you have no wards. Every patient has his own room; is that right?

Dr. BRELJE. That is correct.

Mr. HUMES. But in many of these institutions, as in Selinsgrove, Pa., mentally retarded patients for matters of economy might be 10, 20, or 30 to a room. They have their so-called play area and then off to the side they have their own room. Some do, I suppose, but my experience has been that they have their own cubicle.

If somebody came to your institution, the Chester Mental Hospital, and happened to see somebody who is being physically restrained, maybe isolated, and did not understand the circumstances, he might get the impression that this is modus operandi of your institution; that this is a fairly general occurrence. I am saying that is possible to construe that.

If I first went to Selinsgrove State School, as I did, and I saw young men—and I am sure this is applicable to women, too—but I saw young men in a ward and they were in various stages of dissolution. They were rolling on the floor. Some of them had removed their clothing.

Isn't it true, Dr. Brelje, that in fact the only real solution to this problem is to have one attendant per person? Given the location of the institutions and the fact that they are mainly understaffed, it is physically impossible for one or two persons to minister to the needs of 30 or 40 mentally retarded persons of various emotional problems; is that correct?

Dr. BRELJE. Offhand, I would have to agree that one or two attendants would not be enough for 30 or 40, although I should add that I am really not a particular expert with the care and treatment of the mentally retarded. I work with the mentally ill.

Mr. HUMES. What is the distinction, Dr. Brelje, between mentally ill and mentally retarded?

Dr. BRELJE. I think, very simply, the mentally retarded individual has a deficient intellectual functioning whereas the mentally ill individual has an emotional disfunction.

I work with the mentally ill individual.

Mr. HUMES. You would not use the terms interchangeably then in your professional experience; is that correct?

Dr. BRELJE. No.

Mr. HUMES. Would mentally ill include, for example, criminally insane?

Dr. BRELJE. Yes, in the layman's sense it would, certainly.

Mr. HUMES. You heard testimony earlier of the gentleman from Farview, the former superintendent of Farview. If I am not mistaken, Farview is an institution for severely mentally ill people—people deranged and disposed to committing violence. So those people who show different traits than mentally retarded, who may merely be brain damaged.

It does not come as a revelation, at least to me, that I read in Dr. McGuire's testimony the kinds of things that happened there. Extremely or potentially violent people have to be handled a great deal differently than the mentally retarded, as you and I know.

For example, mongoloids show very, very passive tendencies. Some of them are quite gentle. Most of them are quite gentle. There are two different kinds.

They require different kinds of treatments.

Mr. Halpern talked about "institutionalized mentally disabled persons are frequently incapable of asserting their constitutional rights." I think not frequently but in all cases they are because they lack the brain capacity.

My point is, Dr. Brelje, don't most of them have parents, legal guardians, or relatives who visit them frequently and have them home and would be the first ones to scream if their rights were being abridged?

I realize a lot of them, as you well know, are completely abandoned after they are brought; but a lot of them have legal guardians or relatives.

I am impressed by the fact that all of these excesses are taking place among, say, 2,000 patients for a period of 5 or 6 years, as these gentlemen testified. Yet how do you account for the fact that, assuming that these excesses took place, neither the parents nor the legal guardians nor the relatives nor friends discovered this or saw fit to make a legal case out of these excesses?

Dr. BRELJE. I think frequently the institutionalized person, particularly the mentally ill institutionalized person, does not have an intact family structure. The majority of the patients at my institution, for example, no one writes to them and no one visits them. I think for all practical purposes no one outside that institution cares for them at all.

Many of the families who do show interest in the patients do not have the resources or the prospect of acting against the State or acting against the institution. It is a very threatening and a very frightening kind of thing. They are concerned that some harm might come to their son or husband or whoever it is if they come in and see me, for example, and tell me, "You are doing wrong." They do not want to do that.

Mr. HUMES. You mean they may be afraid of retribution, for example. They may have had a tough time getting them in. They may

have had to pull strings to get them in the institution, and they do not want to take the chance of having them let out of the institution.

I noticed in a lot of the testimony that they seldom made the distinction between patients who have been voluntarily committed by their relatives, friends, or legal guardians, or a court order and people who have been taken there maybe involuntarily. There are two different classes.

I think one of the defects in this legislation is that we are talking about prisoners who have been incarcerated for crimes and mentally ill and mentally retarded. I think obviously there is a distinction. It disturbs me to find people talking about the two or using the terms interchangeably.

Mr. Halpern kept referring to inmates. I would like to think that the mentally ill and the mentally retarded prefer to be regarded as patients rather than inmates. I think there is a tendency to blur the distinction between prisoners who have been convicted after due process and the mentally retarded.

Again, I do not want to belabor the point here.

I appreciate the opportunity to get your views. I am sure that if Senator Scott were not encumbered, he would like to be here.

In essence, what I am concerned about is there may be a tendency, Dr. Brelje, or disposition to bring a number of people here and present what might be horror stories. I do not doubt that some of them happen. Again, you have to look at it in the context of your administration of the institution.

The fact of the matter is that they cannot take care of themselves. There are young people, men and women, who will disrobe and who cannot feed themselves, unfortunately. They are completely physically incapacitated. There are people who become violent and assault people so they have to be restrained with drugs, ropes, or whatever is appropriate. It is a sad fact of life. God made them that way.

In my own mind there is a question whether even the Attorney General is going to be able to do anything.

The gentleman from Farview testified that even after this great exposé the situation has not changed in Farview.

I think there has to be some respect for the point of view that the Attorney General can, even with his vast resources, as he proposes to do, go into every institution in the country and try to cure all of the ills of which the flesh is heir. This is a problem to which I am sure the committee is going to address itself.

Thank you, Dr. Brelje.

Ms. MANELLA. I am not sure if I should direct my questions to Mr. Humes or Dr. Brelje.

Some administrators may feel—and I think Mr. Humes has highlighted some of these concerns—that cases like Wyatt and its progeny, class actions brought with the assistance of the Justice Department on behalf of institutionalized persons, have created more problems than they have solved. Some suggest that, by saddling State administrators with elaborate consent decrees, and ordering extensive changes in institution administration, these suits have resulted in unreasonable burdens on public administrators.

As a State administrator, do you share that view?

Dr. BRELJE. It depends on what perspective you want to take. To be sure, *Wyatt* and *Davis* and the other cases have caused problems administratively, but not for the patient. It is a lot easier not to have to answer to anyone for anything ever. It is a lot easier just to do what you want to do and not be concerned whether someone is checking the quality of what you do.

If one wanted to be very selfish and say, "I'd like to do my job with the least hassle imaginable," certainly *Wyatt* causes problems. However, if you look at it from in point of view is the proper perspective—that is, does it benefit the patient—I think absolutely it does.

I have never heard anyone say in the application of those standards that *Wyatt* has hurt the patient. I have heard lots of people say that *Wyatt* has caused us all kinds of problems and we have to do more of this and less of that, and this kind of thing, but no one has ever claimed that it has hurt the patient.

Ms. MANELLA. Recognizing that there must be many State administrators like you who obviously are sensitive to the needs of the patients, why don't you take the attitude that as the person most familiar with both the problems of patients and the problem of limited resources, you are the one most capable of dealing with them? Why don't you resent Federal interference in what is essentially a province of State responsibility?

Dr. BRELJE. I don't know. It just seems to me that if we represent that what we are doing is what is right, then I should not mind anybody looking at that and seeing whether they agree with it or not.

Ms. MANELLA. Have you ever had any State official or State agency take the kind of action that was mandated by *Wyatt*? In other words, if, as you say, the result of *Wyatt* has been beneficial for the patients, have any similar orders—either executive orders or court orders—ever been issued by State authorities compelling State officials to do the same thing the Federal court ordered in *Wyatt*?

Dr. BRELJE. I certainly could not say no, that has never happened. In my experience I am not familiar with it happening on a wide-scale basis.

I think we are perhaps somewhat of an exception in Illinois in that we have standards which are similar, but they came after *Wyatt*, not before.

I think that most often what occurs is that State administrations and hospital administrators do what the money they are given will let them do. They cannot really do anything beyond that. They may believe there should be higher standards but it makes no difference. They can only do what the money will buy. Therefore, they will not establish internally procedures or regulations which exceed what they are going to be able to deliver. That is not very good judgment as an administrator to say this is what we are going to do, knowing that you are not going to deliver it.

Ms. MANELLA. If I understand you, what you are implying is that the major changes that have occurred in upgrading the conditions of confinement for the institutionalized have been a result not of State-implemented action, but of orders which have come from the Federal courts. Am I correct?

Dr. BRELJE. Yes; I would have no difficulty in agreeing with that. I think there are some few exceptions to that, but in general there are a number of cases on which I have personally worked that the suits, in fact, have appealed to the standards of *Wyatt* or some of the other decisions. The States have eventually maybe negotiated the settlement that was similar to what the suit was. Yes; *Wyatt* and others have precipitated and been the cause behind the upgrading of standards in general.

Ms. MANELLA. Have you participated as an expert witness in right-to-treatment or right-to-protection-from-harm cases?

Dr. BRELJE. Yes.

Ms. MANELLA. In *Davis*?

Dr. BRELJE. Yes.

Ms. MANELLA. Was it your experience that any of the conditions that were brought to the court's attention in *Davis* were the types of conditions to which Mr. Humes referred—namely, the sort of thing that to an outsider might appear to be a violation of human rights but which, if one understands the difficulties of administering a facility for the mentally retarded, the mentally ill or prisoners, is really a legitimate way of treating institution residents? Were those the conditions cited in *Davis* or were they conditions which by any set of standards would be considered gross violations of constitutional and federally protected rights?

Dr. BRELJE. I think more the latter.

I think Mr. Humes makes an extremely good point when he raises these concerns, but I think also that the involved parent, the compassionate reporter, and so forth does for the most part understand. You sit down with them and you say, "Look, this is this person's history. He has assaulted a number of people. This is why we are doing these things." I think most of them do understand that and will accept these kinds of situations.

To me what is of concern, though, are the cases in which some of the procedures are not being done because of the need.

Mr. HUMES. Because of what, Doctor?

Dr. BRELJE. Because of the specific patient's problems. They are being done for much less decent motivations and the parent or reporter would not be persuaded that this is being done out of necessity.

I have been involved in a couple of cases against institutions in which that was in my opinion clearly the case. Individuals were put in isolation for no reason, at least no documented reason. The staff did not offer a reason why.

Mr. HUMES. When an institution confines or isolates an abusive or violent individual, presumably the action is done right then and there. You say documented. Is it required that they prepare a report or something of that particular action? There is no proceeding. I suppose they can deal with him much like a penitentiary can deal with a violent prisoner. Do they have to document it? Do they have to take some action to record that action or something?

Dr. BRELJE. In my institution, yes. I think generally in all institutions, yes.

Given what I have seen in 10 years in working in institutions, both prisons and mental health facilities, I would be very uncomfortable

as the chief administrative officer of that institution if we never asked the staff to document locking someone up or something such as that.

It is only human nature that we get angry and we get irritated. It is very hard to be therapeutic if you have been spit on, for example.

Mr. HUMES. Right.

Dr. BRELJE. I think for the protection of everyone—the employee, the resident, and so forth—it is necessary to document something such as this. I do not mean it has to be a full-scale hearing.

Ms. MANELLA. Are you aware how long the *Davis* case took to try?

Dr. BRELJE. I was involved with it for 2 or 3 years, I think.

Ms. MANELLA. So this was a complex case requiring considerable documentation and discovery?

I would assume that most parents, even the most concerned parents, do not have the kind of financial resources necessary to sustain this kind of litigation, even if they had the wherewithal to initiate suit and hire a lawyer. Has this been your experience?

Dr. BRELJE. Absolutely.

The documentation in that case was thousands of pages, I think, and involved many, many different people. I cannot imagine that a family, no matter how involved or compassionate they might be, would have the resources to seek redress on their own.

Ms. MANELLA. It is my understanding that there are fewer than 50 attorneys in the Nation practicing mental health litigation full time and that the largest mental health advocacy project in the Nation employs 7 attorneys.

Are you aware of any major sources of public interest lawyers who would be available to finance this kind of litigation?

Dr. BRELJE. No.

Several years ago when there was an increase in the attorneys who seemed to be available to people without funds and so forth, many individuals saw that as a real advantage for patients in institutions, prisoners, and so forth. The reality is that they really do not exist. There are not enough of them. Patients do not have a family that will seek them out or, not having a family, they do not have the intellectual or emotional resources of their own to seek them out. The opportunity for the patient to somehow initiate legal action on his own is on a practical basis to me relatively nonexistent.

Ms. MANELLA. I have one final question, Dr. Brelje.

Last week Assistant Attorney General Drew Days, who is in charge of the Civil Rights Division, indicated to us—and I do not purport to quote him exactly—that the experience of the Justice Department in this type of litigation has revealed systematic deprivations of constitutional and federally protected rights of institutionalized persons sufficient to warrant the attention of the Federal Government.

As I understand it, there are, according to you, any number of institutions across the country which are good institutions and which provide the kind of care to which Mr. Humes referred, even if to a layman that care sometimes might seem strange. However, there still remains a sufficient number of institutions where the conditions are so abominable, so deplorable, and so unjustifiable under any standard of treatment, that some action—and in this case probably litigation—must be undertaken.

Would you agree with that statement?

Dr. BRELJE. Absolutely.

Ms. MANELLA. Thank you, Dr. Brelje.

Mr. HUMES. Could I just ask you one final question, Dr. Brelje? Candidly, what would you do, assuming you had this kind of omnipotence, Dr. Brelje, what would you do about the situation in our institutions? I am talking about the institutions for the mentally retarded. I am not talking about prisons. How would you rectify the situation?

Dr. BRELJE. In terms of the abuses?

Mr. HUMES. The lack of physical amenities more or less. Presumably we would stop any abuses. Sometimes that is borderline when you try to restrain a very violent person, as you will concede.

What is the answer in your estimation, Dr. Brelje, to this whole problem?

Dr. BRELJE. This sounds as though I am copping out but money.

Mr. HUMES. Right.

Dr. BRELJE. I think there are no conditions in institutions that exist today which cannot be corrected in terms of the deprivation of rights.

Professor Dybwad, I think it was, talked about cattle prods. Dr. Roos talked about behavior modification techniques. There are really no treatment techniques which are widely used. We do not use cattle prods in any institution in the State of Illinois, for example, of which I am aware. There are no widely used treatment techniques which automatically carry with them the deprivation of rights.

Most deprivations occur from lack of resources, lack of understanding or misunderstanding, a misguided application of something, or that kind of thing.

Very little, if anything, in my view cannot be corrected. Some is expensive; some is long term if it takes physical plant changes; some is very quickly. Oftentimes I think you can correct some problems without an increase in money, but with maybe just an increase in how you allocate the money within the institution itself.

It may mean that you do not need 90 dietary workers; you only need 45. You use the difference in money for attendants on the units, or something like that.

I think it is to some extent the allocation of resources. The easiest way to handle it is just to give the institution more money.

Mr. HUMES. More money. In other words, more money obviously to hire more staff.

Dr. BRELJE. I think that is the least creative way to do it. It might be to reallocate the money you already have in different ways. If you do not want to offend anyone or you do not want to cause problems with unions and so forth, you just hire more people. I do not mean to imply that that is the only way to do it—by adding more money.

Ms. MANELLA. Thank you very much, Dr. Brelje. We appreciate your appearing.

I know that Senator Bayh is sorry he had to leave for that vote.

Dr. BRELJE. Thank you.

[The prepared statement of Dr. Terry B. Brelje follows:]

PREPARED STATEMENT OF TERRY B. BRELJE, PH. D.

In the ten years I have worked in the correctional and mental health fields I have seen much that is good. I have observed the allocation of resources dramatically increase in some facilities. I have seen the development of some new methodologies which seem to hold promise for our institutionalized. I have seen new attention and emphasis given to problems which have always existed but largely been overlooked. I have seen a few more professionals leave lucrative private practices to work in the institutions. I have seen a greater awareness and attention given to the recipient of these institutional services and what is good and bad in that situation.

I have seen more interest and awareness of the problems of the mentally retarded citizen in a correctional setting. We have improved the status of the incompetent to stand trial dependent and insured that he does not languish in an institution for a lifetime with the charges pending against him. Many old and incredibly inadequate structures have been replaced with more reasonable physical plants.

I could add much more to this list and point with pride at how our institutionalization process has been improved over the past few decades. In fact, it would be quite easy—and certainly far less frustrating and demanding—to sit in my office and tell staff and visitors alike about the atrocities of the past at my own facility and others and point with justifiable pride at our modern physical plant, respectable staff to resident ratios, and program efforts.

Yet, I have also seen much that is not grand in this field. In the past five years I have seen an institution in which residents on some units, for all practical purposes, were not permitted to talk to each other. I have seen an institution where there was only one nurse on the staff for over 250 mentally ill patients, most of whom were receiving medication of one type or another. I have seen an institution in which I was fearful of the diseases I might pick up as I walked through what appeared to be puddles of urine in sections of the day room floor. I met a man who had been kept in segregation for almost two years because he had brandished a makeshift weapon and threatened to physically harm someone if they continued to keep him on a lock up status.

It is not my intent to try and determine whether our progress of the last few years weighs more heavily than our abuses. I think it more reasonable to point out that we have a system containing both the very good and the very bad. I think we have a responsibility to do everything possible to enhance and perpetuate the good and to eliminate and reduce the very bad.

While somewhat out of context, perhaps I should add here that I am not an individual who argues for the abolition of institutionalization or of involuntary commitment of the mentally ill. To do so in the correctional system would be to ignore what I believe to be a basic reality. A society cannot survive without order and some degree of control over the expression of the impulses of its members. To permit human beings to revert to a primitive or animalistic level is to permit the steady destruction of any higher level functioning. There are individuals who must be locked up and kept away from the rest of society. While philosophically this may be unfortunate, it is a reality that can be ignored only at great cost to our social order.

Similarly, there are those who argue very articulately that is is wrong and inappropriate to commit the mentally ill to an institution against their will. I would applaud a society which so tolerated the idiosyncracies of its members that it never saw the need to involuntarily place someone in a mental hospital. However, to propose that we are realistically able to adopt such standards at this point in time would be to ignore some of the tragically ill individuals with whom I have worked during the past ten years. I could not in good conscience pretend that their situation would be better if we simply did not assume responsibility for them and place them in an institution. Some individuals dramatically need hospitalization and treatment. I cannot simply ignore that fact and say that while they may need help, if they are unable to recognize that fact themselves and ask for help, that we have no right to give it to them involuntarily. I have seen too many severely ill people whose illness was such that they were unable to recognize or understand that they were not functioning rationally.

There will be others who will appear before you and I am sure list abuses and problems with the system which would suggest that our country's insti-

tutional practices are hardly better than some medieval creation designed to insure that the subjects did not revolt against the ruler. Surely others will suggest that the legislation under consideration here is not needed because of advances we are making or have made or for some other noble reason. As a front line administrator in the field and as neither a critic nor as a representative of a public relations firm, let me suggest that reality lies somewhere in between. Most of what we do is good—or at least not bad. Case after case in our courts, however, demonstrates that there are some things in the system which are not good.

It may strike some as incongruous that an institutional administrator is speaking in support of a bill which will insure that I have the potential right to be sued by the Federal Government. It would strike me, however, as incongruous if I did not support this legislation. I am a hospital superintendent, a professional mental health worker committed to the welfare of my clients, and a human being. It is inconceivable to me that I would not support an effort which might in some way be helpful in reducing the systematic deprivation of the rights of the institutionalized. To me such legislation is needed. From my perspective such efforts in the past have had a demonstrably positive effect on correcting abuses which had long been ignored or at least overlooked.

As I visit other institutions, read the professional literature, and indeed observe the day-to-day processes within my own institution, I cannot deny that *Wyatt* has had a significant and positive impact on all mentally ill patients. Seldom if ever have I heard staff complain that such and such a procedure outlined in *Wyatt* is having a negative effect on the patients and their treatment. In fact, just the obvious seems to have happened. Prior to some of the mandated standards appearing in the more well known cases, it was far too often difficult to justify staffing levels of other program efforts because there were no base lines which an administrator could use to support his program requests. Now it is commonplace to hear—even in some prison situations—that the operation of a program is at variance with the standards and to hear statements as to what must occur to bring a program into line.

It seems to me that if this were the only positive effect of such actions one would have to be supportive. After all, we have standards for the percentages of the components in concrete for our highways, the rag content of the paper we buy, and the type of fibre for our military uniforms. It hardly seems unreasonable for us to have some standard or bench marks for the quality of treatment that we apply to our fellow human beings against their will.

Within this analogy it strikes me as quite unusual that we have many tests and sanctions against our meat and dairy supplies and our cement contractors but many people are loathe to apply standards and potential sanctions against those of us who work with and significantly affect people. Why should I represent myself as above the potential use of sanctions, or at least a testing of whether I am protecting the rights of those with whom I work. It seems that in opposing this legislation I would be saying that I should be allowed to take people into my care involuntarily, but I am unwilling to have anyone check on whether I am abiding by the law of the land. To be sure I believe that we mental health and correctional workers are a special group of people. However, to represent that we are somehow better than or at least above having our work scrutinized and tested in the open may be to admit a problem not unlike that present in many of those with whom we work.

I would surely have to admit that it is far more comfortable not to have such testing or questioning done about one's work. It is certainly more pleasant to never have to convince anyone that the work one does is necessary. Coupled with the rather human characteristic of preferring to believe only the best about oneself is the long standing tradition in mental health circles that the therapist knows best. While this may or may not be true, it also leads to a general philosophy among some professionals that everything we do is in the best interest of those we serve and that no one dare question that except perhaps members of our own profession. I really do not wish to take a particular side on the issue of whether the therapist knows best. The side I would like to present is that such attitudes do influence how we perceive those who question us. I have heard my colleagues say countless times, "What does a judge or a lawyer know about our professional or program adequacy." I would charitably contend that this is a naive assessment of what is occurring when the courts inquire into our practies.

It is obvious to me that in those cases brought to court the basic issue is not generally related to anyone's competence. The point is that we are being asked whether we are abiding by the law and that question has little if anything to do with one's ability to do psychotherapy or other treatments. I think, however, that many professionals do not properly differentiate between the questions being asked and react to legislative or judicial involvement in our efforts in a negative manner for the wrong reasons.

Even when the proper perspective is placed on the nature of the intervention one still has to conclude that being sued is not a pleasant experience. I have participated as a witness in several such activities and I can say I would not deliberately seek out such action to be directed toward me. It does create a realistic burden on one's time and resources and much energy is spent directed at activities other than day-to-day performance of one's duties.

I dwell on the above points only in an attempt to explain why some quite competent and dedicated professionals might be opposed to the legislation under review by this committee. I would also have to admit that not all opposition can be accounted for by the above. There are undoubtedly those who have genuine and reasonable philosophical differences with the intent of this proposed bill. I do not share this position and cannot agree that one can be interested primarily in the welfare of the institutionalized and be opposed to it in principle. Perhaps I have seen enough abuses of our citizens' rights that I feel the need for some higher appeal than what otherwise might exist without its passage.

There are several specific points I would like to make about this legislation which make me particularly comfortable with it becoming law. First, I have admittedly had limited experience with actions in which the Justice Department was a party. In every situation, however, I was impressed with the dedication and decent motivation of the staff involved. I did not find them to be either engaged in a vendetta or unreasonable in their final goals. This experience may have been only because of the personal characteristics of the people involved and I obviously cannot make a general statement applying to every action or case. However, it is only human nature that if one has a positive experience with a situation one tends to be positively inclined to the process itself.

Of more importance is the content of the bill itself. As a hospital and institutional administrator I am ultimately responsible for the actions of hundreds of staff. I have been involved in disciplinary and other actions against employees for behaviors which could be considered a deprivation of our clients' rights, so I know that such activities do occur. I would be naive if I did not accept that there are undoubtedly others happening about which I have no knowledge. It would be difficult for me to be here advocating I be sued for the action of a single employee after the fact. The bill, however, expressly limits jurisdiction to "systematic deprivation". With that I can wholeheartedly agree. It effectively limits intervention to those instances which are not isolated and individual. I cannot, of course, condone even the isolated instance but it seems far more serious to me for such wrongs to be occurring on a systematic basis. Where such is determined to be the case, we cannot advocate anything other than that they must be corrected. This limitation thus seems not only appropriate but should not result in frivolous and harrassing actions being taken against our institutions.

The second limitation contained in the bill is the provision that prior to formal action by the Attorney General, institutional officials will be notified of the alleged deficiencies. It is perhaps this section which I find most comforting and predict will, in fact, have the greatest impact on our institutionalized clients. There is to my knowledge no widely accepted treatment modality which inherently and automatically requires the deprivation of the client's rights. Such deprivation comes only as a consequence of the misapplication of a treatment, the lack of financial or other support for a treatment and/or its programs, the misunderstanding of treatment elements, indifference, lack of adequate staff or physical plant, an honest mistake or misunderstanding, and the like. All of these factors can be corrected. Some can be modified quickly, some only expensively, and some perhaps only with a number of events happening across several years time such as is involved in the construction of new facilities. Nevertheless, they can be addressed and successfully corrected if desired.

There are certain classes of hospital patients and some residents in correctional institutions who by the nature of their behavior or other characteristics present special problems and sometimes challenge the creative energies of staff to respond to their needs in appropriate ways. Even these groups can be handled reasonably and appropriately if the desire and the necessary support is present.

The compelling point of this is that an institution or agency would rarely be in a situation where corrections for deficiencies or deprivations could not be made if desired. Thus, when the Attorney General notified the officials as required in the bill the effect could well be that steps would be taken to correct the problems without having to pursue litigation. I have, in fact, observed this in several instances and dramatic results have been achieved. If the facility believed their behavior and programs were lawful there is always the opportunity to defend oneself in the judicial forum and they are not obliged to change any of their practices or procedures until the facts are tried.

I would regard the section requiring notification as essentially a mandate for negotiation. Since the specific conditions of institutionalization or treatment are in fact not rigid and fixed, there is ample opportunity to modify in order to insure the protection of the clients. There is no absolute which says the type of institutional placement and program for Client X is Facility and Program Y, and that they must be such as to deprive him of his rights. With that reality it would seem quite probable that changes would occur in many instances without the need for long and costly trial proceedings. This would obviously be the ideal situation for everyone concerned. I recognize that it would not happen this way in many and perhaps even most instances, but even a limited number of such negotiated settlements would seem to be a positive and more desirable circumstance.

On the other side of the coin a rather logical appearing reason for opposition to this legislation could be that with the proliferation or economical legal services throughout our country each institutionalized person has ample opportunity to pursue legal redress on his own. This is admittedly a desired goal. I can say with considerable validity that such is not the case in the majority of our hospitalized or incarcerated citizens. Most do not have even marginal access to competent legal counsel. Most are either too disturbed, financially unable, or intellectually incapable of effectively seeking out, retaining, and cooperating in the long and arduous struggle to take action on their own behalf. It seems that once again the government must step in to provide such help if help is to be given. We can hardly expect the State to provide an effective mechanism for litigating against itself (although in my experience, several have done just exactly that). It seems, therefore, that the Federal Government must be the advocate for our institutionalized.

I have primarily addressed the mental hospital resident and those incarcerated in a correctional environment. The bill is not limited to just those two broad categories of institutions. My failure to specifically address the needs of the other facilities does not reflect a belief the need does not exist equally so for them. Rather, it indicated my relative lack of experience with systems other than mental health or correctional.

Let me conclude by stating that the mentally ill and the incarcerated correctional client have clearly been held to have the protection of the same constitution and laws as do you and I. Yet, an institutional environment is one which at times almost generates a situation which could hardly be better designed to provide hourly opportunities for the violation of our constitutional protections. It is true that at times the acutely disturbed mentally ill person is less than attractive or personable. He is, however, no less a human being. We cannot deny our responsibility to him. I urge you to act favorably on this legislation.

Ms. Manella. Dr. Bailus Walker and Mr. Theodore Gordon will be our next witnesses.

I understand you gentlemen are, among other things, environmental health consultants to various Federal agencies, including the Department of Justice. I know that you are not lawyers or public administrators; rather, I gather your job is to evaluate the condi-

tions in the many institutions which you have investigated in your professional capacities.

Can you give me a ball-park estimate, first of all, of the number of institutions that you have visited?

TESTIMONY OF DR. BAILUS WALKER, JR., ENVIRONMENTAL HEALTH CONSULTANT, U.S. DEPARTMENT OF JUSTICE, AND THEODORE GORDON, ENVIRONMENTAL HEALTH CONSULTANT, U.S. DEPARTMENT OF JUSTICE

Dr. WALKER. We have visited about 105 institutions throughout the United States in practically all sections of the country.

Ms. MANELLA. Are these institutions all prisons or are they all types of State institutions?

Dr. WALKER. They are a mixture of jails, prisons, and detention facilities.

Ms. MANELLA. We are not talking about mental health facilities?

Dr. WALKER. No; we have not been involved in the inspection of mental health facilities.

Ms. MANELLA. Could you describe briefly some of the conditions you found on a recurring basis? I am not asking you necessarily to highlight the worst cases of abuse or cite any horror stories, but just indicate to us the conditions which you find over and over again and those which you would consider prevalent.

Dr. WALKER. By and large, the problems of overcrowding and of inadequate food in terms of nutritional quality as well as quantity and the conditions under which the food is prepared and served are among the problems which we find over and over again.

The overcrowded conditions tend to exacerbate other kinds of conditions—inadequate toilet facilities, the lack of adequate ventilation, the problem of insect and rodent control, the problem of basic sanitation. These kinds of conditions are widespread throughout the institutions which we have looked at.

Ms. MANELLA. Are some of these conditions, such as the insect infestation, necessarily problems that would require massive amounts of money to alleviate?

Dr. WALKER. No. In some cases it just requires maintenance and upkeep programs. Good basic housekeeping would solve many of the conditions that we have found.

Ms. MANELLA. Having seen these conditions over and over do you have—and I realize you are not State administrators—do you have any explanation of why these conditions are not remedied by the institutions which obviously must be as aware of them as you have become?

Dr. WALKER. I think our experience would indicate that there is, first of all, a lack of responsiveness on the part of State agencies.

Our prepared statement points out that we have talked to some 35 or 40 State health officials around the country. They have indicated to us that they want no part of some of the political and controversial issues surrounding conditions in jails and prisons.

One of the things that is most disturbing to us is the lack of enforcement on the part of State health officials with respect to con-

ditions in jails. Yet we recognize that physical and mental health in these institutions are, in fact, public health, and should be the responsibility of the publicly supported public health agency which is the State health department.

Ms. MANELLA. So your experience has been that these conditions, even when they are widespread and known and could be alleviated without massive infusions of money, have not been remedied by the State authorities responsible for them, is that correct?

Dr. WALKER. Based on our investigations, they have not seen fit to move forward. In a number of cases we have even seen efforts to cover up and hide these conditions when we would visit the institution. In a number of cases we were even denied admission until we had the force of the Department of Justice behind us to get us into some of these institutions.

Ms. MANELLA. Mr. Humes brought up the point before that persons in mental hospitals perhaps may be in a different category than prisoners, who have been convicted of offenses and presumably are not supposed to be put into settings they would necessarily find comforting.

Are the conditions that you found of the sort that could be described perhaps as "spartan" or are they conditions which by any standards of human decency would be considered substandard.

Dr. WALKER. I think your latter comment would apply. They are by any stretch of the imagination substandard conditions.

Ms. MANELLA. I take it you are referring, for example, to the conditions such as Judge Johnson found in Pugh v. Locke where there was one functioning toilet for 200 men; is that correct?

Dr. WALKER. That is correct.

We have a number of photographs that graphically illustrate some of our findings in these institutions.

Ms. MANELLA. Have you had any difficulty in dealing with State officials during these trials in which you and Mr. Gordon have been witnesses? Has there been much reluctance on the part of the States to provide you or the court with the evidence that would obviously resolve some of the factual disputes?

Dr. WALKER. They do not voluntarily provide this information, but after some order or directive by the court, they would provide this information.

Ms. MANELLA. I thank you for these pictures, which I will distribute to the other subcommittee members' staffs.

Could you make copies of these pictures available to us for the record and provide us with an explanation of what some of them are? I think that would be helpful to us. To laymen it is not always immediately apparent what it is we are looking at.

Dr. WALKER. We will make copies available for the record.

Ms. MANELLA. Thank you.

Mr. Humes, do you have questions?

Mr. HUMES. Dr. Walker, I was impressed by the statement you made on page 3 of your testimony that, "As this subcommittee proceeds . . . you will hear meretricious arguments. . ." Were you assuming that all of the arguments that preceded you or will follow you are meretricious in regard to this?

Dr. WALKER. I think some of them will be.

Mr. HUMES. And those of you and your associate are not necessarily? Isn't this sort of presumptious to presume that everybody who will precede you or follow you will indulge in meretricious arguments?

Dr. WALKER. The point essentially was that there will be legal scholars who will address some of the legal dimensions.

Mr. HUMES. Should we be concerned with legal considerations?

Dr. WALKER. If you will let me finish, my point was that we would speak specifically, to the environmental health issue.

If you will read the next paragraph, I think the health dimensions of our testimony becomes fairly clear.

Mr. HUMES. What do you mean by "meretricious"?

Dr. WALKER. I meant showy or flowery arguments about the legal aspects and States' rights.

Mr. HUMES. How do you define meretricious?

Dr. WALKER. I define it as flowery and showy.

Mr. HUMES. You would not necessarily define it as false or specious?

Dr. WALKER. Not necessarily. I was not using it in that context in this statement.

Mr. HUMES. You said that your concerns are with the higher environmental considerations as opposed to the legal considerations. Shouldn't we also consider the legal impact of this bill?

Dr. WALKER. I am sure you will have scholars who will come forward and speak to that issue. We are speaking specifically to the environmental health dimensions.

Mr. HUMES. The people who do speak on the other aspect, their comments will not necessarily be meretricious? By "meretricious," I mean false or specious or illicit.

Dr. WALKER. Your definition of meretricious and mine are not the same. I did not use it to mean "false" in this statement.

Mr. HUMES. Dr. Walker, you mentioned, in connection with the chairman's statement, the big problems as you find them are overcrowding and nutritional quality. I think we have all been conditioned to overcrowding of prisons.

What is the solution in your opinion? What is the answer?

Dr. WALKER. We have to look, first of all, at who is incarcerated and whether or not some of these people who are confined should be. I think we have seen some approaches around the country: speeding up the probation aspects of it, restitution, halfway houses, and some of these developments have been effective in reducing overcrowding.

Mr. HUMES. You state that we have to look at these people who are incarcerated. This would entail necessarily reexamination of the whole judicial sentencing system, would it not?

Dr. WALKER. I would think that would be one of——

Mr. HUMES. In sum, though, the answer to so-called overcrowdedness—and I am not disputing that they are overcrowded because we live in a very violent and crime-ridden era—but one answer, and I am not necessarily convinced that it is the answer, is to build bigger and more prisons.

Would you suggest we might alleviate it some other way?

Dr. WALKER. Not having a strong background in correctional administration, I am not sure I am qualified to answer that question.

As I indicated earlier, our concern is with the health conditions in these institutions.

Mr. HUMES. Your point is that the Attorney General through this bill somehow would be able to ameliorate overcrowdedness and the deficiency in nutrition which you and Mr. Gordon have discovered; is that correct?

Dr. WALKER. I think the Attorney General could bring the kind of force to bear that is needed to enforce the standards that we have. Our experience would indicate that State officials have not enforced the standards that are already on the books.

Mr. HUMES. What standards are those, Dr. Walker?

Dr. WALKER. We have a number of standards, State standards, for example. Practically every State in the union has a set of standards dealing with food protection. Yet we have seen consistent violation of these standards, such as basic dishwashing procedures. Certainly that is something that, if it were carried on in the community outside of the institution, the restaurant or the food facility would be closed. But we allow this kind of thing to go on in our penal institutions.

We do not allow uninspected meats to be prepared and served in the facilities outside of the institution. We have found in a number of cases that meats were being prepared and served in institutions and not subjected to ante-mortem or post-mortem inspection.

Ms. MANELLA. I assume, too, that there must be Federal standards which pertain to this.

Dr. WALKER. There Federal standards apply when the meat moves across State boundaries.

Ms. MANELLA. I assume some of your work has been involved in seeing whether compliance was achieved with Federal as well as State standards, is that correct? That presumably is the interest of the Federal Government, is it not?

Dr. WALKER. That is correct.

Mr. HUMES. I am impressed, Dr. Walker, by your statement that individuals are required to spend many years in a single environment over which they have no control. That would be the history of prisoners, wouldn't it, for 5,000 years, I suppose? The fact that they are in an environment over which they have no control is precisely why they were put in there because they obviously have violated a law and this is society's way of extracting its retribution—putting them in confinement where they will have no control over their environment.

Dr. WALKER. By the same token, I think that places an even greater responsibility on the correctional administrator to try to ensure that it is a safe and wholesome and nonstressful environment.

Mr. HUMES. Yes; I agree. I think that it is deplorable that there is overcrowding—and maybe we are putting the egg before the chicken—as a result of this tremendous increase in the incidence of crime. I do share your disgust and your loathing for these overcrowded conditions because I am repelled by the notion that assaults are being made on prisoners by another prisoner. I find that the most offensive thing of all, particularly on younger people.

I was reading about something on Riker's Island here. This is a fairly common experience, I suppose. I must confess I am impressed by these incidences whereby old hardened prisoners abuse young prisoners. I think this is one of the most alarming developments in our whole penal society. I wish there was some way we could eliminate this evil.

I am curious from an academic point of view as to how we can solve this problem.

Mr. GORDON. I would like to comment on that.

My experience is in testifying in various Federal court cases and in hearing testimony from correctional experts—and I am commenting purely from a layman's standpoint and not as a student of corrections.

Significant issues have been raised. We must consider the whole classification system of inmates coming into an institution. For example, in Alabama in *Pugh* v. *Locke* we heard testimony from an inmate as well as an expert psychiatrist where a 22-year old inmate was arrested for petty larceny. He was sentenced to a maximum security institution in the Alabama State penitentiary system. Upon sentencing there was no classification of that individual based upon the type of crime that he had committed. He was incarcerated in a maximum security dormitory with inmates that were considered hardened criminals, upon which they attempted to strangle him. Instead of strangling him, this inmate was prostituted and raped approximately 18 times, to obtain resources to purchase soap, toothbrushes, and other basic necessities.

This is a very tragic situation. However, it goes back to the lack of professional correctional mangement.

Here is an inmate that was sent into an institution where, in my opinion, the management of the correctionl system in the State of Alabama was grossly substandard and inept.

I find the whole process of sentencing inmates, classification of inmates, and the kinds of institutions in which they are sent to be very critical in reducing stressful environments—where as improvements in this area would definitely help reduce the overcrowded conditions in many institutions.

Furthermore, some revision in the whole criminal justice system is needed.

For example, 2 weeks ago I testified before the Honorable U.S. District Judge Luther Bohanan in *Battle* vs. *Anderson* in Oklahoma. In reviewing various pertinent documents on overcrowding, it was brought to my attention that within the correctional system they had approximately 451 individuals who had been convicted and sentenced for DWI.

Again, not being a student of the law or of corrections, my opinion is that these people are not that great of a threat to society.

Furthermore, I think we have to take a critical look at the geriatric inmates we have in various institutions. We have both experienced on our surveys inmates in their 70's who are bedridden, nonambulatory, with bedsores, lack of medical treatment, living in filth with rats, substandard conditions, draining bedsores, inmates that are catherized and the catheters have not been changed in weeks with urinary tract infections, human suffering.

These people, in my opinion, are no great tragic threat to society and should be housed in some sort of a skilled nursing facility that can treat and prevent their medical problems.

Mr. HUMES. After they are cared, Mr. Gordon, would you presume they would go back to the institution?

Mr. GORDON. No.

Mr. HUMES. Isn't it true that some of the older ones have really found a home, so to speak, and they really would be hard put to make it in the outside world?

Occasionally you read accounts of prisoners who have been incarcerated for 30 or 40 years. They really have no place to go.

Mr. GORDON. Sir, I just cannot accept the fact that a man who is bedridden and cannot move around and is incarcerated 24 hours a day with bedsores, a lack of medical and nursing treatment, poor nutrition, poor food service, exposed to rats, bad ventilation, exorbitant temperatures. I cannot imagine that those conditions in any way would be acceptable to any human being.

Mr. HUMES. Was this a State or Federal institution?

Mr. GORDON. These are State institutions.

Ms. MANELLA. Thank you very much, gentlemen.

As I understand it, what you are saying is that the abuses you are describing are neither isolated nor minimal. You are talking about gross violations. You believe no matter what crime an individual has been convicted of, it is unlikely that he has been sentenced to spend the rest of his life in a rat-infested cell. Is that correct?

Mr. GORDON. Yes. I might add an experience that I had last week in Oklahoma. That was on the part of the cooperation of the State Attorney General's office.

The Justice Department was involved in litigation regarding the Oklahoma State Penitentiary. As part of their litigation, I served as an expert consultant and surveyed the institution. Upon surveying the institution, there was a definite obstructive attempt on the part of the State Attorney General's office to prevent us in gaining access to pertinent and relevant information regarding that lawsuit.

I might add that the court took judicial notice of this and it was reported in his most recent opinion and findings of fact on the part of the State's behavior in preventing the various experts from obtaining pertinent evidence regarding the law suit. This was not particularly isolated to me but the same attitude was directed towards two other experts. I find this is a most ludicrous situation and it is one which I have never experienced in any other of the 15 Federal lawsuits in which I have participated regarding conditions of correctional institutions.

Ms. MANELLA. Was this the *Battle* case?

Mr. GORDON. Yes; it was the *Battle* case.

Ms. MANELLA. I assume those findings are not yet public.

Mr. GORDON. I believe they are.

Ms. MANELLA. They are public?

Mr. GORDON. Yes; and I believe you can obtain a copy from the Justice Department.

Ms. MANELLA. Thank you.

Dr. WALKER. May we insert two documents into the record? We have heard a lot of discussion about the lack of standards. I would

like to have this entered into the record: "Standards for Health Services in Correctional Institutions,"[1] by the American Public Health Association.

We would also like to insert into the record our findings, "Food Protection in Jails and Prisons."

Ms. MANELLA. Is that the one which was attached to your statement?

Dr. WALKER. Yes.

Ms. MANELLA. If there are no objections, it will be done.

Ms. MANELLA. I want to thank you gentlemen again. I am certainly sorry that Senator Bayh had to leave. Obviously your entire testimony along with the statements you brought will be inserted in the record. I assure you that they will get his fullest attention.

If there are no objections, the hearing is recessed until tomorrow at 10 a.m. in room 1202 of this building.

[The prepared statement of Bailus Walker and the exhibits submitted by Dr. Walker and Mr. Gordon follow:]

PREPARED STATEMENT OF BAILUS WALKER, JR., PH. D., M.P.H.

I am pleased to testify before this subcommittee in response to an invitation from the chairman.

I am appearing as a practitioner of environmental health and as one who served on the Jails and Prisons Task Force of the American Public Health Association.

Last May that Task Force published a set of comprehensive correctional health standards which evolved from an extensive review of the correctional system by a group of public health professionals.[1]

During the past two years, I and my associate, Theodore J. Gordon, have inspected some one hundred jails and prisons throughout the United States, on the Virgin Islands and in Puerto Rico.

These inspections and our analyses of conditions, as well as our opinion testimony in several legal suits, were part of our services as environmental health advisors to the National Prison Project and the United States Department of Justice. Both of these organizations have been involved as intervenors or litigating amici curiae in a large number of cases concerning the rights of confined persons.

Some of these cases and conditions were cited in floor statements by Senator Bayh when he introduced the Bill now under consideration.

Here we can confirm that the examples in institutions cited by the Chairman merely describe the tip of the iceberg of the horrible substandard environmental conditions prevailing in correctional facilities.

We could add to that list the following situations which we observed during our inspections:

In one institution a mental patient (stripped of clothing) in a 7 ft. by 5 ft. cell, with a room temperature of 102° F and no air movement, was sleeping on urine- and fecal-soaked floors. When we asked the correction's officer how long the patient had been confined under these conditions, he replied, "about 6 to 8 weeks."

On another inspection, we noted that mental patients were served "stew" (containing no meats or vegetables) that was lacking in nutritional quality. When asked why this stew did not contain the basic ingredients found in the stew served to other inmates, a correctional officer replied, "mental cases don't know what they eat anyway."

In another facility the five elderly (average age of 70 years) bed-ridden inmates were locked up in a cellblock area that was unquestionably a firetrap, with only one exit. These men had also developed open and draining bedsores that had not been treated because of the lack of adequate nursing assistants.

As this Subcommittee proceeds with its discussion of S. 1393, you will hear

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[1] Standards for health services in correctional institutions, jails and prisons task force. American Public Health Association, Washington, D.C. 1976.

meretricious arguments from legal scholars and experts about the legal ramifications and impact of this Bill on jurisdictional rights.

But from my viewpoint, as a health scientist, I believe this Bill is indeed necessary to lessen the obvious violations of the human rights of institutionalized persons and to further prevent man's inhumanity to man especially in jails and prisons—settings in which individuals are required to spend many years in a single environment over which they have no control.

It is evident that existing resources and methods at the state and local levels of government have not been fully effective in removing many of the severe hazards and stresses in correctional institutions. Let me briefly describe the basis for this judgment.

Almost twenty-five years have elapsed since James Bennett, former director of the Federal Bureau of Prisons, wrote:

"The county jail is a national disgrace. Most state prisons are outmoded obsolete shells and cages to which other structures have been added as the philosophy and function of prisons have changed."[2]

Today, almost three decades later, Mr. Bennett's description is still highly accurate and applicable to the majority of correctional institutions in this nation.

Like many of the witnesses appearing before and after me, I also cannot resist the temptation to reinforce this statement with a quote from the "Memorandum Opinion" in *Puge* v. *Locke*, of the United States District Court for the Middle District of Alabama, Northern Division, because it so clearly illustrates why it is entirely appropriate that Congress considers and enacts S. 1393.

The court found:

"The dilapidation of the physical facilities contributes to extremely unsanitary living conditions. Testimony demonstrated that windows are broken and unscreened, creating a serious problem with mosquitoes and flies. Old and filthy cotton mattresses lead to the spread of contagious diseases and body lice. Nearly all inmates' living quarters are inadequately heated and ventilated."[3]

Perhaps we in the public health field must share some of the blame for these conditions. Unfortunately, we have no grounds for congratulating ourselves on our national record of environmental health and safety in correctional institutions.

In contrast, we have brought most of our chronic sources of water pollution under control, as evidenced by the recovery of fish in many of our streams; we have improved dairy farm conditions for cows through our comprehensive milk sanitation program. In addition, the general cruelty to animals is on the decline, and protecting our endangered species is high on our list of national priorities.

But, we cannot be smug or comfortable about the overcrowded conditions in 98.2 percent of our jails and prisons or about the diarrhea and other food poisoning symptoms which continue at epidemic levels in many large correctional institutions, due largely to overt deficiencies in food service sanitation. Neither can we applaul the existing inadequate toilet facilities and the defective ventilation systems that are so common in correctional institutions, nor the broad spectrum or other conditions which enhance the occurrence and progression of physical and mental disease and disability among confined persons. These conditions not only affect the inmates, but can spill over into the communities surrounding the institution.

For example, Dr. Lambert King, as recently as last February, reported on a study of the rapid transmission of tuberculosis in the overcrowded Cook County (Illinois) Jail.

Writing in the *Journal of the American Medical Association* (February 21, 1977), Dr. King concluded that crowded jail conditions promote close contact among a large number of young men from urban areas where the incidence of tuberculosis remains high. His studies clearly demonstrated that an alarming rate of tuberculosis can and does occur in correctional institutions.[4]

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[2] Handbook of Correctional Institution Design and Construction Bureau of Prisons, U.S. Department of Justice. Washington, D.C. 1949.

[3] *Pugh* v. *Locke*. Civil Action No. 74–57–N and No. 74–203–N. U.S. District Court for the Middle District of Alabama, Northern Division. January 13, 1976.

[4] King Lambert and Geis, George. "Tuberculosis Transmission in a Large Urban Jail." *J.A.M.A.* 237:791–792. 1977.

Unequivocally, the environmental dimensions of health are equally as important as the mental and physical ones in terms of the well-being of persons confined in institutions.[5,6,7]

When an 8 ft. cell (as we have found) must serve as a home for two or more adult inmates where they are forced to breathe and, too often, cough and sneeze in each other's faces; when individual privacy is severely lacking within that cell; when personal hygiene needs and the discharge of human wastes must take place in the same immediate environment where the food is served and eaten; when the rate of fresh air movement is nil and when noise levels often exceed 100 decibels, it is hard to believe that the mind and emotions or physical health go unscathed.

Like medical care services and food, a safe and wholesome environment is a basic necessity. It is a common need of all people. This need cuts across boundaries of race, class or politics and across the definitions of offenders, non-offenders, criminals and non-criminals.

Man is a product of his heredity and his environment. Heredity represents an endowment from the past, an ancestral estate to which each individual falls heir at birth and one which he (or she) must accept, be it rich or poor, to do with it what he (or she) wills.

The environment on the other hand represents the present-day opportunity to develop that endowment, to make good use of a poor inheritance, good use of a good inheritance or poor use of a poor one.

However seriously biologists may debate the relative importance of these two factors (heredity and environment) in the development of mental and moral traits, it is quite plain that in regard to physical health and well-being there is no hereditary endowment so good that it cannot be wasted away by a bad environment and rarely one so bad that it cannot be reclaimed, in part at least, by favorable treatment in an environment reasonably free of overt hazards, stresses and insults.

Conditions today in many of our jails and prisons unquestionably constitute a bad physical environment which is abusing and wasting away the basically good hereditary endowment of thousands of human beings.

We find it most disturbing that many of the state health departments, vested with the primary legal responsibility for public health programs in their respective states, have failed to promulgate and enforce public health rules and regulations for jails and prisons. Yet physical and mental health in publicly-supported correctional institutions is indeed public health and should be the responsibility of the tax-supported health department.

In approximately 14 states the health department, or the lead health agency, assumes responsibility for the monitoring and surveillance of health programs —curative medicine, preventive medicine, health promotion and environmental health—in correctional institutions. And these have lacked the necessary resources for a progressive policy.

Some 35 to 40 state health officials with whom we have talked openly admit that they want no part of the controversial and often political issues which surround correctional institutions, regardless of the public health implications of prison conditions.

In the majority of other states the corrections department has responsibility for promulgating and enforcing its own health standards. More often than not the corrections department inspects and judges the performance and achievements by that department's operation often without the input of persons trained in medicine or public health.

It is this state of affairs that has prompted the Honorable Sylvia Bacon, a distinguished member of the American Bar Association's Commission on Correctional Facilities to conclude that:

"The record is clear that the rights of confined citizens have been ignored or violated in local and state correctional systems. That is the judgment of our courts, that is the judgment of such legislative agencies as the General

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[5] Gruchow, H. William. "Socialization and the Human Physiologic Response to Crowding." *A.J.P.H.* 67:455–459, 1977.

[6] Martin, A. E. "Environment, Housing and Health." Urban Studies 4:1–29, 1967.

[7] "Man's Health and the Environment—Some Research Needs." Report of the task force on research planning in environmental health science. U.S. Department of Health, Education, and Welfare. Washington, D.C. March 16, 1970.

Accounting Office and that is the judgement of the executive branch of the Federal Government." [8]

We thoroughly agree with Judge Bacon's conclusions, and her statement has a broad base of support among legal scholars, health professionals, behavioral scientists and many other groups who are sincerely concerned about state and local correctional systems.

There is one other reason why S.1393 is vitally needed. The manpower, time, energy and other resources necessary to substantiate and resolve allegations of constitutional rights violations are not readily available, because of enormous cost to private advocates.

It does not require a graduate degree in economics to understand the inordinate cost of salaries for lawyers and research staff, expenses for experts in the various fields and for the accumulation of necessary documentary exhibits —costs which soon exhaust the resources of most private human welfare organizations now in operation.

This severely limits the rate and the extent to which private litigants can seek a resolution of the rights of institutionalized persons.

Thus the assistance of the Attorney General, envisioned in this Bill and the vast resources at his disposal are necessary if we are to bring to fruition prompt and effective redress of those grievances.

Also from an economic standpoint the United States has invested very large sums of money, through various programs, in state correctional services and institutions.

S.1393 would provide an avenue for scrutinizing the use and/or abuse of these investments.

In conclusion, we believe this Bill is sound, appropriate and consistent with this nation's tradition of protecting the rights of all citizens, regardless of their physical or mental capabilities.

Thank you for your attention and consideration of this statement.

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[8] Bacon, Sylvia. Statement before the Subcommittee on Courts, Civil Liberties and Administration of Justice, Committee on the Judiciary, U.S. House of Representatives. Washington, D.C. May 11, 1977.

[EXHIBIT No. 10]

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STANDARDS FOR HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS

Prepared by
Jails and Prisons Task Force
Program Development Board
of the
American Public Health Association
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William H. McBeath, M.D., M.P.H., Executive Director

TABLE OF CONTENTS

Forward v

Introduction vii

Section I —Primary Health Care Services 1

Section II —Secondary Care Services 15

Section III —Health Care Services for Women Offenders 17

Section IV —Mental Health Care 25

Section V —Dental Care 35

Section VI —Environmental Concerns 49

Section VII —Nutrition and Food Services 89

Section VIII —Pharmacy Services 97

Section IX —Health Records 101

Section X —Evaluation of Services 105

Section XI —Staffing 109

Glossary 113

Index 117

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FOREWORD

In the wake of the myriad prison uprisings which have occurred in the past few years, attention has come to be focused on the prison population of the United States. Not only did the uprisings awaken the nation to the inhumane living conditions in correctional institutions at the state, local and federal level, but the dire lack of adequate health care also came to light. The American Public Health Association was given impetus to address this issue by the concern of its affiliates and members as health care professionals concerned with the provision of adequate health services to all people whether free or incarcerated. The development of health care standards thus became a goal of the Association in 1972.

A Task Force of approximately 50 persons was appointed by the Program Development Board to develop these standards. It is important to acknowledge the individuals who contributed many more hours and much more effort than had been anticipated.

Deserving of special recognition is Dr. Richard D. Della Penna, who after assuming the chairpersonship of the Task Force in 1973, has brought the standards to the present document. Dr. Della Penna's efforts were assisted in particular by the following subcommittee chairpersons:

Robert Brutche, M.D.
Hilton Hosannah, D.D.S.
Doris Johnson, Ph.D.
Mary E. King
Jerome Rogoff, M.D.
Joseph Salvato, P.E.
Daniel H. Schwartz
Jonathan Weisbuch, M.D.

And, finally in any project of this sort there are always a variety of administrative and editorial tasks. The Task Force was particularly fortunate in having the services of Ms. Ellen Contreras, first while a member of the staff at APHA, and then while a full-time student at the University of Michigan, School of Public Health.

Personal acknowledgements to all who contributed to this endeavor would be impossible. Therefore, on behalf of the Program Development Board, I would like to thank those participating in the development of these standards for a job well done.

John H. Romani, Ph.D.
Chairman
Program Development Board

Introduction

The standards which comprise this document are based upon several overriding principles. Foremost among these is that in setting health care standards for the incarcerated population in the United States, the intent of the American Public Health Association is not to promote special treatment for this population but rather to insure that their incarceration does not compromise their health care. The freedom to seek and obtain health care is lost under confinement. What may be a matter of personal choice and responsibility to the free citizen becomes a public responsibility to the incarcerated, to be borne jointly by the criminal justice and health care systems.

Any prisoner should be able to seek health care. Moreover, the state of incarceration may create or intensify the need for health care services. Concomitant with availability is the issue of accessibility. Inmates should be allowed unimpeded access, implicit or explicit, to health care services. Access is meant to include the knowledge of the availability of these services as well as the mechanism for utilizing them. The ever-growing necessity for bi-lingual personnel in areas where a language other than English is spoken should also be considered essential for effective utilization. Access to health care and the essential quality of health services must not be compromised by detention. In particular, inmates in a restricted movement status or who are not members of the gen-

eral population should not be denied access to health care services.

The level of health care services, including the qualifications of health professionals and physicians provided to the incarcerated individual should be of comparable standard to that prevailing in the community at large. At all times, particularly where a correctional institution is located in a community where health care facilities are absent, the correctional authorities should provide an approved minimum level of health services for the inmates for whom they are responsible.

As health care professionals, we believe that all health care services units in correctional institutions should ultimately be accountable to a governmental agency whose primary responsibility is health care delivery rather than the administration of such institutions. It is felt that health agencies are more likely to possess the competence to evaluate and conduct health programs than those agencies whose expertise is in security and custody. Accountability to such an agency aids in promoting and maintaining the integrity and excellence of health services.

Health services should not be a direct function of institutional security, nor should security requirements unnecessarily interfere with the provision of health care and a healthy environment. The independence of an institution's health program, the professional integrity of its staff and particularly the confidential relationship between patient and health professional must be respected and protected by the correctional administration. Care must be offered in an atmosphere which fosters dignity and reinforces the worth of the individual as well as the health professional.

Innovation and flexibility in health services and their organizational structure should be encouraged. Scientific change, new developments in personnel, and the health needs of the particular confined population will necessitate development

of programs which are adaptable to specific needs and resources. Detainees and sentenced persons should have the opportunity to participate in the process used to plan, modify or improve health services.

Finally, in some prison systems women offenders have received less adequate health services than the prison population as a whole. This has probably been due to the fact that throughout the years fewer numbers of women have been incarcerated. It is therefore necessary for correctional administrators and health providers to give special focus to the assurance of the provision of health care to women offenders.

One further note should be made which concerns the format in which the standards are organized. Other existing standards, as a rule, list only what we list under satisfactory compliance. A principle followed by a public health rationale was deemed necessary in order to reinforce the necessity for compliance requirements.

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I | Primary Health Care Services

94-420 O - 77 - 17

Primary Health Care Services

A. Entrance Examinations—(General Population)

Principle: Each individual committed to an institution of incarceration or detention, should receive a reception health assessment and no person shall be admitted who is not conscious.

Public Health Rationale: The assessment of every person's health status is essential to provide for: a) the detection of health problems which require attention for the protection and well-being of the individual and the institution; b) the gathering of data as a reference and point of departure for planning and delivering immediate and long range comprehensive individual health care; and, c) the collection of information to establish an epidemiological and statistical profile by which health system needs are recognized and program planning decisions are made.

Satisfactory Compliance:

1. At the time of reception and initial evaluation, the inmate shall be made aware of the health services in the institution. This should be written and also explained to each inmate.
2. The reception evaluation shall be recorded in the individual's medical record which shall be started at this time.
3. Those evaluative procedures clearly necessary to detect health problems requiring immediate action to protect the individual and the institution, shall be completed before the inmate is placed in any holding unit or integrated into the institutional population.
4. All other evaluative procedures needed to complete the admitting health profile and to assist in work and activity classification, shall be completed in a scheduled manner not to exceed seven calendar days from the date of initial reception and incarceration.
5. A well-defined written plan and orders formulated by the administrative and professional staffs shall exist and be available for the care and disposition of health problems identified upon admission.
6. Any prisoner found to be in acute health stress on admission and in need of emergency care shall be referred to an appropriate treatment facility immediately.
7. Those health problems identified as a result of the assessment during incarceration which need continuing intervention or attention, shall be referred to appropriate persons and agencies.

The initial evaluation shall take place in an area that is conducive to the encounter. The patient shall be comfortable and clothed in garment suitable for the examination. The initial medical assessment shall include:

1. Measuring of the blood pressure, respiratory rate, temperature, and pulse.
2. Inquiry about:
   a. Headache, recent head injury and loss of consciousness;
   b. Use of prescribed medicines;
   c. Chronic health problems, such as heart disease, hypertension, seizure disorders, asthma, sickle cell disease, diabetes mellitus, and tuberculosis;
   d. Regular use of barbiturates, sedatives, opiates, alcohol, and non-prescribed drugs;
   e. Unusual bleeding or discharge;
   f. Recent fever or chills;
   g. Unusual pains and recent injury;
   h. Allergy to medication and other substances;
   i. Lacerations, bruises, abscesses, ulcers and itchiness.
3. A visual inspection for signs of trauma, recent surgery, abscesses, open wounds, parenteral drug use, jaundice, pediculosis and communicable disease.
4. Observation and evaluation of consciousness, awareness of surroundings and events, and appropriateness of personal interactions as well as height and weight and gross body composition.
5. Physical assessment of:
   a. Head—defects, contusions, lacerations and dried blood;
   b. Ears—gross hearing loss, blood/discharge;
   c. Nose—blood and other discharges, recent injury;
   d. Eyes—bruises, jaundice, gross movements, pupil reactivity;
   e. Chest—labored or unusual breathing, penetrating wounds;
   f. Abdomen—tenderness, signs of blunt injury, surgical scars;

g. Genitalia—discharge, lesions, lice;
h. Extremities—sign of drug use, hyperpigmentation of anticubital fossae, abscesses, deformity, "tracks".

6. Implantation of tuberculosis skin test where not contra-indicated.*
7. Obtaining urine for the detection of glucose, ketones, blood protein and serum for serology.

The procedures necessary to complete the evaluation shall include:

1. Inquiry about:
   a. Prior significant illnesses and hospitalization;
   b. Familial and domiciliary diseases of significance such as diabetes mellitus, hypertension, tuberculosis, and hepatitis;
   c. Immunization status;
   d. Current symptoms and abnormalities in the nervous, gastro-intestinal, respiratory, auditory, integumentary, endocrine, cardiovascular, opthalmic, musculoskeletal, and blood forming systems.
2. Physical inspection and examination of organs and structure of head, neck, chest, abdomen, genitalia, rectum, and extremities with particular emphasis and comment about the presence or absence of abnormalities suggested by the previously obtained history.
3. Mental health screening and evaluation which shall
   a. be conducted by a health worker sensitive to the crisis state in which the new prisoner is liable to be;
   b. include, as a minimum, the following elements of

*Note: The importance of quickly diagnosing and treating venereal diseases and TB cannot be overemphasized. This is not only true for the inmate's protection, but also for the protection of all inmates, the staff, and the outside community.

personal history: mental illness, mental health treatment, education, work, social, sexual, family, drug and alcohol use; and assessment of coping mechanisms and ego strengths; and any indication by the prisoner of a desire for help;

c. be documented in writing in a standardized fashion;

d. include explanation to the new prisoner of the mental health services available and procedure(s) for application.

4. Collective specimens for hepatitis screening, white blood cell count, hematocrit, and other indicated laboratory tests.
5. Vision testing with Snellen Chart and auditory testing with a reliable standard.
6. Immunization with Td in current needle users.

Serologically, syphilis has a long incubation period and is not detectable until the infection has been established. Thus, the serological test should be repeated three months after the initial intake exam.

Repeat venereal disease testing should be available upon request. Facilities should also be available for the diagnosis and treatment of other sexually transmitted diseases such as yeast and trichomonal infections, and genital herpes.

B. Entrance Examinations—(Women)

Principle: A substantial number of health needs of women require the service and sensitivity of persons clinically trained in gynecology and obstetrics.

Public Health Rationale: Each woman committed to a correctional institution shall receive an initial examination in accordance with the principles outlined above with special emphasis on the breasts and reproductive organs.

Satisfactory Compliance: The initial health assessment of women shall also include:

1. Inquiry about:
   a. The menstrual cycle and unusual bleeding;
   b. The current use of contraceptive medications;
   c. The presence of an I.U.D.;
   d. Breast masses and nipple discharge;
   e. Pregnancy.
2. The physical assessment, in addition to the examination performed on men, shall include:
   a. A pelvic examination which must be conducted with the maximum concern for human dignity and which must not be subverted for security purposes;
   b. A breast examination.
3. Specimens collected shall include a culture for gonorrhea, a pap smear, and a serological test for syphilis.
4. The written plan shall provide for the special dietary and housing needs of pregnant women, and the continuation of contraceptives utilized both for family planning and therapeutic reasons. The complete history shall include information about family planning services being utilized or desired.
5. Those procedures necessary for protecting the individual and the institution shall be performed prior to the housing and classification of the inmate.

Addendum:
When an inmate is received from another institution where an *adequate* health evaluation has been performed, it may not be necessary to repeat the entire procedure. The medical record shall be reviewed and the patient interviewed and appropriate supplementary examination and testing performed.

C. Regular Ambulatory Care Services

Principle: Every correctional institution should make provision for those persons treated on an ambulatory basis who have special health requirements such as limitations of activity. The disability due to illness generally occurs at a low threshold because of the highly structured and impersonal nature of institutional settings. Thus, there are many health problems which can be exacerbated by activity that is either too limited or too strenuous. Therefore, in making housing, duty or any activity assignments, on either a temporary or permanent basis, allowance for special health requirements should be made.

Public Health Rationale: The myriad health problems (some with and some without organic base) which arise must be evaluated and accurately treated as soon as they arise in order to prevent the unhappy sequellae from untended disease.

Satisfactory Compliance:

1. Each correctional institution shall demonstrate:
   a. That a regular ambulatory care schedule is provided;
   b. That a qualified provider of medical care or providers of medical care, are in the institution during the scheduled period, and are providing medical services;
   c. That there exists a mechanism whereby inmates can seek health services directly without explicit or implicit obstruction. Health officials shall develop a means whereby inmates may continue to have full access to treatment even when the inmate is not in the general population for whatever reason.
2. The frequency and duration of ambulatory care services shall be determined by the size of the institution,

and the particular health requirements of the population.

D. Specialty Consultation Services

Principle: Health care services should include an active, viable, and well coordinated referral network. The availability of well qualified medical specialists is essential if the quality of services is to be maintained.

Public Health Rationale: In order to provide the best possible care, correctional institution health care services should not be isolated but should be broadened to utilize services available in the community. These specialty services are valuable not only as a resource for medical expertise, but also for special testing, therapeutic devices and other items in the modern medical armamentarium.

Satisfactory Compliance:

1. The providers of specialty care shall be available on a consult basis either within the correctional institution, or in outside facilities.
2. Arrangements for such consultative services shall be made prior to their actual need.
3. These arrangements shall be made in such a way that in the event the necessity of referral arises, it can be made with a minimum of administrative effort.
4. The decision as to the need of such services shall rest solely with the attending physician who shall make the decision taking into consideration the financial and availability constraints.
5. There shall be written guidelines as to the utilization of specialists for cosmetic, restorative, and rehabilitative services. These guidelines should, however, take into consideration the value of rehabilitative, elective, and therapeutic techniques.
6. The providers of specialty services shall each have an

institutional personnel file in which their credentials are delineated, and their schedule defined.

7. Consultation requests and reports shall be on specific consultation forms which shall be included in the unit medical record.

E. Follow-up Services

Principle: The diagnosis and identification of health problems is only the beginning of care. Continued monitoring of health problems, treatments, and diagnostic evaluations is necessary to prevent future complications of the illness and to improve the patients capacity to function with whatever disability the disease has caused.

Public Health Rationale: Health maintenance of this nature will reduce the burden of illness in a prison population, allow for a more stable medical staffing pattern than would be the case if all problems were handled acutely, and reduce overall medical costs through the reduction in utilization of expensive tertiary care facilities.

Satisfactory Compliance:

1. Each correctional institution shall demonstrate:
   a. The methods and procedures for resolving health problems, or unusual or abnormal findings defined by the initial screening assessment or through ambulatory care;
   b. The methods for assuring regular review of problems;
   c. That a regular medical review is part of the general procedures.
      I. An annual evaluation of every inmate along with the medical record.
2. Prior to discharge or release from the system a compilation of the medical history shall be carried out. The discharge summary shall include: medical exami-

nation, review of systems, summary of medical problems, current health status, current therapy, future plans, and source of future care, if known.

F. Emergency Services

Principle: Each correctional institution should provide for the emergency health needs of inmates, staff, and visitors both individually and collectively.

Public Health Rationale: Comprehensive health services in all settings must provide for unexpected major health needs. Serious injury and sudden illness occur universally but rarely where trained persons and needed equipment are available for the immediate provision of care. This situation is further compounded in correctional institutions. Geographic remoteness, the physical and procedural barriers created by security requirements, the presence of heavy maintenance and industrial machinery, the frequency of personal and interpersonal violence are additional factors which demand prompt and effective emergency services in correctional institutions.

Satisfactory Compliance:

1. Each correctional institution shall have a written plan for emergency procedures. The plan shall include the range of services available within the institution and shall be integrated with existing regional emergency medical care resources.
2. All health staff persons shall be well trained in the provision of first aid and emergency care measures and cardiopulmonary resuscitation. In institutions where health staff is not available twenty-four hours a day, there shall always be on duty at least one correctional officer who has completed the equivalent to the primary American Red Cross First Aid course.
3. Emergency equipment and supplies consistent with the written emergency procedure and commensurate with the service capability of the institution shall be

available and readily accessible. First aid supplies shall be located in all areas such as the kitchen and work areas where accidents are likely to occur.

4. Medical criteria alone shall dictate whether or not an inmate shall be transferred out of the facility to a civilian health center for emergency care. Security requirements shall not unreasonably delay the arrival or departure of emergency vehicles used in transfers.
5. Each institution shall include in its emergency procedures specific guidelines for transfer and provision for medical care in the event of fire, riot, or disaster.

G. Health Education

Principle: The recognition of the normal and abnormal functionings of one's body often means the prevention of serious disease. Education, in this sense, can thus avoid serious outbreaks of disease which can easily occur in the confines of the correctional institution.

Public Health Rationale: Special attention should be given to providing personal health information to inmates since the inmate of a correctional institution is at greater risk of not having had proper medical care throughout his/her life prior to entry into the correctional system.* Staff should be prepared and willing to answer any inmates' questions regarding health or health-related problems.

Satisfactory Compliance: Information of a preventive nature is especially relevant in the following areas and shall therefore be given at the most appropriate encounter with the inmate:

1. Information regarding dental hygiene;
2. Information regarding personal hygiene and nutrition;

*Note: Maintaining a "problem list" always at hand would be an excellent way to begin caring for oneself, and can be made part of the health education program of the institution.

3. Training in breast self-examination in women inmates;
4. Information regarding maintenance of health;
5. VD and TB information;
6. Family planning information relating to services and referrals;
7. Education shall be directed to particular epidemiological problems;
8. Upon discharge (whether on furlough, work release, parole, or unconditional discharge) as well as during incarceration inmates shall be made aware of their particular health needs so that they can help themselves stay healthy;
9. Specific advice shall be given to women inmates using contraceptive devices regarding possible negative affects.

II | Secondary Care Services

Secondary Care Services

Principle: Each correctional institution should make available a range of health services beyond those which can be provided on an ambulatory basis.

Public Health Rationale: Comprehensive health services frequently require, acutely and electively, an environment which permits modified activity and services which are not available in the ambulatory setting.

Satisfactory Compliance:

1. Each correctional institution shall define an established plan for the delivery of health services beyond those available on an ambulatory basis. This plan will include the levels of care available both inside and outside the institution.
2. Correctional institutions maintaining hospital services shall meet the requirements of the Joint Commission of Hospital Accreditation.

3. Correctional institutions maintaining infirmaries shall meet the same requirements met by university and college infirmaries.
4. Each correctional institution shall designate an appropriate area in which limited observation and management may be provided for those cases not requiring hospital or infirmary services.

III | Health Care Services For Women Offenders

94-420 O - 77 - 18

Health Care Services For Women Offenders

Principle: Incarcerated women require the same health services on all levels of care as all women, and some of these needs will be different from those of men. The particular health needs of female offenders should be specifically recognized by health persons and correctional administrators alike.

Public Health Rationale: A substantial proportion of the woman offender's health care needs are gynecologically related, and therefore require gynecologically trained and oriented clinicians. Family planning services and health education are also of particular importance to women. Teaching women about the care of their bodies for maintaining their health, prevention of illness, and planning their families, can be an important aspect of rehabilitation and enhancing self-respect. Additionally, concern for children left behind and for the denial of parental rights (which automatically occurs upon incarceration in some states), may have serious consequences for the mental health of women offenders.

Satisfactory Compliance:

1. The particular health problems of women such as menstrual irregularities, shall receive appropriate gynecological care. Feminine hygiene needs should be supplied. Douching should be made routinely available and accompanied by proper education and precautionary advice.
2. Family planning services shall be offered during incarceration. While it is unlikely that an inmate will become pregnant, such incidents do occur. The status of detention should not affect the availability of family planning or abortion services during incarceration. If a women is taking oral contraceptives when she enters the institution, she should be permitted to continue until the end of that monthly cycle, even where contraception services are not provided by the institution.

   It is particularly important that family planning education and services be offered upon release to all women offenders of childbearing age, as well as referral to a community program for continuing family planning services.
3. The woman prisoner who is pregnant and who does not choose abortion, shall receive the same prenatal care that is available to civilian women. This care is not limited to but includes: laboratory tests, diets and diet supplements, prenatal checkups and exercise. Many of the routine prenatal procedures may be performed by a nurse or a nurse midwife.

   The mother shall be allowed to choose between placement with a relative, temporary placement, or adoption to the maximum extent allowable. The prisoner mother should receive reports about all her childern. If the newborn infant is permitted to remain in

the institution with its mother, medical care for the infant is the responsibility of the institution.

4. Abortion is a right of all women and shall not be mitigated by reason of incarceration. The woman should be transported to a civilian clinic or hospital for the same pregnancy counseling she would receive if not incarcerated. If she chooses abortion, it should be performed in a civilian clinic or hospital from physicians accustomed to carrying out the procedure.
5. Since many women have children at home, health professionals should be aware of such situations and facilitate provision of support services to families from outside agencies.
6. Health maintenance procedures shall be established including, but not limited to, Papanicolaou tests (pap smears*), venereal disease screening, breast examinations, etc.
7. Note the Entrance Examination requirements for female inmates under the Primary Health Care Section for other specifics.

*Pap Smears: This procedure shall be included in the examination of adolescents as well as adults, since abnormal findings in adolescent females have been found to be more common than previously thought.

IV. Mental Health Care Services

Mental Health Care Services

A. Provision of Care

Principle: Mental health services should be made available at every correctional institution.

Public Health Rationale: Any person should be able to seek mental health care. Moreover, the very fact of incarceration may create or intensify the need for mental health services.

Satisfactory Compliance: Every jail and prison shall have a written description of mental health services available to its population. To be adequate, these services shall meet the standards set forth in these guidelines.

B. Principles of Care

1. Services Shall not be Mandated

Principle: The State (jurisdiction) may not mandate treatment for any individual, unless a person, by reason of mental disability poses a clear and present danger of grave injury to

himself or to others. Then, and only then, intervention may be mandated, but only with the least drastic measures, in response to a) an immediate emergency, or b) on a continuing basis, only after civil judicial direction by the appropriate court, in which proceeding the individual is accorded an independent psychiatric evaluation and due process of law.

Public Health Rationale: Legally and ethically, health professionals do not have the right to impose treatment on an individual unless there exists a clear and present danger to the public or the individual himself. When by virtue of mental disorder, the public safety is threatened, the public, including the individual who is mentally disordered, shall be protected. At the same time the mentally disordered have the right to the best treatment available for their disorder, with adequate protection for their civil rights and right to due process.

Satisfactory Compliance:

1. Each correctional facility shall provide for the hospitalization and treatment of persons who require it because of mental illness. Forced hospitalization and treatment shall occur only when in compliance with the principle stated above.
2. No reward, privilege or punishment shall be contingent upon mental health treatment. All mental health personnel shall base all treatment decisions, including the decision to treat or not to treat, on professional grounds only. Mental health treatment will be provided on a voluntary basis for valid emotional or psychological reasons only, as determined by the mental health staff.

2. Professional Independence; Separation of Functions

Principle: Mental health professionals who participate in administrative decision-making processes, such as, but not limit-

ed to, parole and furlough relating to a prisoner, should be other than those mental health professionals providing direct therapeutic services to that prisoner. Exempted from this principle are those mental health professionals involved in the treatment of hospitalized inmates where decisions relating to activity and similar issues are integral elements of the treatment program of the illness for which the patient was hospitalized.

Public Health Rationale: The intent of this principle is to protect the therapeutic relationship. Therapeutic relationships are inevitably contaminated by the patient's knowledge of the therapist's role in relation to his/her rewards or sanctions.*

Satisfactory Compliance:

1. Treating professionals shall not compromise the therapeutic relationship by assuming a dual role, vis-a-vis a prisoner in therapy. For example, when any administrative board is addressing the affairs of an individual prisoner who is in therapy, the treating mental health professional shall not then sit on that board. Whenever such a board requires appropriate mental health input, and if it is to be provided, it shall be provided by an independent mental health professional who is not treating the individual.

   The therapist shall make clear, at the outset of therapy, that she/he will not contribute to the decision-making process of any administrative board, and mental health professionals shall not allow themselves to be obliged by the administration or the correctional system to involve themselves in such a proc-

*The Task Force is aware that there is a dynamic tension between this principle and the one that follows. This tension was wrestled with in an attempt to do justice to both aspects of the controversy and to the necessary compromise that must be made.

ess. When in an extraordinary situation where the therapist is convinced that there is a clear misunderstanding of mental health parameters affecting a prisoner by decision-making persons, the therapist with, and only with, the consent of the prisoner, may make available relevant opinion or data to the decision-making process.

2. Determination of competency and criminal responsibility shall be addressed by court appointed mental health professionals who are not working within the correctional system.
3. Although treating professionals shall not be involved in forensic decisions, an exception exists, when the treating professional believes that a person is or may have been incompetent to stand trial, and the issue was not previously or is not then being addressed. The professional shall notify the appropriate court that the issue of competency should be addressed by the court independently.

3. Confidentiality

Principle: Full confidentiality of all information obtained in the course of treatment should be maintained at all times with the only exceptions being the normal legal and moral obligation to respond to a clear and present danger of grave injury to the self or others, and the single issue of escape.

Public Health Rationale: Mental health providers have an ethical responsibility to protect the trust placed in them and to honor the expectations of consumers that information communicated to them will be kept in strict confidence. Moreover, mental health treatment, in purely practical terms, simply cannot be conducted unless consumers have confidence in the protection of the information they reveal.

Satisfactory Compliance: In all therapeutic relationships, the mental health professional shall explain the confidential guar-

antee, including precise delineation of the limits (as stated in the exceptions above) and periodically review the guarantee and its limits, to insure continued awareness. The prisoner who reveals information that falls outside the guarantee of confidentiality shall be told, prior to the disclosure, that such information will be disclosed. If informing the prisoner of the therapist's intent to disclose information will increase the likelihood of grave injury, the therapist may delay informing the treated prisoner of that disclosure.
Mental health data shall be entered into the unit health records to be handled in accordance with the provisions of the Records Section of the overall standards. The mental health data shall be restricted to the facts of treatment, diagnosis, prognosis, treatment plan, and medication. Sensitive or highly personal data shall not be included in the medical record.

C. Direct Treatment

Principle: Direct treatment services should be provided in a context of varied modalities, with emphasis on eclectic breadth.

Public Health Rationale: Inherent in a person's right to health care is the alleviation of suffering; secondary prevention, which is relief of presenting symptoms and early case fundings; and tertiary prevention, which may include the possibility, on a voluntary basis, to address issues of personality that are related to his/her crime(s) and that may be helpful in post-prison adjustment.

Satisfactory Compliance: The following direct treatment services shall be made available as a minimum:

1. Crisis Intervention. Special note is made that entry into a jail or prison is a crisis which may often manifest itself in emergent ways. Epidemiologically, special attention must be paid to suicide.
2. Brief and extended evaluation/assessment.
3. Short-term Therapy: Group and individual.

4. Long-term Therapy: Group and Individual.

5. Therapy with family and significant others.

6. Counseling shall be available for all inmates. In particular, since many heterosexual inmates develop homosexual relationships for the first time in prison. They are often troubled about the long term consequences of sexual behavior with others of the same sex and feel guilt or worry about whether this will affect their mental health. They often leave prison with lack of knowledge, concerns about how to behave, and as victims of many myths. Both inmates and correctional staff need to have access to solid factual information about homosexual behavior.

7. Medication. In all instances psychotropic medication shall be prescribed in accordance with generally accepted pharmacological principles and standards of good practice in the general community, including biochemical monitoring where indicated and evaluation of efficacy in all cases. Periodic revisions should be undertaken to update practices to current standards.*

8. De-toxification. Because de-toxification is not an exclusive mental health function, the de-toxification element for drug and alcohol abuse shall be established on the basis of shared responsibility between the medical and mental health units/professionals. Where independent drug and alcohol abuse treatment resources exist, they should be integrated.

9. In-patient hospitalization for the severely disturbed.

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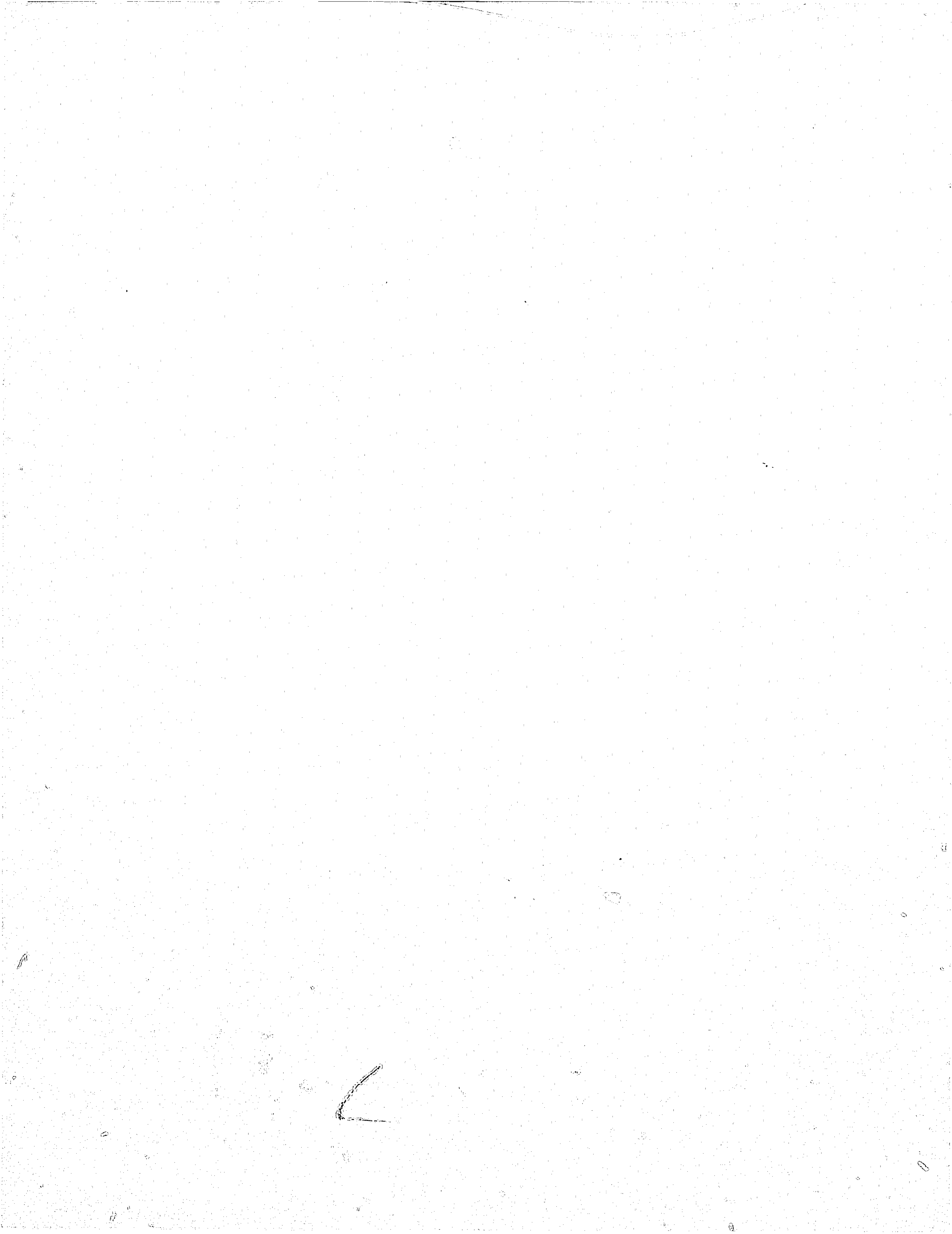
*In all cases, psychotropic medications shall be prescribed only by *legally authorized persons* specifically trained in psycho-pharmacological therapeutics.



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3 OF 12

D. Mental Health of Institution

Principle: Mental health professionals should work toward the enhancement of the mental health of the institution as a whole.

Public Health Rationale: Mental health professionals often possess, by virtue of their training and experience, expertise that can epidemiologically and constructively influence a healthier functioning of the institutional community.

Satisfactory Compliance: Mental health professionals shall, where possible, attempt to:

1. Promote and protect mental health values by consulting with administrators who determine and maintain general policies and procedures;
2. Influence major institutional patterns through formal and informal contact with the prisoner population;
3. Promote and protect mental health values and offer mental health expertise, for example, in communication skills, group interaction dynamics, or crisis intervention skills, to all elements involved in an institutional crisis;
4. Participate in those administrative decision-making boards, non-perfunctory in nature, where participation is related to mental health expertise;
5. Be available to participate as advisors to prisoner and staff organizations;
6. Be available to work with prison or jail personnel in training groups, crisis situations, etc.;
7. Be available to participate in institutional administrative staff meetings;
8. Be available to consult with any other treatment components of the institution;
9. Insure that all institutional staff members are aware of mental health services available and of procedures to refer individuals seeking treatment.

V | Dental Health Care Services

Dental Health Care Services

A. Principles of Care

Principles: Toothaches, the esthetic and functional impairment of broken and missing teeth, the social and psychological consequences of poor oral hygiene and halitosis should be corrected with the consent of the inmate.

Public Health Rationale: The inmates of correctional institutions are predominantly from economically deprived groups where dental problems are common. It thus becomes very important that each inmate be provided with a meaningful dental health program which shall be arranged according to the detention period.

Satisfactory Compliance:

1. Administration.

   The execution of technical skills shall be supported by proper administrative methods in order to maximize the efficiency of a dental program. Whether the

dentist works alone or with dental auxiliaries, the responsibility for an efficiently run program is with the dentist.

The role of dental auxiliaries shall be expanded to permit job enrichment with the state-defined guidelines. They may take complete charge of scheduling patients, keeping records, inventory, ordering and replacing instruments and dental supplies. Auxiliaries who work at the chair beside the dentist shall, with the proper training, perform expanded duties.

2. Responsibilities of the Dentist.

   The dentist shall be responsible for the conduct of the facility and the following are to be given constant attention:

   a. Planning the day-to-day operations of the dental clinic;
   b. Cleanliness and proper functioning of dental equipment, dental instruments, and the storage of dental materials;
   c. Creation and propagation of good public relations between the staff and patients, as well as between the staff and other employees;
   d. Maintenance of professional decorum;
   e. Requisitioning for supplies;
   f. Inventory of dental clinic items;
   g. Compilation of dental records as well as completeness of records.

B. The Dental Health Facility

Principle: Every correctional institution should have as a component of its medical care facilities, a Dental Health Facility.

Public Health Rationale: Oral hygiene is a part of total body hygiene. The correctional authorities shall therefore make available to their inmates dental care which is preventively

oriented and inclusive of instructions in methods and techniques of preventing oral disease.

Satisfactory Compliance:

1. The Dental Facility within the institution shall meet the following:
   a. A dentist shall be present at each clinical session;
   b. A dental hygienist or dental assistant shall be present at all sessions;
   c. The dental assistant shall always be supervised by the dental hygienist or by the dentist;
   d. The following records shall be obtainable in the case of trauma to teeth or bone:
      I. Intra oral and/or extra oral radiographs;
      II. Study models;
      III. Full face and lateral face snapshots.
   e. When these services are not obtainable on the premises they shall be obtained by referral;
   f. Dental counseling and preventive services shall be available on the premises or by referral;
   g. The dental operatory shall:
      I. Have sufficient light, heat, cooling, water and nearby toilet facility;
      II. Afford privacy for patient examination and interview by the dentist or the dental hygienist;
      III. Have available all diagnostic and record keeping equipment and materials such as x-ray machine and developing facilities, alginate or rubber base materials, pulp tester, stone or plaster and camera with suitable lens and flash attachment;
      IV. Provide for a counseling and education area;
      V. Be equipped with desk, chair and dental visual aids materials.

C. Dental Care

1. Dental Assessment

Principle: Each inmate should have a dental assessment on admission to identify acute problems such as toothaches, pain and mouth infection.

Public Health Rationale: A dental assessment is important in the identification of a communicable disease or condition, and for the public record. Only when such a disease or condition which threatens the health of an inmate population is found, can treatment be required.

Satisfactory Compliance:

1. The dental assessment shall be performed by a dentist or a dental hygienist on all resident inmates.
2. The assessment shall include clinical examination, plaque evaluation, charting and a history from which should be derived a treatment plan for correction of dental defects, dental habits and improper dental attitude.
3. The dental assessment shall classify individuals according to the priority of their treatment needs and the time frame into which that individual is detained in terms of length of stay.

See Appendix "A" for suggested priority categories.

2. Correction of Dental Defects

Principle: All correctional institutions should provide for the care of dental emergencies, non-emergency dental conditions and recall, depending on the duration of the inmates stay.

Public Health Rationale: Oral diseases involving the hard and soft tissues are responsible for many social and psychological problems which plague an inmate population.

94-420 O - 77 - 19

Satisfactory Compliance: Services shall include the following:

1. An oral profile which shall include the number of fractured teeth, mobile teeth, erupted and unerupted teeth, the type of dentition, the type of occlusion, any present or past trauma to the maxilla or mandible; the types and location of fillings in the teeth, diastema, condition of frenae, size and shape of the tongue, the color of tissues, presence or absence of tumors and lesions of the soft and hard tissue, speech impediment, and parasthesia.

   The profile of an individual reveals the state of oral health and assesses damage which has been done to the hard and soft tissues of the mouth. The oral profile shall include a tally of the number of decayed teeth, missing teeth, and filled teeth (DMF-T Index) and the state of the gum tissues shall be measured by the Oral Hygiene Index and/or the Peridontal Index. These indices are used to quantify the amount of calculus and food debris present on the teeth.
2. Preventive dentistry shall include plaque evaluation, plaque identification, plaque control, flouride treatment and counseling including information on oral hygiene. The basis for instruction is twofold:
   a. To develop awareness of the importance of good dental health in the interpersonal and social relationships of individuals, and;
   b. To expose inmates to information which will improve their abilities to make decisions concerning treatment for their present and future dental conditions.
3. Treatment and Restoration. The extent of restorative, corrective dentistry or treatment provided by an institution shall be determined by resources available. It shall include as a minimum the restoration of

the dental apparatus to adequate masticatory function. When feasible the use of quadrant dentistry, the use of immediate denture replacement, and oral surgery under optimum aseptic conditions, is the optimum method of operation.

4. Minor oral surgery (routine extraction).
5. Periodontics.
6. General recall and maintenance.

OPTIONAL

7. Crown and Bridge.
8. Prosthodontics.
9. Orthodontics.
10. Major oral surgery (elective oral surgery).

Appendix A

Appendix A

Suggested Priorities

This structuring of priorities for dental care is not a replacement for professional dental judgment, but rather to serve as a guide for providing dental care to a specific population who by virtue of situation and time limitations must receive structured dental care. Dentist and Dental Hygienist should use these categories to identify and treat oral conditions.

CATEGORY I (C-I)

Category I includes inmates with the following symptoms and conditions:

a. An oral condition if left untreated that would cause bleeding and/or pain in the immediate future.
b. An oral infection or oral condition which, if left untreated, would become acutely infectious.
c. An oral condition such as edentulousness or missing upper or lower anterior teeth which presents a psy-

chosocial or physical problem to the inmate's sense of well being, confidence and adjustment.

d. An undiagnosed or suspected oral condition such as an ulcerative lesion or growth of tissue.

CATEGORY II (C-II)

Category II includes inmates with the following symptoms and conditions:

a. The presence of medium to large non-painful carious lesions.
b. A localized gingival involvement.
c. Class II, class III, or class IV fractured anterior tooth or teeth.
d. The presence of temporary, sedative or intermediate restorations.
e. Broken or ill-fitting prosthetic appliance.

CATEGORY III (C-III)

Category III will include inmates with the following symptoms and conditions:

a. Small carious lesions which radiographically present an imminent danger to the pulp.
b. The need for dental restorative procedures with significant laboratory costs involved, such as cast partial dentures.
c. The use or restorative procedures involving the use of precious metals.
d. Severe non-functional bite and mal-occlusion which involves social-psychological factors in the inmate's appearance and his/her potential for adjustment.

CATEGORY IV (C-IV)

Category IV will include inmates with the following symptoms and conditions:

a. Radiographical absence of carious lesions.
b. Lack of clinically visible gingival irritation.

CATEGORY V (C-V)

Category V will include inmates with no symptoms or apparent need for dental treatment related to the type of assessment or inspection performed.

Conditions requiring emergency treatment may include:

1. Bleeding and pain
2. Acute periapical abscess
3. Acute periodontitis
4. Vincents infection
5. Acute gingivitis
6. Acute stomatitis
7. Fractures of teeth
8. Fracture of jaw or jaws
9. Gaping wounds of lip and cheeks

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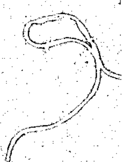

VI. Environmental Health Concerns

Environmental Health Concerns

Introduction

The environmental aspects of correctional institutions are in many respects similar to those of other institutions for which standards have already been established. To draft an entirely new set of standards and explanations for this special group of institutions would be a monumental task and repetitive of much that now exists. Therefore, in order to conserve effort and space, and still do justice to the task, reference will be freely made to the nationally recognized standards, codes, ordinances, regulations and explanations. Emphasis can then be placed on those special aspects of correctional institutions not adequately covered elsewhere.

State and Local Regulations: All designs, construction, operations, and maintenance shall comply with applicable codes, rules and regulations, such as for building construction, fire, safety, plumbing, water supply, wastewater disposal, air pollution control, and food service. Many resources are available

in each of these areas in various departments and agencies of government (including federal), as well as national organizations, and these shall be utilized to identify and help resolve potential and actual deficiencies.

A. Grounds and Structures

1. Location, Accessibility, Service Entrances

Principle: All structures and facilities, such as inmate and staff buildings, power plants, fire stations, water plants, water towers, sewage treatment plants and pumping stations, should be located on stable ground, not subject to excessive noise, vibration or air pollution, nor so as to be subject to effects of slides, fire or explosive hazards. Access roads and service entrances should be safe, convenient and adequate for the purpose and of such design, width and grade to minimize accident, facilitate entrance and exit, and permit ready use and turn-around by the intended vehicles and equipment, including street cleaners, snow plows, fire trucks and service vehicles, without impeding traffic. Consideration should be given to the accessibility and use of water, sewer, gas, electricity, telephone, fire and other community services in the location of buildings and other structures.

Public Health Rationale: Facilities should be located, designed, constructed and maintained so as to minimize the spread of disease, fire damage, uneven settlement, accidents and effects of natural disasters, so that the facilities can function as intended and thereby prevent hazardous conditions or situations.

Satisfactory Compliance: Municipal services and utilities are usually under competent management and regulatory surveillance thereby assuring safe and adequate essential services. In their absence the institution shall provide the service and be properly staffed and equipped to maintain it. Such structures and facilities as are provided shall be located as noted above.

See also References 2, 3, 4.

2. Protection from Flooding and Drainage

Principle: All occupied structures and facilities and those essential to the maintenance of service should be located in well drained areas not subject to flooding or mosquito breeding. Surrounding grounds should be graded to prevent ponding and drained to readily carry away surface waters. Ditches, drains and culverts should be adequate to handle anticipated flows.

Public Health Rationale: Construction of facilities above flood plain levels and on well drained land will reduce risk of flooding and help control spread of vector born diseases and minimize breeding of insect pests. Proper location and drainage will also reduce equipment operational problems associated with periodic flooding or high ground water levels.

Satisfactory Compliance: Structures and facilities shall not be located in areas designated by the Corps of Engineers as flood plains. Areas that collect water shall be drained; culverts and ditches shall be adequate to prevent ponding, backup or flooding.

See also Reference 2.

3. Construction Materials and Maintenance

Principle: Construction materials should be sound, suitable for the intended uses and require minimal maintenance. Materials should comply with the requirements of nationally recognized building construction codes.

Public Health Rationale: The use of fire resistant construction materials and finishes will retard the spread of fire and minimize the formation of toxic substances in case of fire. The provision of suitable surfaces which are readily cleanable and will not retain moisture, will prevent or reduce algal, microbial and fungal growths and will enhance sanitary maintenance.

Satisfactory Compliance: Construction materials meeting the standards and specifications of nationally recognized building

codes as applicable to any institutional building shall be considered acceptable for jails and prisons. Such materials shall retain their fire resistiveness, be suitable for that purpose, and shall be kept in a sound, clean and sanitary condition.

See also References 5, 6, 7, 8, 9.

4. Fire Protection

Principle: Fire fighting and control services should be readily accessible to all structures and facilities. Equipment shall be well maintained, and personnel adequate.

Public Health Rationale: In view of the security requirements of the residential population, the potential for internal disturbances which may result in set fires, and limited exit potentials, it is essential that fire control services be readily accessible and fire prevention techniques and procedures be strictly adhered to.

Satisfactory Compliance: Fire fighting apparatus, facilities and alarms shall be adequate, readily available and meet, as applicable, the "grading Schedule for Municipal Fire Protection" (Insurance Services Office, 160 Water Street, New York, NY 10038, 1974) for Water Supply, Fire Department, Fire Service Communications and Fire Safety Control.

See also References 2, 5.

5. Highway Safety

Principle: Road widths, shoulders, grades, and lines of sight should be adequate for the expected vehicular and pedestrian traffic. Separate lanes should be provided to permit safe egress from or entrance to main highways. Intersections and other natural or man-made hazards shall be properly marked and lighted with adequate advance warnings.

Public Health Rationale: Properly designed roads and clearly identified hazardous conditions will reduce accidents.

Satisfactory Compliance: Road intersections, speed limits and hazardous locations shall be marked and lighted where indicated and comply with state standards.

See References 3, 44.

B. Utilities

1. Water Supply

Principle: The water supply should be of satisfactory sanitary quality, and adequate in quantity to meet the demands, including fire fighting, without significant reduction in water pressure. The water system should be under competent operational control and be protected against backflow of non-potable water and against back-syphonage from any plumbing fixture connection. The water source, treatment process, storage and distribution system, should be under surveillance by the appropriate regulatory agency, and should comply with applicable federal and state standards. Consideration should be given to the use of municipal supply where this is feasible.

Public Health Rationale: Water has been found to be responsible for the transmission of many diseases including hepatitis, amoebic dysentary, and typhoid. Adequate supplies and access to hot and cold water is essential for maintenance of personal hygiene and sanitation.

Satisfactory Compliance: The water quality, quantity, source, treatment, storage, distribution and pressure shall meet federal and state standards, including sampling frequency, operator certification, operation, maintenance, monthly reporting on operation, watershed surveillance, cross-connection control, backflow prevention, and water system sanitary survey evaluation. The system shall be adequate to provide fire protection and shall be approved by the Fire Assurance Association. Drinking fountains shall be of the sanitary angular jet type, if single service drinking cups are not provided. Nonpotable piped water shall not be utilized for drinking.

See also References 1, 11, 12, 13, 18.

2. Wastewater Collection and Disposal

Principle: All sewage and all other liquid wastes should be disposed of in accordance with established state and federal standards. Sewers, pumping stations and treatment facilities should be operated and maintained to prevent surcharge, backup and overflow or bypass of inadequately treated wastewater.

Public Health Rationale: Improper treatment and disposal of wastewater has been linked to the transmission of water borne diseases. Improper disposal of human wastes allows access for humans, animals, flies and other insects incriminated in the transmission of disease.

Satisfactory Compliance: The wastewater treatment, facilities, operation, maintenance, safety, equipment, monthly reporting and effluent quality shall meet federal and state standards. Sewers shall not become surcharged and cause overflow or bypass of the sewer system or treatment works. The potable water supply shall be protected by suitable backflow prevention devices and non-potable piped water shall not be utilized for drinking.

See also References 1, 14, 16, 17.

3. Solid Wastes

Principle: Solid waste storage, collection, disposal, and on-site processing shall not lead to air or water pollution, vermin breeding or attraction, create a fire hazard, produce objectionable odors, or cause a nuisance. Potentially hazardous wastes (such as wastes from infirmary or health service) should receive special handling and disposal.

Public Health Rationale: Proper storage and disposal of solid waste is necessary to minimize the development of odors, to prevent such waste from becoming an attractant and harborage or breeding place for rats, flies and other vermin, and to prevent the soiling of food-preparation and food-service

areas. Improperly handled solid waste creates nuisance conditions, is a fire hazard and makes sanitary housekeeping difficult. Proper disposal of solid wastes is also necessary to prevent air, water and land pollution.

Satisfactory Compliance: All refuse (garbage and rubbish) contaminated with or containing organic matters shall be stored in clean, durable, leakproof, non-absorbent containers, kept tightly covered when not in use, and stored so as to be inaccessible to vermin. Rubbish shall be stored and packaged in an orderly manner. All refuse, containers and processing equipment shall be placed in a well-drained location maintained in a clean and sanitary condition. Collection frequency shall be adequate to prevent odors, fire hazard or other nuisance. Refuse shall be disposed of on-site or off-site in a manner acceptable to the regulatory authority. Hazardous wastes shall be collected, stored, transported and disposed of separately and in a satisfactory manner.

All garbage, and rubbish containing food wastes, shall, prior to disposal, be kept in leak-proof, non-absorbent containers which shall be kept covered with tight-fitting lids when filled or stored, or not in continuous use. Containers used in confinement areas shall be flame retardant. All solid waste shall be stored, collected and disposed of in an approved manner with sufficient frequency as to prevent a nuisance, and in compliance with applicable local and state laws and regulations.

See References 1, 2, 19, 20, 21, 22.

4. Heating and Electricity

Principle: The heating, electricity and air conditioning (central and unit) should be designed to meet the demand load likely to be imposed under the climatic, structural, and operating conditions existing, and with sufficient standby emergency power to maintain essential services.

Public Health Rationale: Properly designed and maintained power systems are necessary to maintain essential services

such as heating, food refrigeration equipment, lighting, elevators, security systems.

Satisfactory Compliance: In general:

1. All heating, electrical and air conditioning equipment shall be approved by Underwriters Laboratory.
2. All electrical wiring shall conform to the Underwriters Electrical Code for materials, installation and workmanship.
3. All electrical equipment shall be grounded.
4. The heating equipment shall be capable of maintaining an indoor temperature of at least 72 degrees (F) when the outdoor temperature is at the average minimum temperature for the coldest month in the area where located.
5. All automatically controlled equipment shall be equipped for manual override.
6. Operators shall be trained in proper maintenance and operation, how to detect malfunctions and how to handle emergency procedures.

See also References 5, 6, 7, 8, 9, 23, 24, 25.

5. Air Quality

Principle: Emissions to the air from facilities and equipment (i.e., power plants, incinerators, institutional operations) should meet federal and state air quality standards.

Public Health Rationale: Air pollution has been shown to cause and aggravate respiratory disease, increase the incidence of respiratory infections, as well as cause nausea, headaches, and eye irritation.

Air pollution generated as a result of the habitation and operations in correctional institutions will be comparable to other installations of similar type, such as housing, hospitals and other institutional facilities, commercial, agricultural and

94-420 O - 77 - 20

manufacturing enterprises. Inmates are exposed to pollutants in the air for a 24-hour-a-day, 7 days-per-week period. This aspect is related to internal ventilation and its design.

Satisfactory Compliance: Prison officials shall contact the local or state air pollution control authority for advice on how to handle their air pollution problems. Their advice shall take into account the legal requirements, the local meteorological and topographical conditions. As for control of the source of air pollution in the correctional institution, federal and state occupational health and safety agencies shall provide assistance.

1. All facilities shall comply with performance standards for emissions of state and federal agencies, including installation and operation permits where applicable. Also, local standards where they apply.
2. All air pollution control equipment shall be used and maintained to obtain maximum efficiency. The air pollution control agency shall be notified when equipment is malfunctioning.
3. Operators shall be trained in proper maintenance and operation, how to detect malfunction, and appropriate emergency measures.
4. For fuel burning and incineration, operators shall be trained in a proper firing technique to prevent air pollution and obtain complete combustion.
5. Where air pollution prevention is based on fuel specifications such as low sulfur content, analyses from qualified laboratories, from samples of fuel as delivered, are required.

6. Emergency Power and Disaster Planning for Utilities and Services

Principle: Alternative sources of power should be readily available and adequate to maintain power to essential serv-

ices and lighting to vital areas. A disaster plan for the continuance of essential services should also be maintained.

Public Health Rationale: Alternative sources of power are necessary in order to prevent accidents, to allow exit from secure areas, and to prevent food spoilage. Emergency power should be available to maintain power to all these essential systems.

Satisfactory Compliance: See federal publications on disaster and emergency planning, also institution emergency plan. Emergency power generators shall be provided to automatically cut in at times of power failure with sufficient capacity to operate electrical locking devices and other electrical equipment, including operation of refrigerators, selected elevators, and medical care equipment, and to provide minimum lighting within the institution and its perimeter.

C. Shelter

1. Temperature Control

Principle: Heating facilities should be provided to keep the occupants warm in cold weather. To prevent heat build up, natural or mechanical ventilation should be provided. Ventilation should be sufficient also to prevent the accumulation of odors, smoke, dust, harmful gases and other contaminants. Construction should provide protection against the elements.

Public Health Rationale: In order to minimize the susceptibility to respiratory and other disease, the maintenance of suitable temperature, given level of physical activity, is essential. Temperatures should be maintained within a physiologically acceptable range, in order to assure comfort.

Satisfactory Compliance: The following 'realistic', though not ecologically conservative, guidelines shall be used for the control of interior environments:

1. Summer comfort zone 66— 75 degrees (F) effective temperature
   optimum 71 degrees (F)
2. Winter comfort zone 63— 71 degrees (F) effective temperature
   optimum 60 degrees (F)

Workers and/or other groups of individuals confined to a specific area shall not be permitted to work, etc. when any of the following combination of conditions exist:

Temperature	Humidity
95°F	55%
96	52
97	49
98	45
99	42
100	38

Temperature control requires consideration of the ambient air temperature, air movement, relative humidity and the radiant temperature.

In hot, dry climates, exterior window shields, shutters or awnings shall be provided to exclude solar radiation. The building design, insulation, and exterior surface and color shall minimize heat absorption. Evaporative coolers are normally required. In hot, humid climates, adequate windows, or exterior wall apertures which can be opened, arranged to produce cross-ventilation, fans and preferably air cooling and dehumidification equipment, shall be provided. An air change of 60 cubic feet per minute per person is suggested with one-third fresh outside air.

See also References 1, 2, 3, 23, 24.

2. Lighting

Principle: Adequate and properly designed, located and controlled natural and artificial illumination should be provided

for all purposes and areas, including walkways, assembly areas, cells, kitchens, work areas, dining areas, recreation areas, and for special uses and facilities.

Public Health Rationale: Adequate lighting will reduce accidents and make possible improved sanitation, the carrying out of visual tasks and other off-duty activities. Also, there is a beneficial psychological effect from sunlight entering rooms at certain times and seasons.

Satisfactory Compliance: The adequacy of lighting is determined by many factors including the tasks to be performed, interior surface finishes and colors, type and spacing of light sources, outside lighting, shadows and glare.

See References 2, 3. Also standards developed by the American Society of Illuminating Engineers and The American Institute of Architects.

3. Space Requirements

Principle: Adequate space should be provided for cells, dormitories, dining rooms, recreation areas, assembly areas, visiting areas, and any other places where inmates sleep, live, work or play.

Public Health Rationale: Adequate space is necessary to reduce stress, carry out certain tasks, provide for privacy where and when indicated, and contribute to comfort and mental health.

Satisfactory Compliance: Sufficient space shall be provided to make use of the room or area as intended without crowding, confusion or conflict. Cells shall be designed for the use of one inmate; dormitories are discouraged as are double deck bunks. Single cells shall provide a minimum of 60 sq. ft., 8 ft. ceiling, and 500 cu. ft. per person, and where dormitories are permitted, a minimum of 75 sq. ft., 10 ft. ceiling, and 600 cu. ft. per person. Day rooms shall provide space equal to at least 50 per cent of the cells and dormitories; dining areas 9 to 12

sq. ft. per inmate; classrooms 25 sq. ft. per inmate; kitchen area 7 to 9 sq. ft. including storage, receiving, dishwashing and toilet facilities; refrigeration 1/4 to 1/2 cu. ft. and freezer .1 to .3 cu. ft. per meal served, plus 1 cu. ft. per 50 to 75 half pints of milk.

See References 1, 3, 4.

4. Fire Safety

Principle: Construction, installation, materials, arrangements, facilities and maintenance should minimize danger of explosions and fires, and their spread. Design, arrangement, and maintenance should facilitate ready transfer of inmates in case of fire or other emergency. A fire plan, including emergency evacuation, should be on file and drills held periodically.

Public Health Rationale: Fires affect the physical, mental, and emotional health of inmates. Non-fatal fire injuries frequently require months, even years of treatment, with consequent strain on the individual and family as well as on public facilities and financing.

Satisfactory Compliance: All construction and finishes shall be fire-resistant and fabrics and drapes fire-retardant treated. Chutes, shafts, stairs, kitchens, boiler rooms, incinerator rooms, paint and carpenter shops shall have fire-resistant enclosures. Passageways, doors and stairs shall be of proper width, marked, kept clear, enclosed, and compartmented as required. Flammable liquids require proper storage. Automatic sprinklers are required in chutes, soiled linen areas, trash and storage rooms and automatic extinguishers in kitchen hoods, shops and storage areas. Fire hydrants, hoses, and standpipes shall be operable and fire extinguisher number, type, location, condition, and recharge data satisfactory. Fire detection systems shall be provided in the boiler room, kitchens, laundry, garage, paint, and carpenter shops and the internal fire alarm system shall be connected to the fire depart-

ment or station. No smoking areas shall be posted and supervised. Fire plans shall be posted and training drills scheduled.

See also References 2, 5.

5. Accident Prevention

Principle: Design, maintenance, and arrangement of facilities, including the surface finishes and lighting, should minimize hazards of falls, slipping and tripping. Protection should be provided against all electrical hazards including shocks and burns. Design, installation and maintenance of fuel-burning and heating equipment should minimize exposure to hazardous or undesirable products of combustion and prevent fires or explosions. Facilities shall be provided for safe and proper storage of drugs, insecticides, flammable liquids, poisons, detergents, and other deleterious substances.

Public Health Rationale: Accidents account for a large number of injuries requiring treatment which may cause temporary or permanent disability with consequent cost to the community. There is also the associated danger of infection and severe after-effects.

Satisfactory Compliance: The same principles of injury prevention that apply to any institution, plant, or home shall apply to a correctional institution. These are noted in the principles stated above. Additional conditions to be observed are handrails on stairs and ramps; potential hazard of door and window swings into passageways and stairs; floor and stair tread construction and finishes to prevent tripping and slipping; safety glass in doors and walls; potential electric shock and fire hazard including grounding; burn protection and improper venting and explosion hazard at fuel burning equipment; storage of hazardous drugs and chemicals under lock and key. OSHA standards where applicable shall be compiled with and a record kept of all accidents.

See also References 1, 2, 43 and Occupational Safety and Health Act Standards.

6. Housekeeping

Principle: All floors, walls, ceilings and equipment in all buildings be constructed of easily cleanable material kept in good repair and sanitary. All inside and outside areas should be kept neat, clean, dry and free from litter.

Public Health Rationale: Soil, wall and floor surfaces and the collection of litter or dirt allow the growth of pathogenic bacteria and provide breeding places for vectors such as insects and rodents, which may transmit disease. A clean environment is conducive to a cheerful outlook and helps promote emotional health.

Satisfactory Compliance: All floors, walls, ceilings, light fixtures, equipment and interior and exterior spaces shall be kept clean and in good repair. In addition, walks and exterior areas shall be free of debris. A coved juncture between interior walls and floors and walks, and exterior areas surfaced with concrete, asphalt, gravel or similar material effectively landscaped will facilitate maintenance, cleanliness and minimize dust. Cleaning equipment, supplies, labeling and facilities including service sinks and floor drains, and storage spaces shall be adequate for the tasks.

7. Noise

Principle: The structures, floors, walls, ceilings, mechanical and other equipment, doors and gates should be designed to minimize unnecessary noise and vibration, especially during rest hours.

Public Health Rationale: Excessive noise causes irritation, mental and emotional strain, distraction and inefficiency to all exposed. Noise of sufficient intensity and duration can cause hearing losses, interfere with speech and contribute to accidents.

Satisfactory Compliance: Where available, the services and advice shall be sought of the governmental agency having the

expertise to evaluate the significance of apparent or alleged noise problems and the corrective action indicated.

See References 1, 2, 3, 43; also Occupational Safety and Health Act.

D. Services and Facilities

1. Food Protection, Processing, Manufacturing, and Storage

Principle: All food should be wholesome, clean, from approved sources, free from adulteration, processed, prepared, transported, stored, and served in a sanitary manner. All food service and food vending, planning, design, equipment, construction, operation and maintenance shall be in compliance with applicable federal, state and local requirements. All planning, design, equipment, construction, operation, and maintenance of all food processing, manufacturing plants and storage facilities, milk plants, slaughtering and meat cutting, and food canneries, should be in compliance with applicable federal, state, and local requirements.

Public Health Rationale: The incidence of food-borne diseases continues to be a problem throughout the country with special problems being created in institutions. The same principles and practices that apply to any food handling establishment should apply to correctional institutions. Many foods are fertile media for the growth of microorganisms. When such foods become contaminated with certain types of pathogenic organisms, they become potential vehicles in the spread of disease. Foods may also become contaminated with poisonous and toxic substances during preparation, storage, display, and service. Such contaminated foods often cause consumers to become ill.

Satisfactory Compliance: See as indicated References 1, 2, 26, 27, 28, 29, 30.

2. Radiation Protection

Principle: No person should operate or permit the operation of a radiation installation nor shall he operate, transfer, receive, possess or use, or permit the operation, transfer, receipt, possession or use of any radiation source unless: a) every effort is made to maintain radiation exposures and releases of radioactive material as far below the limits set forth in health standards as practicable; b) a radiation installation safety officer and radiation protection program are provided satisfactory to the radiological health authority; c) all radiation equipment and other radiation sources under his/her control are operated or handled only by individuals adequately instructed and competent to safely use such radiation equipment or other radiation sources; and d) each individual operating or handling such radiation equipment or other radiation source is provided with safety rules, including any restrictions required for safe operation or handling, and is required to demonstrate familiarity with such safety rules.

Public Health Rationale: Radiation exposure due to medical, dental, commercial, and industrial reasons has been shown to be a significant portion of total radiation dosage. Therefore, the same standards that apply to any radiation source should be applied to correctional institutions.

Satisfactory Compliance: In general:

1. All equipment shall be surveyed and approved by state or local radiological health authorities;
2. All personnel handling radioactive materials shall be certified for that purpose;
3. Operating personnel shall be trained in equipment use and maintenance;
4. The radiation protection program shall be acceptable to the state agency.

See also References 1, 31, 32, 33, 34 as applicable.

3. Vermin Control

Principle: The premises should be free of vermin at all times. An effective program to eliminate the presence of rodents, flies, mosquitoes, bedbugs, roaches, and other vermin should be maintained and premises should be kept in such condition as to prevent the harborage or breeding of vermin.

Public Health Rationale: Insects and rodents are vectors or carriers of communicable diseases. They are often an indicator of filth. When they are controlled, a possible link in the chain of disease transmission is broken. In addition, the presence of insects and rodents may affect the comfort and aesthetic senses with consequent mental anguish and annoyance.

Satisfactory Compliance: The adequacy of vermin control measures can be determined by physical conditions: cleanliness and general sanitation, observation of vermin and signs of their presence. The vermin likely to be encountered are flies, roaches, mosquitoes, cockroaches, bedbugs, rats and mice. The control of these pests shall be indicated by the absence of rodents, insects and other arthropods; the tightness of foundations, walls and ceilings; the screening and fitting of doors and windows, and covering over drains and other openings; the absence of rodent excreta, runways and dead rodents; the absence of insect excreta and characteristic odors on premises, fixtures, beds and bedding; the adequacy of food storage; and the handling of garbage and other refuse. Pesticides shall also be properly stored, handled, selected, used and reserved as a supplement to general sanitation. A qualified pest control officer shall be available and his records shall show evidence of an organized control program.

See also References 1, 35, 36.

4. Laundry Facilities

Principle: Adequate facilities or services for the processing, handling, storage and transportation of soiled linen and clothing and clean linen and clothing should be provided.

Public Health Rationale: Clean clothing, linens and bedding are essential to minimize the presence of pathogenic organisms and to reduce the spread of disease and parasites.

Satisfactory Compliance: There shall be an adequate supply of linen, handled and stored in such a way as to minimize contamination from surface contact or air-borne deposition.

Soiled linen shall be collected in such a manner as to avoid microbial dissemination into the environment. It shall be placed into bags or containers at the site of collection. It is important that separate containers be used for transporting clean and soiled linen. Also, laundering facilities, when located in the institution, shall be separated from the clean linen processing area, from occupied rooms, from areas of food preparation and storage, and from areas in which clean material and equipment are stored.

The laundry area shall be planned, equipped and ventilated so as to prevent the dissemination of contaminants. Soiled linen from isolation areas shall be identified and suitable precautions shall be taken in its subsequent processing. Institutions using commercial linen processing must require that the company providing the service maintain at least the standard outlined herein. Further, the company must ensure that clean linen is completely packaged and is protected from contamination upon delivery to the premises.

See also Reference 1.

5. Plumbing

Principle: Water, soil and waste lines, and plumbing fixture materials, design, installation and operation, including cross-connection and backflow control, should be in conformance with nationally accepted standards. Drinking fountains with diagonal jets, or single service drinking cups, shall be provided in each cell and in assembly areas.

Public Health Rationale: In order that the plumbing may be adequate, prevent back-syphonage and cross-connection and the resulting contamination of water with non-potable water or sewage, it is important that the proper plumbing codes and regulations be followed. To reduce transmission of communicable diseases, no common drinking utensils should be used, nor any drinking utensils made available which cannot be appropriately sanitized after every use.

Satisfactory Compliance: Water, soil, waste and drain lines and fixtures shall be of acceptable materials and installed in conformance with nationally recognized codes. Hot and cold water suppliers shall be adequate in quantity and pressure with approved type backflow prevention devices where needed. There shall be no cross-connections with non-potable lines. All plumbing, including fixtures and connections, shall be properly operating and maintained.

See also References 1, 37, 38, 39, 40.

6. Recreational Facilities

Principle: Safe, sanitary, adequate and suitable indoor and outdoor recreation space, facilities and programs should be provided for inmates and staff adapted to the prevailing weather conditions.

Public Health Rationale: Recreation facilities coupled with a moderate exercise program and leisure time activities are conducive to improved physical and mental health.

Satisfactory Compliance: Outdoor recreation areas shall be level, except for drainage needs, and maintained so as to be well drained. Indoor areas shall include day rooms providing a minimum of 30 square feet per inmate having access to the day room and preferably 35 square feet. The recreation areas shall have ready access to showers, toilet and lavatory facilities, and sanitary drinking fountains or single service drink-

ing cups. Where a bathing beach or swimming pool is made available, it shall comply with the state health department rules and regulations. All facilities shall be safe and maintained in a clean and sanitary condition.

See References 10, 15, 43.

7. Institutional Operations

Principle: All prison and jail industries, institutional maintenance, and manufacturing should be in compliance with federal and state standards normally applicable to the same types of private sector operations.

Public Health Rationale: Safe, sanitary and healthful working conditions, processes and procedures are essential to prevent injury, illness, disability and deaths associated with the individual, manufacturing operations and work sites.

Satisfactory Compliance: Canning, dairy, milk and food processing and ice making shall comply with FDA standards; meat and slaughter house operations with USDA standards; hospital operations with DHEW standards; manufacturing and all operations with OSHA standards.

See "A Bookshelf of Occupational Health and Safety," Carnow, B. W., *et al. American J. Public Health May 1975*, Vol. 65, No. 5.
Also References 1, 11, 12, 17, 18, 19, 20, 21, 22, 26, 27, 28, 29, 30 as applicable.

8. Facilities Available to the Public

Principle: Facilities for the public should include an adequate waiting room, toilet facilities, a sanitary drinking fountain and a public telephone booth.

Public Health Rationale: Adequate toilet facilities and drinking fountains conveniently located are necessary for reasons of personal health and hygiene and to minimize the spread of disease.

Satisfactory Compliance: Toilet facilities shall be within 100 feet of public areas served and the number of plumbing fixtures provided for each sex shall be based on the maximum number of visitors accommodated at any one time as follows:

No. of Visitors	No. of Water Closets	No. of Lavatories
1–15	1	1
16–35	2	2
36–55	3	3
56–80	4	4

In addition, a sanitary drinking fountain shall be provided for each 75 persons and a slop sink shall be available on each floor for cleaning. Urinals may be substituted for up to 2/3 of the water closets for men. Water closets shall be in separate compartments. Construction and appurtenances shall meet plumbing code requirements.

See References Section D. 5 Plumbing.
See also References 37, 38, 40.

9. Medical Care Facility

Principle: Adequate facilities and personnel should be provided for the care of inmates and arrangements made for their treatment and care.

Public Health Rationale: Adequate facilities and personnel for medical care will make possible prompt treatment of illness and disease thereby reducing secondary infections, prolonged treatment, serious disability and possibly death.

Satisfactory Compliance: In addition to the basic sanitary facilities, services and practices discussed elsewhere in the text, hospital infirmary and other medical care facilities shall comply with the following:

1. Adequate medical care areas: examining, patient and isolation rooms; bath and toilets; nursing and service areas; central and general storage.

2. Proper storage of drugs and biologicals shall be dispensed by a responsible person, stored under lock and key, inventory maintained.
3. Adequate disinfection and sterilization facilities; infection control committee; sterilization facilities, procedures, supervision, records available, disinfection of anesthesia and inhalation apparatus, also surgery and isolation.
4. Refrigeration shall be provided for pharmaceuticals and blood storage; morgue.

See also *Environmental Health Aspects of Hospitals*, Vol. I-IV, USDHEW, Washington, DC; Bond, Richard G., *et al; Environmental Health and Safety in Health Care Facilities*, University of Minnesota; and appropriate Medicare standards.

E. Personal Hygiene

1. Personal Hygiene

Principle: All practical measures should be provided to control communicable diseases including ringworm and pediculosis. Adequate supplies and facilities for personal hygiene and grooming should be provided.

Public Health Rationale: Ringworm of the scalp, body, nails or foot is communicable to others, may cause baldness, lesion on various parts of the body including hands and feet, and secondary infections. Supplies and facilities for personal hygiene and grooming promote cleanliness and minimize possibilities for infection and illness. Pediculosis (lousiness) may involve the scalp, hairy parts of the body or clothing; it is communicable and may also lead to secondary infections.

Satisfactory Compliance: Follow control measures given in *Control of Communicable Diseases in Man* (APHA, 1975). Clean towels should be issued to each inmate and at least twice per week thereafter. Each inmate shall be provided with toothpaste/powder and a toothbrush, shaving equip-

ment* and supplies. If an inmate does not have adequate clothing of his own, he shall be provided suitable clothing. Washable clothing shall be laundered at least once per week. Facilities for the storage of personal belongings shall be provided, including clothing and towels. There shall be no signs of infestations and facilities shall be available for the disinfections of bedding and clothing.

2. Bedding

Principle: Each inmate should be provided with clean bedding including linen, except where in the opinion of the institutional officer it may present a hazard to the inmate. Bedding shall include a prison-type mattress and pillow, a blanket and a sheet or a mattress cover.

Public Health Rationale: Adequate clean bedding provides for comfort and well being and minimizes acquisition or aggravation of illness or infection.

Satisfactory Compliance: The facilities provided shall include:

1. Individual flush toilet or equivalent and lavatory for each cell.
2. If dormitories are used, flush toilets and lavatories in the ratio of 1 to 8 inmates.
3. Shower facilities in the ratio of 1 to 15 inmates, also soap and individual towels.
4. Tempered water (110 degrees F) connection for showers.
5. Adequate supply of toilet paper for toilets.
6. Metal mirror at each lavatory.
7. Sanitary type drinking fountain or single service drinking cups for each cell and cell block floor.
8. Service sink for each cell block floor.

*Except where this may present a hazard to the inmate.

94-420 O - 77 - 21

All facilities shall be clean and in good repair. For dormitories, urinals may be substituted for up to 2/3 of the water closets for men.

3. Barber and Beauty Shops

Principle: Barber and beauty shops should be properly designed and operated and maintained in a sanitary manner.

Public Health Rationale: Skin diseases (i.e., ringworm, pustular inflammation of the beard, and other staphylococcus infection), favus, impetigo, and pediculosis (head lice) may be transmitted either through direct contact or by fomites, in towels, combs, clippers or razors. If a towel has been used on an infected person, its re-use may transmit the disease. Instruments such as combs, clippers, and razors, if used successively on patrons without proper cleaning and disinfection, provide a likely opportunity for the spreading of skin infections.

Satisfactory Compliance: Barbering shall be done in a separate location, designed and equipped for that purpose, which is maintained in a clean and sanitary condition. Construction, light, heat, plumbing, hot and cold water, ventilation, space, fixtures and toilet facilities shall be given bactericidal and fungicidal treatment after each patron use. Employees shall be free of communicable disease. Patrons whose face, neck or scalp is inflamed, contains pus or is erupted; or who are infested with head lice, shall not be served and instead referred to the dispensary. Employees shall have clean attire, wash hands with soap and running water before each patron; use individual sanitary neck strips and towels and use hygienic practices. Common dusters, brushes, or mugs shall not be permitted. The same principles and practices shall apply to beauty parlors.

See also Reference 42, Army Regulations 40-5, and State Health Department Regulations.

F. Inspection, Personnel and Supervision

Every institution shall designate a qualified individual and adequate staff with supporting services to be directly responsible for all environmental sanitation. Every institution shall be inspected at least every two years by the health authorities and reports of such inspections shall be made to the responsible individual, agency and/or board.

1. Inservice Training

Principle: Institutional staff and inmates responsible for environmental sanitation should be given training appropriate to the inspection duties, monitoring, or supervisory roles to which they are assigned.

Public Health Rationale: Defects or deficiencies in the physical environment can result in hazardous situations that may be responsible for illness or injury of the inmates and staff. In addition to those environmental risks typical of institutional living generally, correctional institutions have certain conditions that accentuate such risks, or may present hazards unique to this category of institution.

Satisfactory Compliance: Training that is comparable to that provided for supervisors and employees of community facilities shall be provided for the institutional personnel.

Training shall be planned by, and if possible provided by, the staff of the appropriate government agency, such as the Health Department, in the same manner as such training would be provided in the community in which the institution is located.

2. Self-inspection

Principle: Correctional institutions should, in addition to the formal inspections and consultations by professionally trained staff of state and local regulatory agencies, have frequent, even daily, inspections made by a qualified staff member of the institution.

Public Health Rationale: Since much of the risk resulting from unsanitary or unsafe environmental conditions is the consequence of human factors, neglect, carelessness, ignorance, and frequent oversight, it is essential to provide maximum surveillance of critical operations and activities. Self-inspection helps to develop an approach to prevention of health risks versus one of cure and correction. Self-inspection is especially important to assure uniformly acceptable living and working conditions in the institution.

Satisfactory Compliance: Self-inspection and compliance with all the provisions of the sections in this report shall accomplish the objectives of this section. However, a broadly competent person directly responsible to the institution administrator is necessary to identify the needs and assure the remedial action required to obtain a healthful and safe institutional environment.

3. Regulatory Agencies

Principle: Regulatory agencies should be invited to make a minimum of biannual inspections and reports to the responsible institution administrator, agency and boards or commission on the health and environment engineering and sanitation aspects of the institution.

Public Health Rationale: Environmental health engineering and sanitation inspections and recommendations, when followed, can minimize the incidence of preventable illness and death due to a breakdown in sanitary safeguards.

Satisfactory Compliance: This is achieved when a minimum of semi-annual and preferably annual inspections are made by the agencies having similar responsibilities to the public. The inspections shall be carried out without hindrance and reports and recommendations made to the responsible institution administrator, agency and board or commission. The regulatory inspection shall cover the areas in this report and include specifically the housing, water supply, wastewater

treatment and disposal, air pollution control, solid waste collection, processing and disposal, food service, radiation surveillance, fire protection, electrical hazards, safety, medical care facilities, and general environmental sanitation.

G. Construction Planning and Design of Facilities

Principle: Plans and specifications for any new construction or remodeling should be prepared by a registered architect or engineer and should be in accordance with applicable building codes, laws, rules and regulations and should be approved by the appropriate federal, state and local agencies prior to advertising for bids and prior to construction. Plans and specifications shall consider the environmental impact of proposed structures, locations, facilities, service and their uses and undesirable effects shall be minimized as required.

Public Health Rationale: The preparation and review of construction plans are next in importance to site selection in determining a healthful institutional environment. Careful work at this state will prevent many unfavorable situations from developing. Wise administrators will carefully and properly plan an institutional environment to avoid costly alterations after the building has been erected.

Satisfactory Compliance: Plans and specifications shall consider the environmental aspects of structure and facility location, including geographic and climatic conditions, accessibility and use; availability of municipal services, and include details concerning water supply, sewage and other wastewater collection treatment and disposal; solid waste storage, collection, processing and disposal; power source; air pollution control; drainage and flood control; food service; laundry; housing and space requirements; construction materials and maintenance, and other aspects covered by this report. Governmental agencies, local, state and federal, that may have a role

in the review of the project or in providing a community service shall be involved early in the planning.

Qualified environmental health staff shall review and evaluate plans for the construction of proposed correctional institutions as well as additions to and rehabilitation of old facilities, and necessary approval obtained from regulatory agencies having the particular expertise or jurisdiction. Assistance shall be provided by the agencies for the site selection and construction in the course of and subsequent to inspection. Guidance shall also be provided and encouragement given in the correction of environmental deficiencies.

See also References 2, 3, 43, and references under Satisfactory Compliance for applicable sections.

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(See also state and local regulations and recommendations)

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VII. Nutrition And Food Services

Nutrition And Food Services

State and Local Regulations: All standards for nutrition and food service shall comply with rules and regulations, where applicable, such as for nutritional standards, food service facilities and sanitary and safe food service procedures.

A. Nutrition

1. Nutritional Standards

Principle: Food supplies in correctional institutions should meet an individual's nutritional needs.

Public Health Rationale: Adequate nutrition is necessary for good general health. Since inmates are predominantly from economically deprived groups and groups characterized by an irregular life style, among whom malnutrition may exist, adequate nutrition within confinement is very important. Malnutrition may take the form of underweight, anemia, obesity, hypercholesteremia, or any of numerous deficiency states. Among adolescents, in particular, caloric and nutrient

deficiencies may exist. It is essential that malnutrition be detected and carefully corrected during the detention period. Instruction in general nutrition can be appropriate under these circumstances and may prevent any future malnutrition.

Satisfactory Compliance: All prison fare shall be nutritionally adequate. Special diets shall be provided for those in need of diet therapy. The "Recommended Dietary Allowances of the Food and Nutrition Board" as set forth by the National Academy of Sciences of the National Research Council in the latest edition shall be adhered to. Whether the food is prepared on the premises or brought in from outside the institution, it shall meet the basic requirements as set forth in these standards.

2. Provision of Adequate Nutrition

Principle: Menus should contain a ration which includes the "Basic Four Food Groups." Selections are to be made from these groups to supply a nutritionally adequate diet.

Public Health Rationale: The individual nutritional needs of persons should be met through the furnishing of food in accordance with established menu planning concepts. So that food will be eaten, it should be of sufficient quantity, appetizing, palatable, well prepared and wholesome.

Satisfactory Compliance: Menus shall be planned at least one month in advance. Caloric needs of the individual shall be met and increased nutrients for special groups such as youth and pregnant women shall be supplied by the addition of certain foods. Arrangements shall be made for inmates requiring modified diets, for either medical or religious reasons.

B. Dietary Consultation and Management

Principle: The services of a qualified registered dietitian should be available for consultation and approval of the food service procedures.

Public Health Rationale: In order to assure that nutritional standards are met, a registered dietitian should be available to advise and to monitor compliance with the established standards.

Satisfactory Compliance: In an institution where size does not warrant the employment of a registered dietitian and where food is prepared on the premises, management of the food service shall be under the direction of a competent cook-manager who can supervise food preparation and service in its entirety.

In those institutions where a registered dietician is not employed full time, consultation shall occur at least on a monthly basis.

C. Food Preparation and Service

Principle: Food preparation should be carried out using approved methods and procedures.

Public Health Rationale: The preparation and service of food should be such that those for whom it is intended will eat it. Eating is an important part of the activity of a captive residential group and should be a positive aspect in their daily routine.

Satisfactory Compliance:

1. Tested quantity recipes shall be available for all menu items and shall be adhered to. This ensures portion control, good food products and prevents waste.
2. Food shall be well seasoned, served at the proper temperature and in an attractive manner.
3. The cook shall taste all food before it is served for acceptability for flavor, texture and temperature.
4. Utensils such as cutlery, plates, cups, glasses, etc. should be such that the food may be attractively served.

94-420 O - 77 - 22

5. All utensils shall be washed in such a manner as to provide proper sanitation.

D. Sanitary and Safe Food Service

Principle: Sanitary and safe food handling should be practiced at all times.

Public Health Rationale: To ensure that there is no spread of infectious diseases to those eating the food or to those who' prepare it, sanitary and safe food handling is essential.

Satisfactory Compliance:

1. Training in sanitary and safe food handling practices shall be carried on continuously.
2. Clean uniforms shall be worn at all times.
3. All areas and equipment for food preparation, storage and service shall be kept immaculate.

E. Facilities

1. Food Service Area

Principle: An adequate food service area shall be provided where on-premise food preparation is done.

Public Health Rationale: In order to effect as efficient and economical food preparation as possible it is essential to have adequate facilities to meet the needs of the individual institution.

Satisfactory Compliance: The area shall be adequate to provide for the number of people to be served. It shall be equipped in accordance with basic practices in food preparation and safety.

2. Food Storage

Principle: Adequate facilities shall be available to provide for storage of all perishable foods.

Public Health Rationale: Food storage areas shall be such as to ensure proper preservation of all foods in order to prevent food wastage and spread of food borne diseases.

Satisfactory Compliance: Dry storage and refrigeration facilities of proper temperature, ventilation and cleanliness shall be available for storage of all non-perishable foods.

3. Dining Area

Principle: Dining shall be as comfortable and relaxed an experience as possible to insure proper digestion as well as to maximize enjoyment of food.

Public Health Rationale: The atmosphere in which food is served shall be such that it is conducive to making the time of eating a positive experience.

Satisfactory Compliance: A dining room of adequate size to meet the needs of the number of people to be served shall be provided. It shall be well lighted and ventilated and kept immaculate.

VIII. | Pharmacy Services

Pharmacy Services

Principle: Comprehensive health services require the availability of pharmacy services.

Public Health Rationale: Pharmaceuticals are an integral part of the regimen in the diagnosis, prevention and management of many health problems.

Satisfactory Compliance:

1. Each correctional institution shall designate a secure area for the storage of all medications.
2. In those facilities in which an actual pharmacy exists it shall be physically separate from other activities.
3. Every institution shall have access to the professional services of a pharmacist who will provide the regular and general supervision of pharmacy activities. The pharmacist will approve all pharmacy activities. The pharmacist will approve all pharmacy related proce-

dures and shall provide monitoring of drug therapy and the overall pharmacy program.

4. Non-prescription (over-the-counter) medications may be made available in the correctional institution at places other than the health services facility such as the institution commissary, after consultation with the health staff. Specific written rules governing the dispensing of these medications shall be available.
5. All other medication shall be administered only by adequately trained health services personnel. The administration of each dose of medication shall be appropriately documented in an acceptable fashion for inclusion in the medical record. Medications not administered shall be accounted for and returned to the pharmacy daily.

   Where size of the facility does not warrant sufficient health services staffing for administration of all medication, such administration may be carried out by adequately trained non-health personnel by sealed single doses, packaged, delivered daily, adequately identified and labeled with directions.
6. When available, liquid forms of medications shall be utilized.
7. Prescription of medication shall be done only by adequately trained, legally authorized health personnel.
8. Medication shall be prescribed only after an evaluation which should include history, physical exam and diagnosis.
9. Medications that alter mood or behavior, or that present a significant danger of toxicity or that may otherwise be subject to abuse by the inmate population, shall be administered under well controlled conditions. These medications shall be prescribed only by persons involved in a genuine professional-patient relationship for bonafide medical reasons.

IX. Health Records

Health Records

Principle: An accurate and complete health record is an essential instrument for delivery of health services.

Public Health Rationale: The health record enables larger numbers of the health team to document health encounters and events. It also enables them to communicate with each other information about the inmate in whose care they are participating. It permits continuity of care when inmates are transferred to new areas or institutions.

Satisfactory Compliance:

1. A health record shall be kept on all inmates;
2. The health record shall accompany the inmate whenever he/she is transferred to another institution or treated in a specialized area;
3. The health record shall be complete, current and accurately reflect the health status and problems of the inmate;

4. The health record shall be treated as a confidential document and shall not be released to anyone who is not a member of the health staff, or who has not been legally authorized to receive it;
5. The health record shall be kept as a unit and not fragmented by the separate health departments; medical, dental and mental health entries shall be made into the same record;
6. Each correctional system shall standardize the format of the health record in a manner that facilitates the communication between the members of the health staff*. The health record shall be organized in a manner such that review and quality of care can be easily audited.

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*Note: It is recommended that the health record be organized along the general concepts of the Problem Oriented Medical Record as developed by L. L. Weed. This system organized the health record into 4 basic elements:

1. **Data Base:** This is health information about the inmate and includes, but is not limited to, history, physical examination and laboratory studies.
2. **Problem List:** This is a numbered list of problems containing the patient's health problems, both past and present. New problems are added as identified.
3. **Plan:** This is the proposed course of action relating to diagnostic, therapeutic and health education activities for identifying health problems.
4. **Progress Notes:**

a. *Narrative Notes:* Are related directly to the list of problems and are numbered and titled accordingly. The format for each progress note includes:

- subjective complaints of the patient;
- objective findings of the provider;
- assessment of the problem; and
- plans for continuing diagnostic, therapeutic and health education activity centering on the problem.

b. *Flow Sheets:* Contain all moving parameters on all problems where data and time relationships are complex.

X. Evaluation Of Health Services

Evaluation of Health Services

Principle: Health care facilities and their individual unit programs should be audited and reviewed for evaluation and corrective action programs.

Public Health Rationale: Optimal health care services require ongoing assessment of individual programs, professional performance, resource development, financing for captial and operating budgets, etc.

Satisfactory Compliance:

1. Each correctional institution shall provide for both independent and internal audits of health care services and programs. These audits shall be regular, systematic, documented and made available to consumers, providers and those established as responsible authorities.

   Among the mechanisms that may be utilized in this connection are

a. Selective reviews of random records by a committee of the staff in large institutions;
b. Setting up with several institutions joint review committees who perform the same functions;
c. Requesting nearby medical schools to provide auditing teams;
d. Inviting PSRO organizations to participate in the review, as well as health departments, and other organizations;
e. Asking their local medical society and/or local hospital to provide individual members of a committee staffed by the institution to do such reviews on a monthly, quarterly or annual basis.

2. Consistent, ongoing, internal evaluation shall be a part of administrative and health staff activity, including both peer review and utilization review.

XI. Staffing

Staffing

Principle: Health staff should be in sufficient numbers, of sufficient diversity, and of sufficient training and expertise to deliver responsibly the services outlined in these standards.

Public Health Rationale: No program can be meaningfully implemented without qualified staff in sufficient numbers.

Satisfactory Compliance:

1. The health staff shall be of such a size* as to be able to afford to any prisoner in the institution who needs it, quality health care that meets these standards. This is meant to include not only staff for direct treat-

*Note: Absolute numbers are not the only indicators to be used in determining the number of health personnel required. Smaller institutions with high turnover rates, which admit alcoholics, addicts and other populations with greater risks, frequently need far more self-staffing coverage than larger institutions with more health and stable populations.

ment service, but also consultative, training, advisory, administrative and evaluative personnel.

2. The qualifications of all providers—dentists, hygienists, nutritionists, dieticians, nurses, physicians' assistants, nurse practitioners and medical-technical assistants and physicians—shall be on file.
   a. All providers shall be licensed or certified in their speciality and be qualified to practice.
   b. The working schedule of all medical providers shall be available.

Glossary

Glossary

The following terms are here defined in order to avoid any confusion that may arise between common usage and the intended meaning within these standards.

NOUNS:

Correctional institutions—

This term is used herein interchangeably with the term "jails and prisons" and is meant to include institutions of incarceration, both sentenced and detention facilities, although traditionally the use of this term has been restricted to sentenced institutions.

Incarcerated

This term refers to both those persons held in a detention as well as sentenced status.

Inmate(s)

This term refers to both male and female persons, sentenced and detained in a "correctional institution".

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VERBS:

May

This term is meant to reflect an acceptable compliance though not necessarily preferred.

Shall

This term indicates an imperative or mandatory statement, the only acceptable compliance.

Should

This term, though not mandatory, is meant to be interpreted to be in compliance with the norm acceptable to the community standards.

Index

Index

Abortion services 22
Accident prevention 64
Air conditioning 57, 61
Air pollution 52
Air quality 58
Alcohol 5
  abuse 32
  detoxification 32
Ambulatory care services 9
American Institute of Architects 62
American Red Cross First Aid
  course 12
American Society of Illuminating
  Engineers 62
Appendix A 45
Audits, of health services 107

Barber shop 75
Barbiturates 5
Beauty shops 75
Bedbugs 68
Bedding 74
Breast examination 8, 14, 23

Cockroaches 68
Communicable disease 5, 40
Correctional institutions, defined . . . 115

Contraceptives 8, 22
Control of Communicable Diseases in
  Man 73
Construction 53
Construction planning 78
Consultation services, specialty . 10

Dehumidification 61
Dental auxiliaries 38
Dental health care services 37
  assessment 40
  communicable disease 40
  dental defects, correction of . 40
  fluoride treatments 41
Department of Health, Education, and
  Welfare 71
Diet
  consultation 92
  management 92
  and pregnancy 8, 92
  special 92
Dietitian 92
Dining area 95
Disaster planning 59
Discharge summary 11
DMF-T Index 41
Drinking fountains 55, 69

Drugs 5
abuse 32
detoxification 32
storage 73

Electricity 57
Emergency power 59
Emergency services 12
Environmental health 51
Evaluation of health services
staff committee 108
joint review committee 108
medical school audit teams .. 108
PSRO Organizations 108
Exercise Program 70

Family planning services . 14, 21, 22
Favus 75
Feminine hygiene 22
Fire Assurance Association 55
Fire 13, 54, 63
First Aid 12
Flooding 53
Flies 68
Follow-up services 11
Food
facilities 94
manufacturing 66
preparation 93
processing 66
protection 66
service 91, 93, 94
storage 66, 68, 94
Food and Drug Administration . 71

Garbage 57, 68
Glossary 113
Gynecology and obstetrics ... 7, 21

Health education 13, 21
Health records 103
Health services
evaluation of 107
primary 3
women 21
Heating 57
Highway safety 54
Homosexuality 32
Hospital infirmary 72
Housekeeping 65

Hygiene
personal 73
Hypercholesteremia 91

Impetigo 75
Incarcerated, defined 115
Inmate, defined 115
Inspection 76
Insects 53, 68
Institutional operations 71

Jaundice 5
Joint Commission of Hospital
Accreditation 17

Laundry facilities 68
Lighting 61

Maintenance 53
Malnutrition 91
Medical care facilities 72
Medical entrance examination
general population 3
women 7
Medical records 4
Menstrual cycle 8, 22
Mental health
of institution 33
Mental health care professionals 28
Mental health services 21, 27
confidentiality 30
screening 6
treatment 31
Mosquitoes 68

Noise 65
Noise pollution 52
Nutrition
health education 13
standards 91

Obesity 91
Occupational Safety and Health
Administration 64, 71
Opiates 5
Oral Hygiene Index 41
Over-the-counter medications . 100

Papanicolaou tests (pap smears) 8, 23
Pediculosis (lousiness) 5, 73, 75
Pelvic examination 8

Peridontal Index 41
Personnel 76
Pharmacy services 99
Plumbing 69, 72
Pollution
air 52
noise 52
Pregnancy 8, 22, 222
Prenatal care 22
Problem Oriented Medical
Records 104
PSRO organizations 108
Psychotropic medication 32
Public facilities 71

Qualifications, of staff 112

Radiation protection 67
Recreational facilities 70
Refuse 57
Regulatory agencies 77
Respiratory rate 5
Ringworm 73, 75
Rodents 68

Secondary care services 17
Sedatives 5
Services and facilities 66

Sex 32
Shelter 60
Solid wastes 56
Space requirements
and mental health 62
Staffing 109
Suicide 31

Temperature control 60
Therapy
group 31
individual 31
short-term 31
long-term 32
Tuberculosis skin test 6

Underwriters Electrical Code ... 58
United States Department of
Agriculture 71
Utilities 55

Venereal disease 8, 14
screening 23
Vermin Control 68

Wastewater
collection 56
disposal 56
Water supply 55

[Exhibit 11]

Food Protection in Jails and Prisons

Abstract

In recent years substantial attention has been given environmental health and food protection in jails and prisons in the United States. As a result several commissions and task forces, as well as the courts, have studied conditions in the correctional setting which are hazardous to the health and well-being of the inmates. This report, based on an investigation of 100 selected jails and prisons, summarizes the findings on food service operations and its role in penal and correctional institutions.

(By Bailus Walker, Jr. and Theodore Gordon, Environmental Health Administration, Government of the District of Columbia, Washington, D.C.)

During the past decade substandard environmental conditions and inadequate health care in penal and correctional systems have been found by the courts to constitute a cruel and unusual punishment in violation of the Constitution of the United States. In its 1971–72 term the U.S. Supreme Court decided eight cases directly affecting offenders' rights and in each case the contentions of the offenders prevailed. More recently in its 1976–77 term the highest court ruled that deliberate indifference by prison officials to serious medical needs of an inmate violates the Eighth Amendment's ban against cruel and unusual punishment and gives the inmate grounds to sue the officials in Federal court.

In addition to the judicial system, several governmental and quasi-governmental organizations have been concerned about environmental health services in jails and prisons. Notably, the United States Department of Justice and the National Prison Project separately requested the assistance of the authors in the identification and evaluation of environmental health issues existing within the penal and correctional system. This identification and evaluation required visits to 100 preselected institutions throughout the United States, Puerto Rico and the Virgin Islands in which the Department of Justice and the National Prison Project had reasons to believe that environmental conditions were less than adequate. These visits were made between 1974 and 1976.

It is the purpose of this report to describe only one of the several environmental health issues which were investigated—food service and its ramifications.

The correctional system

In order to summarize intelligently the findings of the investigation, certain dimensions of the correctional system of the United States must be reviewed.

Institutionalization as a primary means of enforcing customs, mores or laws of a people is a relatively modern practice. In earlier times restitution, exile and a variety of methods of corporal and capital punishment, many of them unspeakably barbarous, were used. Confinement was used only for detention.

Today the backbone of the nation's correctional system is composed of 36 federal prisons, 11 federal community treatment centers, 600 administratively separate correctional facilities operated by state governments and 3,921 jails operated by local units of government.

State-operated institutions probably embody most of the ideals and characteristics of the early attempts to reform offenders. It is in these facilities that most intensive correctional or rehabilitative efforts are conducted. Here inmates are exposed to a variety of programs intended to help them become productive members of society. But the predominant consideration is still that of security. About half of all state correctional facilities in the United States are located in the South, with the remaining institutions about equally distributed among the other three regions of the country. North Carolina has the largest number (76), followed by Florida (46), Virginia (38) and California (35).

Operating expenses of jails and prisons for the latest fiscal year (1975) range from less than $50,000 to more than $3 million. Expenditures made by each institution are a function not only of its type and size, but also of such factors as the proportion of inmates in each confinement status, the amount of labor contributed by inmates toward operating expenses and maintaining the facility, the existence of a prison industry, the scope of rehabilitative programs, and the extent to which volunteers perform certain functions.

For the most part jails are not places of final deposition. Approximately 2.5 to 5.5 million jail commitments occur in this country annually. The obvious result is a highly transient jail population. However, pretrial detention can stretch into years through legal maneuvering by law enforcement officials. Local control, multiple functions and a transient heterogeneous population have shaped the major organizational characteristics of jails. Typically, they are under the jurisdiction of the county government and they retain the dual purposes of custodial confinement and misdemeanant punishment. The most conspicuous addition to the jails' functions have been services to the homeless and to alcoholics. Thus jails are, in a sense, one of the catchalls for social and law enforcement problems in a community.

In summary, both jails and prisons are communities within themselves. Their "metabolic" requirements include complex mechanical services, heating and ventilation systems, domestic water supply, sewage disposal facilities, industry and labor programs, recreational services and food service operations. All of which must be managed in such a way as to effectively meet at least four basic human needs: (1) fundamental physiological needs; (2) fundamental psychological needs; (3) protection against contagion; and (4) protection against accidents. These needs are common to all human populations and they cut across boundaries and definitions of social behavior, socioecenomic status, criminals and non-criminals. Accordingly, persons confined in penal and correctional institutions are just as susceptible to environmentally-induced diseases and disabilities, including the hazards of food infection and food intoxication, as are law abiding citizens in other institutional settings.

The pattern of food service varies among the nation's correctional institutions. In all state operated prisons food is prepared and served within the institution. However, in 70 percent (2,753) of all jails, meals served to inmates are prepared in the jail, whereas in 1,135 other jails the meals are prepared elsewhere and brought into the institution. In small jails (less than 10 inmates) it is fairly common practice for the sheriff or chief jailer to arrange for meals to be brought in. In at least two small county jails food service is provided by a nearby fast-food outlet.

More than two-thirds of the jails and all state prisons serve meals at least three times a day, while the remaining jails serve meals once or twice a day. In 12 percent of the nation's jails meals are served exclusively in dining halls or in a central food service area. However, in 65 percent of the jails food is served solely in the cells. About 17 percent of the jails use both dining halls and cells, and 23 percent have other food service arrangements.

For state prisons food service follows four general patterns: (1) mass feeding and mass cooking in one dining room; (2) mass cooking with feeding in several dining rooms or day rooms; (3) cottage-type feeding with small kitchens and small dining rooms for each cottage inmate group; or (4) one kitchen with feeding in individual cells or rooms. Patterns (1) and (4) are being followed by an increasing number of institutions because of overcrowded conditions.

FINDINGS

Food supplies

All institutions visited, except two, prepared and served food which either originated from approved sources or which was considered satisfactory by the state and local health authorities. However, two state-operated institutions, each housing more than 2,500 inmates, carried out their own meat processing operation which was not under the supervision of appropriate meat control authorities; no antemortem or postmortem inspections were performed to eliminate slaughtering of sick or fatigued animals or to detect gross pathology of the carcasses.

Food protection

In all 100 institutions investigated there was substantial evidence of inadequate food protection. This evidence included the following:

Food was transported from central kitchen to cell block in unheated and/or uncovered containers, followed by the lapse of an inordinate amount of time (3–4 hours) between preparation, delivery to cell blocks and service to inmates.

Raw food ingredients and prepared foods contained animal and insect filth including live insects and insect parts.

Raw and cooked products were managed in such a way that the opportunity for cross-contamination was enhanced.

Steam tables and similar devices for keeping food hot were defective and in need of major repair.

Prepared foods such as salads, hash and left-overs, were placed in large deep containers which required an extended time interval for the entire mass to chill sufficiently to inhibit bacterial growth, especially in the center portions of the food.

Refrigeration space was inadequate to store and maintain perishable food at a proper temperature without packing and crowding and impeding air circulation.

Clean food contact surfaces of equipment were not protected from recontamination between uses.

Cleanliness of equipment and utensils

Substandard dishwashing procedures and equipment were prevalent in 85 of the 100 institutions.

While mechanical dishwashing was common, problems of inadequate hot water for final rinse cycle, clogged spray jets and inoperable detergent dispensers hampered effective cleaning and sanitizing of eating and drinking utensils; greasy and food-stained tableware was the rule rather than the exception.

In ten of the institutions dining utensils were not returned from the cells to the central kitchen for washing but were "cleaned" in a utility sink located in the cell block area. The procedure was simply "rinse and dry."

Single-service knives and forks were used and reused in the maximum security section of four large prisons. Here cleaning of the utensils was the responsibility of each inmate. This was usually carried out in individual cells, none of which were provided with warm water or detergent for cleaning purposes.

Vermin control

Regular pest control services were provided in 97 institutions by commercial pest extermination services. Three institutions carried out their own insect and rat control program on an "as needed basis."

However, substantial cockroach infestations were evident in all 100 institutional food service operations. Thirty institutions, visited during warm weather, had a significant fly problem.

The missing element in the insect and rodent control service was a comprehensive housekeeping and maintenance program designed to eliminate those conditions which encourage growth and development of flies, cockroaches and rats.

Personnel

Inmates, under the supervision of civilian personnel, were "employed" as food service workers in all of the institutions. None of the institutions provided food sanitation training and orientation for food service personnel.

The warden and food service supervisor in all but five institutions gave high priority to "pre-employment" and periodic physical examinations of all inmates who performed duties in the food service program.

As is well known among health service personnel, periodic physical examinations are not effective in preventing the development and progression of food-borne epidemics because most of the conditions detected in physical examinations are transient and develop and pass away in the interval between such examinations.

On the other hand training of food service workers is one of the most effective approaches in minimizing problems of food hygiene and sanitation at the preparation and service levels of the food distribution system.

However, in the four state-operated institutions where culinary vocational training was established, food service sanitation and hygiene were not emphasized in the "curriculum."

DISCUSSION AND CONCLUSIONS

Food and other environmental health issues occupy such an important place in every inmate's life that their affect on morale, and physical and mental health cannot be overestimated.

To be sure most incarcerated offenders are of the lower socioeconomic classes which generally have worse nutritional problems than more affluent groups. Thus there is a need for greater attention to the quality and quantity of food served to the confined inmates than on the population at large.

In fact, in many instances food can determine the success or failure of the most carefully designed rehabilitation and correctional programs. This was clearly indicated in the most recent civil disturbance in the Tennessee State Prison in Nashville in September 1975. As described in the Nashville Tennessean: "It all began for the lack of pork chops (which ran out during an evening meal and cold bologna was served as a substitute) and when it was over, 39 people had been injured and one inmate was dead."[1]

Jail and prison food service systems operate under budgetary constraints and under physical limitations which make it difficult to provide the variety of foods which are found in facilities in the "free" community. As such meals often become monotonous to the inmates who have no choice but to consume food provided by the institution or experience one of the many manifestations of primary malnutrition.

Even the cold gray metal of the food trays detracts from the appetizing appearance of the food. Unless unusual precautions are taken, speedy service often produces an unattractive tray with gravy spilled over the edges and vegetables scattered outside the vegetable compartment.

Unfortunately management of food service in jails and prisons is under the supervision of non-professional food service personnel. The workers are inmates, and in such work force there are new and untrained personnel; others who have had limited experience, and very few who have acquired experience which is valuable to the management of mass feeding systems. Among this group of food service workers, every attitude from active interest to open antagonism is manifested.

The incarcerated food service worker often feels alienated, angry and isolated in an environment which he does not understand. A situation which frustrates his performance as a member of the food service staff.

Compounding this problem is the fact that the correctional officer—who is usually in charge of the "food service detail"—sees his primary role as guardian of custody, discipline and security in the immediate environment and not as that of supervisor of food hygiene and sanitation practices.

This complexity of attitudes of the worker and of the officer in charge is often reflected in the level of sanitation in the food preparation area and quality of food offered to inmates.

In this setting it must be recognized that the methods of operating food service programs—like other subsystems of the correctional institution—should never be static. They must be reconciled with changing patterns produced by social and economic characteristics. Changes in the penal and correctional process and the newer aspects of institutional food management demand a continuous evaluation of methodology and the application of resources to promote maximum food protection and reduce the potential of foodborne illness.

Cost must be considered in relation to goals and results; duplication and waste of efforts must be avoided. Economy demands maximum results compatible with the concerns about increased productivity and better acceptability of food service in the institutions.

It would therefore seem appropriate, from a food protection standpoint, to abolish the participation of inmates in the food service program and replace them with professional food service personnel who could, using modern techniques of food service management, plan, prepare and serve all meals required of the institution.

This view is supported by several groups, including the National Sheriff's Association which recently suggested that, "It i stime now to think of eliminating inmates entirely from the food service."[2] The Federal District Courts have taken a similar position and in one case the judge ordered that "the food served to inmates shall be nutritionally adequate and properly prepared under the supervision of a food service supervisor for each institution; each supervisor shall have at least bachelor's level training in dietetics or its equivalent."[3] The court also required the institution to employ a qualified nutritionist to assist in menu planning, in food purchasing and preparation and to monitor food service hygiene and sanitation.

Hospitals, academic institutions and industrial feeding operations have for several years recognized the benefits of putting food service management on a sound professional foundation. Such an approach has increased productivity, reduced cost and improved consumer satisfaction with the quality and quantity of foods which are served.[5]

The problem of food service in jails and prisons is also complicated by the physical environment—the preparation and serving area. Outmoded and archaic food equipment, inadequate ventilation systems, insufficient refrigeration, and totally inadequate working and storage space perpetuate a substandard rather than effective and efficient food management system.

Of the 100 institutions studied in this project 56 were constructed between 1830 and 1900. They were built to be internally and externally secure and reflected concern for complete surveillance of inmates. Evidently in the process of achieving the goals of security, the food service plant was given less than a high priority.

Thus some correctional institutions are saddled with the physical remains of last century's concept of food service for jails and prisons and with an ideological legacy that poor quality food and substandard food service are part of the penalties which an offender must pay during confinement.

The result has been an inefficient food service program, "economical" perhaps in its daily operation, but tragically expensive in its ultimate effect on the overall goal of food service hygiene and sanitation.

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ACKNOWLEDGEMENT

We thank the U.S. Department of Justice, Division of Civil Rights, and the National Prison Project for their support and cooperation.

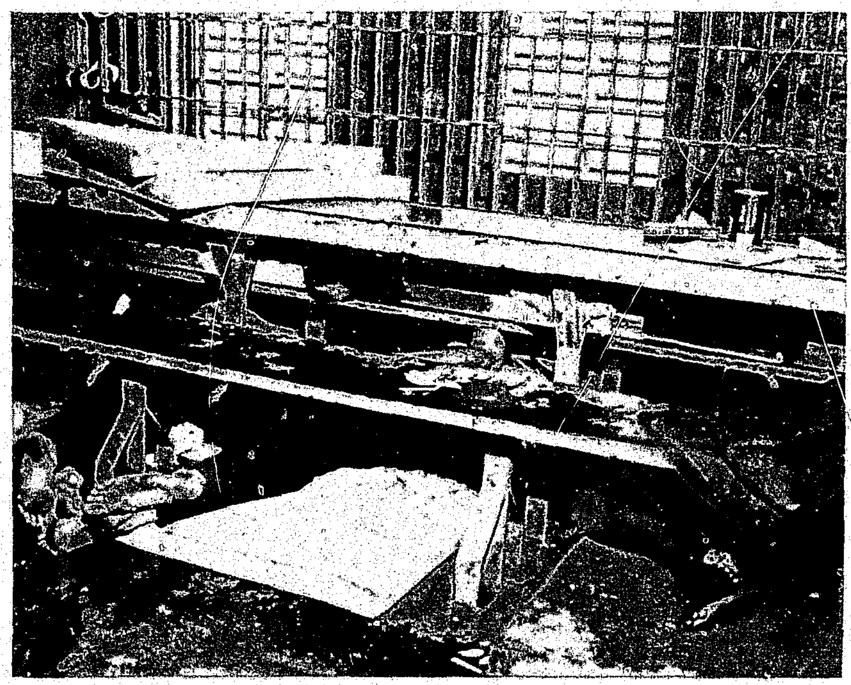
[Exhibit 12]

PHOTOGRAPHS OF EXAMPLES OF SUBSTANDARD LIVING CONDITIONS IN JAILS AND PRISONS IN THE UNITED STATES

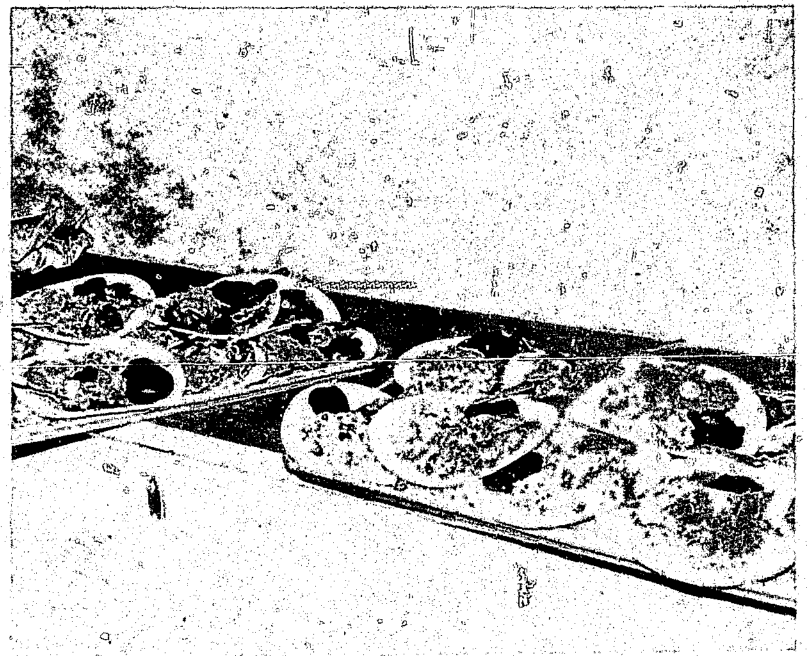
Isolation cell for mental patient inmates

Shower facilities within a day room. No ventilation—Unsanitary

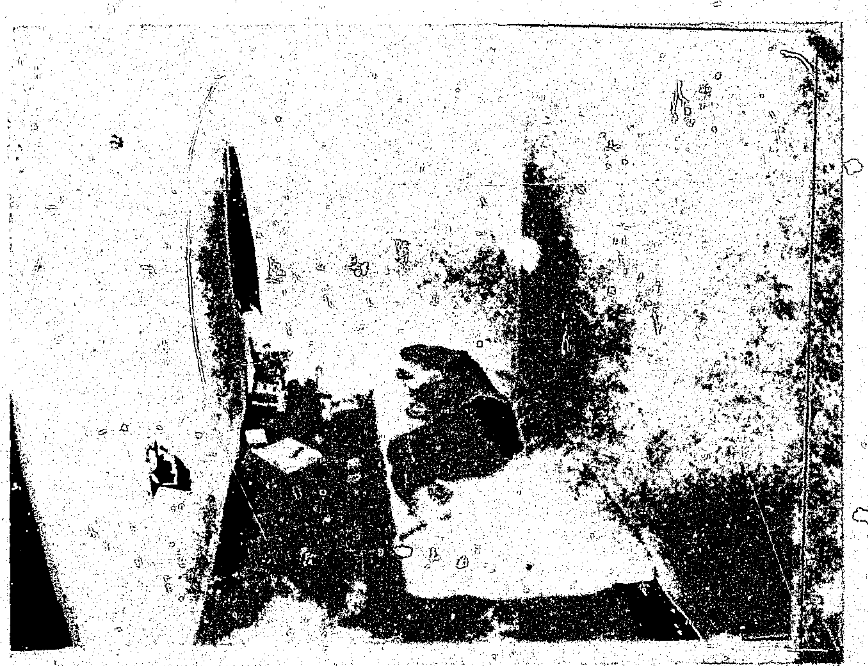
Two inmates, confined in a cell 40 sq. ft. No toilet, no running water, no bed, poor lighting, no ventilation



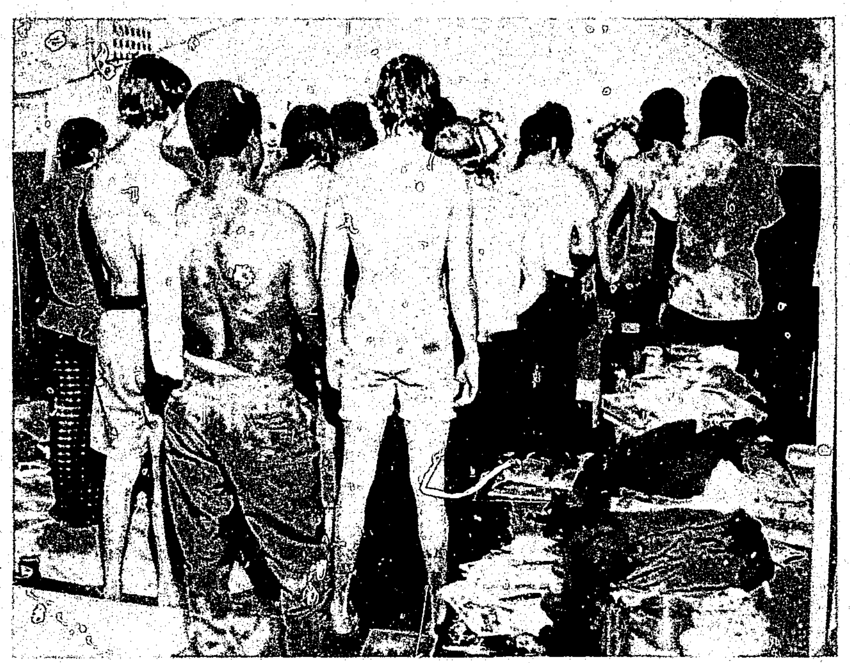
Inmates compelled to sleep on the floor as a result of overcrowded conditions in a day room



Food prepared for inmates—Left at room temperature for 3–4 hours. Also nutritionally inadequate



Inmate compelled to sleep on the floor of a cell 8 x 5. 40 sq. feet with no toilet, no running water, no ventilation



Example of overcrowded conditions where inmates are compelled to sleep on the floor of a day room

Example of unsanitary condition and poor plumbing of inmate's toilets

Example of inmates compelled to sleep on the floor of a cell with no toilet or running water, poor lighting

Example of inmate toilet facilities and substandard plumbing

[Whereupon, at 5 p.m., the hearing recessed to reconvene at 10 a.m. on Thursday, June 23, 1977.]

CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS

THURSDAY, JUNE 23, 1977

U.S. SENATE,
SUBCOMMITTEE ON THE CONSTITUTION
OF THE COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met, pursuant to recess, at 10:15 a.m., in room 1202, Dirksen Senate Office Building, Hon. Birch Bayh [chairman of the subcommittee] presiding.

Present: Senators Bayh and Scott.

Staff present: Nora Manella, counsel; Nels Ackerson, chief counsel and executive director; and Linda Rogers-Kingsbury, chief clerk.

Senator BAYH. We reconvene our hearings this morning with our first witness, the Honorable Robert W. Kastenmeier, our distinguished colleague from the State of Wisconsin.

He is the Member of Congress who has really been more interested over a longer period of time in this area which is the focus of our hearing than has anyone else.

He has introduced legislation in the House H.R. 2439 which is similar to S. 1393, or perhaps I should say S. 1393 is similar to his bill.

It is a privilege to have you with us this morning. I know how busy you are and the kind of activity that is going on in the House right now, so please proceed and let us have your thoughts on this important subject.

TESTIMONY OF HON. ROBERT W. KASTENMEIER, A MEMBER OF CONGRESS FROM THE STATE OF WISCONSIN, CHAIRMAN, SUBCOMMITTEE ON COURTS, CIVIL LIBERTIES, AND THE ADMINISTRATION OF JUSTICE, COMMITTEE ON THE JUDICIARY, U.S. HOUSE OF REPRESENTATIVES

Mr. KASTENMEIER. Thank you, Mr. Chairman.

It is an honor to appear before your subcommittee. I have the greatest respect for the work that you personally have done and for the work of your subcommittee in a number of areas— not merely this one.

I am well-aware that you already have a distinguished list of witnesses and have a number of witnesses following me who will contribute to the subject under discussion today— the civil rights of institutionalized persons.

I am pleased to testify in behalf of S. 1393. I am a sponsor of similar legislation in the House—H. R. 2439.

These bills, which as you have suggested differ in some respects, have one important intent. They are very much alike. They provide explicit authority to the U.S. Attorney General to intervene in or initiate civil suits in Federal court on behalf of the people of the United States when there is a reasonable cause to believe that the constitutional or Federal statutory rights of institutionalized persons are being violated.

This authority will permit the Attorney General to protect the constitutional rights of the institutionalized elderly, mentally handicapped, children, and prisoners, by moving into Federal court when he believes that a pattern or practice of resistance to the full enjoyment of those rights exists.

While discussing this legislation with my colleagues and others, many have been surprised that the Attorney General does not already have such authority.

As the subcommittee has learned from the Assistant Attorney General, Mr. Days, the Department of Justice in some districts is able to initiate such suits or to join other plaintiffs in an intervenor status or to serve as an amicus of the court.

However, the courts have been increasingly reluctant to recognize such authority absent statutory direction from the Congress. In two recent cases, one in Maryland and one in Montana, the United States has been denied standing as a plaintiff to protect the rights of the mentally handicapped and children. In a Pennsylvania case, the State is challenging the authority of the Attorney General to maintain even an intervenor status.

Clearly, in this important area, it is not acceptable for the Attorney General to have variant authority to enforce the Constitution and Federal statutory rights, depending upon the location of the alleged violations.

The Constitution and laws of the United States are national in scope and must be national in application and nationally enforced.

It is with this in mind that I support this legislation, and I urge my colleagues in the Senate to give it serious consideration.

I am interested in this legislation principally for two reasons: First, the subcommittee which I chair has had a long-standing concern for and jurisdiction over the issue of corrections.

Generally, this is a responsibility for the Federal Bureau of Prisons and the U.S. Parole Commission. However, we also have a duty with regard to the Federal impact of State and local corrections programs and facilities. Of course, this legislation could have an impact on those efforts.

Secondly, I am concerned, as I know this subcommittee is, about the fundamental question of access to justice in our society. In this regard, I am pleased to have assisted in the enactment of the Civil Rights Attorney's Fees Awards Act of 1976, and I am proud of our recent efforts in behalf of the Legal Services Corporation.

Also, my subcommittee is now in the midst of a series of hearings on the question of citizen access to justice and the state of the Federal judiciary generally.

S. 1393 is clearly legislation which addresses the important issue of access to justice for a unique category of our contituents. I can think of no citizens less able to secure their own access to justice under the Constitution and laws than the mentally ill, the handicapped, institutionalized children, the elderly, and prisoners.

I know that this subcommittee has assembled a necessary, but grisly, record of the abuse of basic decency that is all too often the daily fare in many of this Nation's institutions, so I will not dwell on that, unfortunate, but urgent need for legislation to help defend the rights of perhaps over 1 million institutionalized citizens.

Rather, I think it might be helpful to you, Mr. Chairman, if I comment on a few of the criticisms—some of them quite constructive—which were made of this type of legislation during our recently concluded hearings in the House.

First it has been suggested that this legislation would require that a large bureaucracy be established within the Justice Department to screen the complaints of each institutionalized person in the country in order to determine which are meritorious and possibly worthy of Department involvement.

It has been pointed out that there are over a million institutionalized persons at any one time. Conceivably they could generate thousands of complaints of violations of their rights.

In response to this concern, I would point out that the purpose of this legislation is not to provide the Justice Department with assitance in individual cases. Rather, the bills would permit the Department to address violations of rights which are systematic in nature and represent a pattern or practice of denial. And then only if the Attorney General concludes that such a suit is in the public interest, only if he first notifies the State institutional officials, and only if he is satisfied that the officials have had a reasonable time to correct conditions which cause deprivation of rights.

Clearly, it is not the intent of this legislation that the Department of Justice review every complaint of every institutionalized person. I do not believe that such a review is necessary to a professional or responsible use of the authority granted by the legislation.

What I envision is an effort by the Department to carefully, organize its resources to identify the most egregious problems and to try to address those situations through a thoughtful program of litigation designed not to rectify individual problems within institutions but to target the most serious and troublesome of situations—those that are systematic and affect many, many more than the individual plaintiff.

I believe that such a litigation effort could be quite modest. It may, in fact, not result in more institutional cases than, for example, the Civil Rights Division is currently pursuing.

In response to concerns about the adequacy of the resources of the Civil Rights Division to handle this new authority, Assistant Attorney General Days wrote to me, and I would like to quote just a part of his letter to you. He says:

> As I emphasized in my testimony, we cannot solve all of the problems in institutions through litigation and do not intend to do so if a bill such as one of those under consideration by the subcommittee is enacted. Our role in this

area has been, and will be, to coordinate our efforts with those of other agencies and with the states to bring about constitutional conditions in institutions. To do this, we must be selective in the kinds of cases which we institute, as we have been in the other areas of substantive litigation over which the Attorney General has had "pattern or practice" authority, such as housing and employment, so that we institute suits where we believe they will have the greatest impact. Based upon these considerations, we do not expect the portion of our budget allocated to this program to increase significantly if a statute is enacted giving pattern or practice authority to the Attorney General in this area.

I believe that the concern that the resources of the Department are not great enough or that Congress will be faced with requests for huge budget increases merits consideration. However, on reflection and questioning of the Department, I do not believe that the concern is of sufficient legitimacy to merit opposition.

Another criticism of the legislation has been that it will add to an already-strained Federal-State relationship and jeopardize the idea of federalism.

The Washington Counsel of the National Association of Attorneys General said in a statement before the House subcommittee:

Our point of view is that the most timely and efficient method of solution (to the problems of the institutionalized) can be arrived at by cooperation among levels of government rather than by suing each other.

To a large extent, I agree with him and believe that we should do all that we can to insure that the Federal Government is required to work cooperatively with the States on these and other problems.

However, as the testimony this subcommittee has heard shows, the States have been sadly slow to place improved institutions very high on their lists of priorities and many thousands of powerless citizens, particularly the elderly, children, and the mentally impaired, are made to suffer for this slowness.

This legislation is necessary in those cases, in my view, where the tools of cooperation fail and the adversary forum of the Federal courtroom must then be entered as a last resort.

Too often, I think, the State attorneys general see their own role as a narrow one—as a corporation counsel—rather than to vindicate even those civil rights which their own State constitutions provide.

Senator BAYH. Commonsense would lead one to believe—and the testimony we have heard thus far confirms—that when State attorneys general are faced with the task of enforcing Federal rights of institutionalized citizens of their States, they often face a decided conflict of interest.

No lawyer is supposed to represent both sides of a case. Attorneys general have a responsibility, on the one hand, to be concerned about the rights of citizens within their States and within their State institutions. Yet, from everything we have learned they have an overriding responsibility to defend the State against suits from those individuals whose rights are being jeopardized.

Have you found that to be the case in your hearings?

Mr. KASTENMEIER. I have, Mr. Chairman. In fact, I think some of us were surprised that the State attorneys general were not more active—or more importune to act—in behalf of citizens, under their own State constitutions, if not the Federal Constitution.

In fact, they are apparently brought into the situation when institutions are finally confronted with a suit. They find that rather

than acting on behalf of citizens whose rights are affected, they are acting as a sort of corporation counsel that attempts to justify the present state of affairs and institutionally upholds the State institutions, no matter how egregious the situation is.

I think this is unfortunate. But given the case, it is altogether more important that the U.S. Attorney General have this authority that we provide for in our respective bills.

We must realistically recognize the role that, perhaps most, State attorneys general have carved out for themselves in this regard.

Senator BAYH. Thank you.

Mr. KASTENMEIER. Mr. Chairman, I would like to conclude by saying that we have had a number of other criticisms or reservations, such as that this type of legislation may be unconstitutional.

I think many of the witnesses before, and subsequent to, me will substantiate the constitutionality of both of the bills—yours and the one before the House.

I will not in my oral statement here attempt to meet the criticism of Mr. Lefkowitz, attorney general for the State of New York, and others in that connection. But I will ask leave to file my statement in its entirety with the committee, which does touch on that point.

Senator BAYH. That would be very helpful.

Mr. KASTENMEIER. Another suggestion is that the public interest bar be called upon to vindicate the rights of Americans who are under disabled circumstances.

This, however, is unavailing. It is to me unacceptable to leave the enforcement of constitutional rights of institutionalized citizens entirely in the hands of a small, overworked, underpaid portion of the bar which has voluntarily chosen to make its business the representation of these clients.

I think the suggestion by the State Attorneys General Association that the public interest and the appointed lawyers in this field represent a formidable legal armada against which the States must do battle is simply not supported by the facts.

A number of other lesser criticisms have been made.

First, it has been suggested that a statement of findings be drafted to precede the text of the ligislation. Such a statement could provide a congressional recognition that the rights of the institutionalized, as expressed by the courts, are legitimate and evolving and worthy of enforcement.

Such a statement could be provided in lieu of spelling out specifically what rights Congress is prepared at this point to recognize.

Second, it has been suggested by Professor Chayes that we provide some mechanism for the involvement of inmates and other institutionalized persons in the fashioning of the various requests for relief in the suits filed by the Attorney General pursuant to this legislation.

Such a mechanism could, I suppose, prevent duplicative litigation and would insure that complaints are addressed adequately. Perhaps actual appointment of counsel to represent the institutionalized, in this regard, should be considered.

It is also argued that we consider adding a provision that the act will not preclude any private litigation or effort to vindicate any

right. Such a provision could be added in the report language I suspect. We certainly do not want to restrict the ability of private citizens to exercise existing standing in the Federal courts.

Lastly, it has been urged by both supporters and opponents of the legislation that we provide explicit report language on definitions of the terms "pattern or practice" and "State agents." These terms are well-defined in civil rights litigation in this country, and we should consider this legislation part of that worthy and productive tradition.

There are other suggestions, such as amplified notice to the attorney general of each State and to the Governor and the personal certification by the U.S. Attorney General as to the necessity for these suits.

Such additional provisions, I think, might dislodge the concerns of some who have reservations about the legislation before your committee and mine.

In conclusion, I would like to suggest that this legislation alone is not going to solve the problems of the quality of life in our Nation's institutions. Rather, we hope that this will be a tool in that effort—and a somewhat modest one at that.

In the end, the question is one of commitment of resources. We in Washington must do what we can to see that Federal funds continue to be committed to meet those needs.

Also, as leaders in our communities, I believe we must speak out in behalf of the all-too-silent plight of our institutionalized constituents in the hope that our colleagues in local and State government will be increasingly willing to confront these needs.

Thank you, Mr. Chairman.

Senator BAYH. I appreciate your willingness to let us have your thoughts and to share your expertise.

I think you accurately described it when you talked about the necessary, but grisly, information that together we are compiling.

I think you have done a very good job to emphasize the so-called soft spots—or, at least, the targets of criticism and to refute them.

This legislation is really designed to deal with the situations which are the most serious and the most troublesome.

It would seem to me to be a more efficient use of our prosecutorial forces to permit the Attorney General to initiate these suits, where necessary, rather than limit his response—as is now the case—to intervention in pending suits.

I have a number of things that I would like to discuss with you, but I know you are hard pressed over in the House.

Why don't you and I and our collective staffs continue the kind of communication it has been the good fortune for us to have.

Mr. KASTENMEIER. We are at your disposal, Mr. Chairman, and look forward to that.

Senator BAYH. I think the record should show, before the Congressman leaves, that it has been the Senator from Indiana's good fortune to know him as a colleague and a friend for a long while and to share common interests.

What he has done to try to alert the Congress and the country to the abuses that have gone on in our Federal penitentiaries has served

as an example for States, as well as the Federal Government. He has had concern with the parole system.

It has been my good fortune to join him in some of these efforts. Thank you.

Mr. KASTENMEIER. Thank you, Mr. Chairman.

[The prepared statement of Hon. Robert W. Kastenmeier follows:]

PREPARED STATEMENT OF HON. ROBERT W. KASTENMEIER

Mr. Chairman, members of the subcommittee, I am pleased to testify today in behalf of S. 1393. I am a sponsor of similar legislation in the House, H.R. 2439. These bills, while different in some respects, have one important intent: they provide explicit authority to the United States Attorney General to intervene in or initiate civil suits in federal court on behalf of the people of the United States when there is reasonable cause to believe that the Constitutional or federal statutory rights of institutionalized persons are being violated. This authority will permit the Attorney General to protect the Constitutional rights of the institutionalized elderly, mentally handicapped, children and prisoners by moving into federal court when he believes that a pattern or practice of resistance to full enjoyment of those rights exist.

While discussing this legislation with my colleagues and others, many have been surprised that the Attorney General does not already have such authority. As the Subcommittee has learned from Assistant Attorney General Days, the Department of Justice in some districts is able to initiate such suits or to join other plaintiffs in an intervenor status, or to serve as an amicus of the Court. However, the courts have been increasingly reluctant to recognize such authority absent statutory direction from the Congress, and in two recent cases, one in Maryland and one in Montana, the United States has been denied standing as a plaintiff to protect the rights of the mentally handicapped and children, and in a Pennsylvania case, the state is challenging the authority of the Attorney General to maintain even an intervenor status.

Clearly, in this important area it is not acceptable for the Attorney General to have variant authority to enforce the Constitution and federal statutory rights depending upon the location of the alleged violations. The constitution and laws of the United States are national in scope and must be national in application and nationally enforced. It is with this in mind that I support this legislation and urge my c olleagues in the Senate to give it serious consideration. I am interested in this legislation for two reasons. First, the Subcommittee which I chair has had a long standing concern for and jurisdiction over the issue of corrections. Generally this is a responsibility for the Federal Bureau of Prisons and the U.S. Parole Commission. However, we also have a duty with regard to the federal impact of state and local corrections programs and facilities, and of course this legislation could have an impact on those efforts. Secondly, I am concerned, as I know this subcommittee is, about the fundamental question of access to justice in our society. In this regard I am pleased to have assisted in the enactment of the Civil Rights Attorney's Fees Awards Act of 1976 and am proud of our recent efforts in behalf of the Legal Services Corporation.

Also, my subcommittee is now in the midst of a series of hearings on the question of the citizens access to justice and the state of the federal judiciary generally. S. 1393 is clearly legislation which addresses the important issue of access to justice for a unique category of our constituents. I can think of no citizens less able to secure their own access to justice under the Constitution and laws than the mentally ill and handicapped, institutionalized children, the elderly and prisoners.

I know that this subcommittee has assembled a necessary, but grisly record of the abuse of basic decency that is all too often the daily fare in many of this nation's institutions, so I will not dwell on the unfortunately urgent need for this legislation to help defend the rights of the over 1 million institutionalized citizens. Rather, I think it may be helpful to you if I comment on a few of the criticisms, some of them quite constructive, which were made on this type of legislation during our recently concluded hearings in the House.

First, it has been suggested that this legislation would require that a large bureaucracy be established within the Justice Department to screen the com-

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4 OF 12

plaints of each institutionalized person in the country in order to determine which are meritorious and possibly worthy of Department involvement. It has been pointed out that there are over a million institutionalized persons at any one time. Conceivably they could generate thousands of complaints of violations of rights. In response to this concern, I would point out that the purpose of this legislation is not to provide Justice Department assistance in individual cases. Rather, the bills would permit the Department to address violations of rights which are systemic in nature and represent a pattern or practice of denial; and then only if the Attorney General concludes that such a suit is in the public interest, only if he first notifies the state institutional officials and only if he is satisfied that the officials have had a reasonable time to correct conditions which cause deprivations of rights. Clearly, it is not the intent of this legislation that the Department of Justice review every complaint of every institutionalized person. I do not believe that such a review is necessary to a professional or responsible use of the authority granted by the legislation. What I envision is an effort by the Department to carefully organize its resources to identify the most egregious problems and to try to address those situations through a thoughtful program of litigation designed not to rectify individual problems within institutions but to target the most serious and troublesome of situations: those that are systematic and effect many more than the individual plaintiff.

I believe that such a litigation effort will be quite modest; and may, in fact, not result in more institutional cases than the Civil Rights Division is currently pursuing. In response to concerns about the adequacy of the resources of the Civil Rights Division to handle this new authority, Assistant Attorney General Days wrote to me, and I would like to share his letter with you. I quote from a portion of it. He states,

"As I emphasized in my testimony, we cannot solve all of the problems in institutions through litigation and do not intend to do so if a bill such as one of those under consideration by the Subcommittee is enacted. Our role in this area has been, and will be, to coordinate our efforts with those of other agencies, and with the States, to bring about constitutional conditions in institutions. To do this, we must be selective in the kinds of cases which we institute, as we have been in the other areas of substantive litigation over which the Attorney General has had 'pattern or practice' authority, such as housing and employment, so that we institute suits where we believe they will have the greatest impact. Based upon these considerations, we do not expect the portion of our budget allocated to this program to increase significantly if a statute is enacted giving pattern or practice authority to the Attorney General in this area.

I believe that the concern that the resources of the Department are not great enough or that Congress will be faced with requests for huge budget increases merits consideration. However, on reflection and questioning of the Department, I do not believe that the concern is of sufficient legitimacy to merit opposition to this legislation.

Another criticism of the legislation has been that it will add to an already strained Federal-State relationship and jeopardize the idea of Federalism. The Washington Counsel of the National Association of Attorneys General said in a statement before the House Subcommittee, "our point of view is that the most timely and efficient method of solution (to the problems of the institutionalized) can be arrived at by cooperation among levels of government, rather than by suing each other." To a large extent I agree with him and believe that we should do all that we can to ensure that the Federal government is required to work cooperatively with the States on these and many other problems. However, as the testimony this subcommittee has heard shows, the states have been slow to place improved institutions very high on their lists of priorities and many thousands of powerless citizens, particularly the elderly, children and the mentally impaired are made to suffer for this slowness. This legislation is necessary in those cases where the tools of cooperation fail and the adversary forum of the federal courtroom must be entered as the last resort.

I would support however, an amendment to both my legislation and S. 1393 which would beef up the notice to the state section, to require that the Governor and State Attorney General be notified as well as the institutional officials. Further I think it reasonable that the U.S. Attorney General be required to personally certify that the suit is of the public interest and would support an

amendment to prohibit the delegation of that responsibility. Also, I could support amendatory language which would require, except in genuine emergency situations, that the Attorney General provide the state with more than notice and a reasonable amount of corrective time, but also with technical assistance in resolving the alleged rights violations. While I would resist an elaborate negotiation process, I do believe we shoudl do all we can to cooperatively work out these problems. Assistance following litigation might also be required. It has been suggested that this legisation may well assist the states in meeting constitutional standards without litigation. An important state official, Mr. Stanley Van Ness, the Commission of the Department of the Public Advocate of the State of New Jersey, stated to the House Subcommittee, ". . . I think that what I am most hopeful of is that the passage of this legislation would send out a signal to people—look you really do have to shape up; it isn't just a question of business as usual; that there is authority in Washington to make sure that these constitutional rights are protected, and I think it would have a good effect." So not all state officials are opposed to this legislation, and hopefully when it is understood better it will become more popular with state leaders.

Another comment which several State Attorneys General have made is that this type of legislation may be unconstitutional. New York State Attorney General Louis Lefkowitz has been the most articulate in this argument. I would like to share his letter with you. Frankly, I do not believe that these arguments hold much water. The same technique of authorizing suits by the Attorney General in "pattern and practice" cases has been used in each of the Civil Rights Acts. No serious constitutional challenge has been directed against that authority even though there has been significant resistance in several states to the intent of those Acts. Professor Abram Chayes from the Harvard Law School testified before us on this point and I'd like to quote him. He states, "Section five of the 14th Amendment provides 'That Congress shall have power to enforce, by appropriate legislation, the provision of this article. There can be no doubt that empowering the Attorney General to bring suit to enforce the provision of the Amendment is an appropriate mode of enforcement. The X amendment is no bar. It reserves to the States or the people, respectively, powers not granted to the Federal Government. But no power is reserved to the states to confine people in violation of the Constitution of the United States." I share Professor Chayes' view that the constitutional arguments against this legislation are captious. I point out that the states do not challenge the authority of the Federal Courts to hear these cases, but only resist the standing of the United States Attorney General to file suit.

The last major criticism of this legislation made by Mr. Leftowitz and some of his colleagues is that it is unneeded because the institutionalized are able to get into court on their own steam and do not need the Attorney General's help. At present these Americans are left to fashion their own complaints, frequently confronting recalcitrant institutional administrators and busy federal courts which are ill-equipped to consider the motions of inarticulate nonlawyers from the most powerless segments of our society. Of course, not all institutionalized people are unrepresented. Some of the most distinguished public interest lawyers in the nation have brought fundamental landmark litigation to the federal courts in behalf of institutionalized clients. The caliber of the public interest bar notwithstanding, it is unacceptable to me to leave the enforcement of the Constitutional rights of institutionalized citizens entirely in the hands of a small, overworked, underpaid portion of the bar which has voluntarily chosen to make it its business to represent these clients. The suggestion, by the State Attorneys General Association that the public interest and appointed lawyers in this field represent a formidable legal armada against which the states must do battle is simply not supported by the facts. The 1975 budgets of all tax exempt public interest law firms was $40 million, less than the combined income of two of the many Wall Street firms. The much commented upon, National Prison Project of the ACLU consists of seven lawyers. The Mental Health Law Project, generally regarded as the major litigant in the mental health field, has one full time lawyer in New York and from 3–6 lawyers in Washington. The Legal Services Corporation project lawyers are usually unable to marshall the time and energy needed to enter into institutional litigation, and it is estimated that the Federal Courts appoint counsel in less than one percent of the civil rights petitions filed by the institutionalized.

Clearly, the public interest bar cannot be relied upon to shoulder the responsibility of effectively vindicating the rights of the institutionalized persons in the way in which the Department of Justice could. The continuity and stability which the Attorney General's role in this litigation would provide cannot be reached by continuing to rely on private attorneys for this important public policy work.

A number of less major criticisms have been made on this legislation as it is pending in the House and it may be profitable to share some of them with you.

First, it has been suggested that a statement of findings be drafted to precede the text of the legislation. Such a statement could provide a congressional recognition that the rights of the institutionalized, as expressed by the courts, are legitimate and evolving and worthy of enforcement. Such a statement could be provided in lieu of spelling out specifically which rights Congress is prepared to recognize.

Second, it has been suggested by Professor Chayes that we provide some mechanism for the involvement of inmates and other institutionalized persons in the fashioning of the various requests for relief in the suits filed by the Attorney General pursuant to this legislation. Such a mechanism may prevent some duplicative litigation and will ensure that complaints are addressed adequately. Perhaps actual appointment of counsel to represent the institutionalized should be considered.

In a similar vein, it is argued that we considered adding a proviso that the Act will not preclude any private litigation or effort to vindicate any right. Such a provision could be added in report language, I suspect. We certainly do not want to restrict the ability of private citizens to exercise existing standing in the Federal Courts.

Lastly, it has been urged by both supporters and opponents of the legislation that we provide explicit report language on the definitions of the terms "pattern or practice" and "state agents." These terms are well defined in the civil rights litigation of this country and we should consider this legislation as part of that worthy and productive tradition.

I hope these specific suggestions are valuable to you, Mr. Chairman.

I would like to conclude by suggesting that this legislation alone is not going to solve the problems of the quality of life in our nation's institutions. Rather, this will be a tool in that effort, really a somewhat modest tool. In the end, the question is one of commitment of resources and we in Washington must do what we can to see that federal funds continue to be committed to meet these needs. Also, as leaders in our communities I believe we must speak out in behalf of the all too silent plight of our institutionalized constituents in the hope that our colleagues in local and state government will be increasingly willing to confront these needs.

This legislation is modest, but it is imporant and I hope that we can join together to move it forward swiftly.

Senator BAYH. Our next witness is Dr. James Clements who is the director of the Georgia Retardation Center and chairman of the Willowbrook Review Panel. He is a former president of the National Association on Mental Deficiency.

Dr. Clements, it is good to see you again. It was the good fortune of another subcommittee in Judiciary—the Subcommittee on Juvenile Delinquency—which I chaired, to have the expertise of Dr. Clements in an area not totally unrelated to that which brings us together again today.

Welcome.

TESTIMONY OF DR. JAMES D. CLEMENTS, DIRECTOR, GEORGIA RETARDATION CENTER, AND CHAIRMAN, WILLOWBROOK REVIEW PANEL

Dr. CLEMENTS. Thank you, Mr. Chairman.

In my written statement to this committee, I said that people who

are retarded in institutions in the United States have been stripped of their dignity, exiled, shunned, sterilized, had their liberty, their citizenship, and even their lives capriciously torn from them without plea or rebuttal.

I did not make these charges lightly.

It is important for you to understand that these charges do not result from isolated incidents in one or two places. These occurrences are all too commonplace throughout the United States.

There are approximately 250 public residential facilities housing approximately 150,000 individuals who are retarded, in the United States.

Additionally, there are over 1,000 known private facilities, housing over 30,000 people.

There are tens of thousands of so-called nursing homes, housing an unknown number of people who are retarded.

I have personally evaluated 32 public residential facilities in 13 States, housing approximately 25,000 retarded people.

The people and the places that I'm going to describe to you are, indeed, representative and not extraordinary as to the situations that they represent. They are extraordinary in the sense that they continue to occur in the United States.

Senator BAYH. Some of the grisly—as Mr. Kastenmeier said—horror stories that have been expressed to this committee are not, in your judgment, isolated examples. There is the example of the woman who was kept in a strait jacket for 9 years and girls who were tied spread eagle to beds in three-quarters of a ward of 70 patients in a mental institution. That kind of thing, unfortunately, is not isolated.

Dr. CLEMENTS. They are not isolated. I could take you today and show you such examples.

I think perhaps the best way to give you an idea of what I'm talking about is to tell you about some of the people I have known in public institutions for the retarded.

I wish you could have known a lady that I will call Sue Ellen.

Senator BAYH. These are actual cases?

Dr. CLEMENTS. These are actual cases with fictitious names.

I first met this lady when I was evaluating an institution. She greeted me at the door. I could best describe her by saying that she is what we ordinarily think of as a lovely, fragile, elderly, Southern lady.

She was living in a building housing approximately 60 other people. I found out later that she had been there for over 40 years. She asked me if she could show me through the building and, indeed, she did.

The last place she wanted to show me was the bathroom. I went into the bathroom with her, and she pointed out to me a box and a kitten asleep in the box.

She turned to me and said: Do you know why the kitten prefers to stay in the bathroom? And I said: No. She said: It's the only place that it's quiet. In 40 years, this is the only place that I've been able to come and be quiet.

I got very interested in this lady, and I started checking her records to see why she was in this institution.

It was very curious. I found a letter from her to her attorney and the reply.

Her request to the attorney was this. She said: They tell me here that my birthday is a certain day, and that's incorrect. Would you please send an affidavit telling them when I was born. And he, in fact, did.

There was another letter from a daughter in the files which I found very curious.

In going through the files, the employees of this institution finally said to me: We might as well tell you the full story, because you obviously are going to find it out anyway.

It turned out that this lady, as a young lady in a Southern city, became pregnant and she was not married. Even more disastrous for her, at that time and place, was that when the baby was born, it was black.

Because of this indiscretion, she had been in an institution for the retarded over 40 years.

I would like to tell you about someone that I will call Dr. X. I met him in an institution for the retarded. I was evaluating the medical services of that institution.

I asked Dr. X what he mainly did there—What did he spend his time doing? He said: I remove toenails. I said: How many toenails have you removed? He said: I don't really know, but it's been on over 500 people that I've removed all of their toenails.

I said: Why? He said: It's simple. If toenails are not cut properly, you get an infection, so we find it easier to remove them.

Senator BAYH. What happens to a foot or a toe which has had the toenail removed from it?

Dr. CLEMENTS. It's very uncomfortable. As you can imagine, when wearing shoes, it is easy to lacerate your toes without the toenails.

That probably was not a problem in that institution, however, because most people didn't have shoes to begin with.

Senator BAYH. Isn't that a rather tender part of the body?

Dr. CLEMENTS. Yes, it is.

Senator BAYH. Do they grow back?

Dr. CLEMENTS. No. These were removed in such a fashion that they did not grow back.

Senator BAYH. I'm surprised they didn't amputate the toes.

Dr. CLEMENTS. I did try to work later on with the board of medical examiners in that State to try to get some reeducation and certification for this physician. This physician had no license to practice medicine anywhere in the world—not in the United States or not in that particular State.

When I made this suggestion to that board, their reply was this: My God, if we give that man a license to practice, he'll go out and start practicing on the citizens of this State.

Senator BAYH. This fellow was staff?

Dr. CLEMENTS. Yes.

Senator BAYH. He was being paid by the State in question?

Dr. CLEMENTS. That is correct.

Senator BAYH. Can you tell us what State?

Dr. CLEMENTS. I would prefer not to.

It is not an uncommon practice, Mr. Chairman, to have physicians with only an institutional license in institutions.

Senator SCOTT. When you speak of unlicensed physicians in the institutions, are they practicing medicine without a license? Is that what you're saying?

Dr. CLEMENTS. Yes. They have only an institutional license, not a regular license.

Senator SCOTT. Then they would be in violation of State laws.

Dr. CLEMENTS. The State usually gets around this by issuing a so-called institutional license which means that you can only practice in an institution. You cannot practice outside of the institution.

Senator SCOTT. Is that part of the law of your own State?

Dr. CLEMENTS. It is.

Senator SCOTT. In Georgia, the legislature has enacted legislation which says that someone can practice medicine in mental or penal institutions of the State without having a license to practice medicine generally in the State?

Dr. CLEMENTS. That is correct.

The intent of this type of license was originally this. For example, you do not necessarily have reciprocity in licensing from one State to another. The intent of that was to allow a well-qualified person to move into the State. Once residency was established, he could take the licensing exams. But this is not what has always happened.

Senator SCOTT. It is not uncommon to have unlicensed people serve as medical technicians or to do a number of medically related matters. But it is surprising to me. I did not know it, and I appreciate your advice on this: That a person would have all of the rights that a licensed physician would have except that he would be confined only within institutions—mental and penal—within the State; is this what you're telling us?

Dr. CLEMENTS. That is correct.

Senator SCOTT. Are you, yourself, a licensed physician?

Dr. CLEMENTS. Yes.

Senator SCOTT. Do you have a speciality?

Dr. CLEMENTS. Pediatrics.

Senator SCOTT. Thank you, Mr. Chairman.

Dr. CLEMENTS. I would also like to tell you about Johnny.

Johnny was in the third grade and a normal, curious young man. One day at school he pulled up the skirt of a little girl and looked.

The teacher sent a note home to his parents—not understanding that the parents came from a very strict religious sect.

The parents saw this note, felt that they were disgraced, and went to the court and had Johnny committed to an institution. There he remained for approximately 20 years.

During that time, he had no more formal academic education.

Due to court action, this young man was released from the institution where he had been for all of this time.

Despite the fact that he had no formal education, he had taught himself. In taking the examination for public school, he tested at the twelfth grade level on all subjects except mathematics. He took the State merit system examination for attendant. These were the

people who had been "caring for him" all these years, and he made one of the highest marks ever recorded in that State.

I guess my question to you would be: What might have become of this young man had he not been subjected to these disastrous experiences?

Another young lady that I knew was in an institution, and this was a private one. This was an institution in which the medical community in that area sent children to die.

These were newborn children that had some identifiable congenital defect at birth. A physician had made the arbitrary decision that the quality of life of this individual—or the predicted quality of life—would not warrant surgical intervention of her condition.

I saw this infant at about 3 weeks of age. She was dying, and it was too late to do anything about it.

These episodes are not uncommon. They occur in institutions for the retarded; they occur in nursing homes. Even more startling is the fact that they occur in the nurseries of our teaching centers—our medical school hospitals—every day in this country. Someone will make the arbitrary decision that the predicted quality of the life applied to the individual does not warrant the continued life of that person. And these individuals are let starve to death in our nurseries.

Senator BAYH. A State institution?

Dr. CLEMENTS. No, sir. Medical schools, some of which are run by the Government, of course.

A young gentleman that I knew in another institution was in his thirties. He didn't belong in the institution, and he kept trying to leave.

They put this young man on Thorazine, supposedly under the supervision of the physician. Unfortunately, he was not observed very well; and, in fact, he was not identified until he had the most severe case of tardive dyskinesia I have ever seen.

He went from a well-functioning person able to care for all of his personal needs to an individual who can do nothing now but writhe in bed continuously. He will do so for the rest of his life, totally dependent on someone trying to get enough food in him in order for him to survive. And I can assure you it is very difficult to do that with an individual who is in constant continuous motion.

Senator BAYH. That was the result of drugs?

Dr. CLEMENTS. That is correct.

Senator BAYH. Thorazine?

Dr. CLEMENTS. Yes, sir. And the condition is irreversible.

Judy was a young lady I knew who was confined to bed with herself. She could not speak. She was profoundly retarded. She was multiple physical handicaps. She could not move or get out of bed not toilet trained. She could not feed herself.

Recently, in one of our institutions, someone came during the night and tore the screen from the window, went in and took her out, and it was discovered several hours later that she was gone.

The State police and dogs could not locate her. Approximately 24 hours later, an anonymous phone call directed the officials of that

institution to go to a certain spot on the grounds of that institution where there were deep weeds if they wanted to retrieve her.

She had been brought back, dumped into the weeds, and left.

Senator BAYH. Dead or alive?

Dr. CLEMENTS. She was alive, fortunately.

Another young man at an institution whom I knew on Christmas Eve wandered out of the building. It was very cold. He was unable to speak. He didn't know where he was going.

This was reported by the ward staff in that building, but nothing was done about it, except the mother was sent a telegram saying that the young man had disappeared.

Nothing further was done until 3 days later. The mother came to inquire as to what had happened. She had assumed they had found him.

The startled officials of that institution then began to search, and about 4 a.m. the next morning, they found the young man frozen to death approximately 300 yards from the administration building of that facility.

Another young man was physically handicapped. He was unattractive to look at, and he was literally the butt of all the jokes among other residents of that institution. He was the scapegoat.

One night during a gang bathing session, in which people were being bathed by being hosed down, someone inserted a hose up the rectum of this young man and turned on the boiling water. He was killed almost instantly.

Of course, no one ever knew who did it. Therefore nothing was ever done about it.

I visited another young man who had been locked in a cell for 7 years.

Senator SCOTT. Could you tell us more about this case where the hose was inserted in the young man, and it resulted in his death. What State was that?

Dr. CLEMENTS. It was in Alabama.

Senator SCOTT. Did the authorities make an effort to determine the facts? Was there an investigation made of this?

Dr. CLEMENTS. There was an investigation made. The staff that was on duty said that another resident did it. The other residents said the staff did it. It could never be proven who did it.

Senator SCOTT. Now were you working at the institution?

Dr. CLEMENTS. I was not working there at the time.

Senator SCOTT. Where do you get your information?

Dr. CLEMENTS. By going to the institutions, sir.

Senator SCOTT. Do you talk with people in the institutions, and they told you this happened?

Dr. CLEMENTS. That is correct.

Senator SCOTT. Do you know what effort was made to determine who did this?

Dr. CLEMENTS. Yes. The attendants who should have been at the site in the bathroom at the time were interviewed, but no one could pinpoint who actually did this.

Senator SCOTT. Was there any grand jury investigation made of it?

Dr. CLEMENTS. As far as I know, there was no grand jury investigation.

Senator SCOTT. Dr. Clements, I am concerned about all of these matters. You're citing a number of instances.

I notice, from background information, that you appeared as expert witness in a number of cases that have been tried.

You mentioned in your written testimony that in one of the cases—the *Willowbrook* case—there were 3,000 hours of expert testimony. If you divide that by 8, you will come up with 375 days. I would judge that case took more than 2 years to try.

Dr. CLEMENTS. That case was heard twice—from 1972 through 1974—at different times during those 2 years. The 3,000 hours was largely courtroom testimony plus depositions testimony, and there was extensive documentation beyond that.

Senator SCOTT. It wasn't just depositions? It was before the court?

Dr. CLEMENTS. That's right.

Senator SCOTT. That was 3,000 hours before the court; then it did take over 2 years.

Dr. CLEMENTS. To complete the case, yes, sir.

Senator SCOTT. How does it happen that you appeared in the several cases as an expert witness. Are you a professional witness?

Dr. CLEMENTS. I would not view myself as that, sir.

Senator SCOTT. I just noticed that in the *Wyatt*, *Willowbrook*, *Boulder River*, and several others—there were a number of cases—are you a full-time employee and full-time director of the Georgia Retardation Center?

Dr. CLEMENTS. Yes, sir, I am. I contribute my annual leave to doing this type of work.

Senator SCOTT. Is this a State Institution in Georgia?

Dr. CLEMENTS. Yes, it is.

Senator SCOTT. You are a State employee?

Dr. CLEMENTS. That is correct.

Senator SCOTT. Full time?

Dr. CLEMENTS. Yes.

Senator SCOTT. And not in practice as a pediatrician?

Dr. CLEMENTS. I am employed full time by the State as an adminitrator.

Senator SCOTT. Mr. Chairman, I don't know if this is the proper time for me to continue with this. Would you prefer that I wait until the doctor finishes his statement?

Senator BAYH. How much longer will you be, doctor, on your statement?

Dr. CLEMENTS. Mr. Chairman, I would like to tell you about one additional case.

Senator BAYH. Why don't we just let him finish his statement then.

Dr. CLEMENTS. I could go on all day, I'm afraid, citing cases. One of the points I'm trying to make is to impress you with the fact that these simply are not isolated instances, but they are relatively common.

The last case I would like to tell you about was a young man named John. During evaluation of a facility, someone kept telling me: Go see John.

I did locate John. John was in a room by himself. The windows were blocked out with heavy covers so that light did not come in to the room. The door was closed. There was a sign on the door saying: Do not play music; he might enjoy it. And another sign said: Women must not go into this room; he does not relate well to women.

I went there seven times to try to see if the individual was ever out of bed.

I went through the records and discovered that this young man had been in bed, tied spread eagle, with a cover over him with just slits for the eyes and the mouth. He was totally covered from head to toe.

One time I found this young man out of bed. You must remember this young man had been that way for 22 hours out of every day for 2 years.

I found him out of bed. I asked him his name, and he told me. He took me and showed me his toys which he was not allowed ever to use. They were simply in a box.

But I discovered why this young man had been tied in this fashion. The night that he was admitted to the institution he was frightened. He had never been away from home before. And he banged his head on the bed until he had a black eye. This frightened the institutional officials and from that point on, for a few months, they tried electric shock on this individual every time he would bang his head to try to prevent him from ever having a black eye again.

This did not work. In fact, seemingly, it made the matter worse. So from that point on, this young man had been bound in this fashion for 2 years.

This, to me was one of the most horrifying things that I had seen. That was, in fact, a case that I was investigating for the Justice Department.

After leaving that institution, I called the Justice Department weekly until I got them to do something about it.

That young man is now out of bed and he is relating to the other children, and he is going home to visit with his parents weekly. Hopefully, he will shortly be discharged.

I think what I'm saying to you today, Mr. Chairman, would be a lot easier to say if I felt that any of these conditions that I have described to you were due to evil intent of people.

Generally, I have not felt that way at all. I think it has been a lack of perception on the part of people dealing with people in institutions. They simply do not deal with them as they would on the outside. They do not perceive them as human beings with rights that you and I have and that we exercise daily.

Most of these people cannot demand their rights and, in fact, few even know what rights they have.

I have been involved, as Senator Scott has stated, on a number of cases. In every one of these cases, I have worked also with the attorney general, or his representative of that State. I refuse to go into an institution without the State being represented by an attorney who goes with me. Because I want to be sure that the attorney sees what I see, and we both see the same thing, and we both interpret it in the same light.

I have seen attorneys representing the State vomit. I have seen attorneys representing the State weep.

But again and again I will tell you that their job is to defend the State, and that, of course, they will have to do. And it is a very unpleasant job for them. These are good people too.

I think you might want to ask some of the attorneys general how many of them have been into their State institutions and taken a look. They might be very shocked at what they see.

I would hope that you wouldn't just take my word for what I have said and what I have reported to you that I've seen today. I have hundreds of pictures of these incidents. The Justice Department has tapes.

With their permission, I would hope that you would look at these pictures and see the tapes, because I feel very strongly that without the support of the Justice Department these cases would not only continue but improvements in institutions in the United States would not be forthcoming.

There are many, many people—the majority of people—in institutions in the United States who do not need to be there. They are being incarcerated for treatment and to learn how to return to the community. And I say to you today: One does not learn in an institution how to live in a community.

I would hope that you would see that this legislation is passed. I would hope further that the Justice Department would utilize people in directing them as to what cases they should try.

They certainly cannot run around and pursue every reported violation of civil rights in the United States, but there are people who are knowledgeable about the conditions that have existed and continued to exist in these institutions.

I think the Justice Department can spend their efforts wisely if they will utilize people who are familiar with these conditions to help them with which are the cases that will have the most important results.

It is even more important that they do this, because most often these cases have been brought by individual plaintiffs, by the Legal Aid Societies, and by associations for retarded citizens.

The cases are long, difficult, and extraordinarily expensive. And after the court gives an opinion, we are just beginning. The effort that must go into implementing the order is horrendous.

I have been involved now with the Willowbrook Review Panel, which is an arm of the Federal court in New York, for over 2 years. And we are just beginning to make some headway. despite the fact that the State of New York wishes to implement that order.

The problem, Mr. Chairman, with the States is—we talk about money; that's not the main problem. It is a lack of knowledge and know-how to get the job done.

Even more important than that is the fact that if you are ever going to clean up institutions, you must discharge the majority of people that are in those institutions who should not be there—and should never have been there. And that is the hardest problem.

In order to really correct it, those people must be released and returned to the community to live as normal lives as possible.

Thank you. Mr. Chairman.

Senator BAYH. Thank you.

I am anxious for us to have a chance to look at those photographs. You have no objection if we secure them through the Justice Department?

Dr. CLEMENTS. I would hope you could, Mr. Chairman. I have quite a collection of my own as well, and I would wish this commission to use them.

Senator BAYH. The case that you referred to of the individual who was killed with the scalding water sounds like the *Wyatt* case.

Dr. CLEMENTS. Yes; it was the *Wyatt* case.

Senator BAYH. It seems to me that part of the problem there was that those who were in charge of the patients were patients themselves.

Dr. CLEMENTS. That is frequently one of the problems, yes.

Senator BAYH. I only bring up the *Wyatt* case as an example of why I think this legislation is important. I would just like to get your appraisal.

The Justice Department now, if the Maryland and Montana cases are sustained by the Supreme Court, would be powerless to do anything in the *Wyatt* kind of situation, unless someone had initiated the case.

Dr. CLEMENTS. That's correct, as I understand it.

Senator BAYH. What this legislation would do—and I understand from what you say that you feel this is necessary—to permit the Justice Department to initiate cases in those instances where there seems to be the greatest chance to do the greatest good for the most people.

Dr. CLEMENTS. That's correct.

Senator BAYH. Not just to be sort of a prisoner of events where you have a *Wyatt* who somehow or other manages to bring the case himself.

Dr. CLEMENTS. Yes. That's the reason I feel it is important that they, either officially or unofficially, have a group of advisors who actually are working day by day in these situations who are aware of what is going on, so they can use their resources most efficiently.

Senator BAYH. We are all aware of the dockets in Federal courts and the strained resources there. Some of the critics have said: This is just going to inundate the courts with a lot of suits.

From your experience, do you believe that the mere presence of the Attorney General and the Justice Department, negotiating with States prior to suit, could accomplish a tremendous amount without having to go the route of suit?

Dr. CLEMENTS. Without question that is true. In fact, there have been cases brought that have at least heightened the sensitivities of the State officials in similar conditions and their own institutions have been recognized in violation and some improvements have been made.

There have been two things which have caused the States to begin to look at what they're doing.

One is the cases that have been brought. The other is the title 19 legislation with medicaid in which Federal funds, subject to certain regulations, are going into the State institutions.

Unfortunately, States, in most cases, are simply substituting these Federal funds for State funds and not using them in addition to the already existing State funds. So you don't get dramatic improvement. There are not substantial additional resources because of that.

But these two things have done more to improve, or begin to improve, conditions in institutions than the professionals have done in the last 100 years—since we have had institutions in this country.

I think without this things are going to go backward again. There is a beginning movement. People are beginning to understand that retarded people do have rights and do have feelings. But unless there is a constant vigilance and a constant reiteration of these things, people will forget. You have to keep the pressure on.

Senator BAYH. Thank you.

Senator Scott?

Senator SCOTT. You indicated that for the most part the maltreatment the institutionalized people receive was not probably because the persons operating the institutions were bad people. That was my understanding of your testimony. It was because the people were lacking in the necessary knowledge or skill for taking care of the institutionalized persons. Is that correct?

Dr. CLEMENTS. That's correct. Even more important, they have been forced into taking a lot of people in institutions who did not belong there.

Senator SCOTT. And yet you spoke of the hose that was inserted into a young man, and his death resulted. That certainly must have been an intentional act, regardless of who permitted it. You gave examples, and it would appear to me from your testimony that it was done by bad people rather than people lacking in skill.

I can see no basis for a person of even average intelligence who had any skill at all in this psychiatric field or the care of the retarded, doing a thing like that. So there seems to be a little bit of conflct here. Could you clarify that?

Dr. CLEMENTS. I'll try.

I said that it would be a lot easier to talk about these things if I felt that the majority of these instances were do to people of evil intent.

Some of those things, of course, were due to bad people or people with evil intent.

Senator SCOTT. You would say just a small percentage then were people with evil intent?

Dr. CLEMENTS. I would think so.

The majority of these things occur without people recognizing or realizing what they are doing. Those are the things that are difficult to get at.

If someone is deliberately breaking the law and recognizes it, it is a lot easier to deal with than someone who does not have a perception that you are destroying the life of a human being.

Senator SCOTT. I believe that no thinking person would want to see things as you have described continue to happen.

To me, the thrust of our job is to make a judgment decision that if these facts do exist and are fairly common, then what should be

done about it and what part does the Federal Government play in making a determination?

You are the director of a State-operated institution. How do you operate your own institution to see that matters such as you have just described do not happen?

Have you been there for a period of years as director of this institution?

Dr. CLEMENTS. Since 1964.

Senator SCOTT. Then you have been there for 13 years.

What do you do to see that these things you have just described do not happen in your own institution?

Am I correct in thinking that they do not happen in your institution?

Dr. CLEMENTS. You should not make that assumption.

Senator SCOTT. Tell me about your own institution then.

Dr. CLEMENTS. Things do happen. You have maybe 100 different people dealing with one individual over the course of 24 hours. People perceive what should and should not be done differently.

For example, I have people who will strike a child, which is clearly against the rules and regulations. But they strike their own children at home, and they think that it is alright.

The thing I have to be constantly vigilant about is to have enough supervision that when those things do occur, I can do something about it. I fire the people.

Senator SCOTT. Are you saying that no child, in your judgment, should ever be struck under any conditions?

Dr. CLEMENTS. I'm saying you cannot allow it in an institution in which you have 24-hour control over an individual and where the individual is so easily intimidated that they could not report it.

Senator SCOTT. You are speaking of children then?

Dr. CLEMENTS. Children and adults.

Senator SCOTT. You are saying that neither a child nor an adult should be struck at any time for any reason?

Dr. CLEMENTS. In an institution. That is correct.

Senator SCOTT. Why would it be different in an institution than in a home? Do you draw a distinction there?

Dr. CLEMENTS. I would say that in a home, first, it is in the community. If a child is being badly abused or bruised or battered, it is more evident to the community. People tend not to know or to care what goes on in an institution, and that's the reason why one has to apply extraordinary management efforts against any of these things. Because if you don't, they literally become epidemic.

Senator SCOTT. How do you require a child to behave in a reasonable manner if no punishment is meted out? Or is there some other form of punishment?

Dr. CLEMENTS. We try to reinforce good behavior and not bad behavior.

Senator SCOTT. Reward good behavior?

Dr. CLEMENTS. Reinforce.

Senator SCOTT. What is the difference?

Dr. CLEMENTS. For example, children in institutions and adults in institutions lack attention which you and I get every day. We can relate to one another as human beings.

It is difficult in an institution when you are trying to deal with 60 people in a group together to form those sorts of relationships.

So when very little attention is given, many people will do anything to get attention.

For example, if a child is acting up and you swat the child, that is one way of getting attention. Very likely that child and that situation is going to continue. So what you try to do is praise and reward the individual for appropriate behavior and not the inappropriate behavior.

Senator SCOTT. I do that with my dog. I am familiar with the theories that you are discussing, and I am not in disagreement with them. But let me go further.

How about your own institution? You say it isn't operated in the way that you would like to have it operated at times. Everything is not being done you would like to have done, or that you attempt to have done.

What would you say is lacking in your own institution?

Dr. CLEMENTS. I would say the major problem I have to face day by day is to incarcerate people who do not need to be incarcerated.

Senator SCOTT. Why are they incarcerated?

Dr. CLEMENTS. Sometimes by order of court; sometimes by the request of parents; sometimes by——

Senator SCOTT. How would you change that?

Dr. CLEMENTS. If a child needs room and board, he doesn't need to be in an institution. There are plenty of facilities in our communities for that.

Senator SCOTT. The child that needs room and board has no mental defect. How does he get into the institution?

Dr. CLEMENTS. It is very simple. Someone simply says——

Senator SCOTT. I am trying to relate to your own institution, and then spread out from there.

Dr. CLEMENTS. If you are under 17 years of age, the juvenile court in Georgia can commit you to an institution due simply to the fact that you are retarded. All a parent has to do is go to the court and say the child is retarded and give reasonable proof.

Senator SCOTT. Does a parent have to show that they have no way to adequately care for the child? Isn't there some further requirement?

If a person has the necessary funds and can care for a child, can the parents still have the child committed?

Dr. CLEMENTS. Yes.

Senator SCOTT. Then it might be that you need a change in the State law. Is this what you're suggesting?

Dr. CLEMENTS. I believe that would help, yes, sir.

Senator SCOTT. Has the medical society or have you and others in the mental institution or retarded field made any effort to have the legislature change the law?

Dr. CLEMENTS. We are in the process of proposing a change in the law at the present time.

I do not mean to imply that most parents want to get rid of their children. The problem is the parents have not been given an alternative. We have not provided the parents with proper schooling or proper treatment method for their children in the community. These programs could be made more readily available in the commuity than can in an institution.

Senator SCOTT. On a national basis, in the last decade or two, hasn't there been an effort to get away from the concept of just boarding people at mental institutions and trying to provide treatment and then to have them on a released basis rather than just being full-time patients at the institution? Is this something that has been going on? Has an effort been made in that direction, or am I fully informed on this?

Dr. CLEMENTS. Yes, sir. An improvement has begun. It is very slow.

The States, unfortunately, have tied up a substantial part of the State's resources in trying to operate institutional programs.

We must reallocate those resources in order to get people back into the community where they belong.

Senator SCOTT. Would it cost less to have them be outpatients and receive treatment as outpatients than it would if they were full-time patients in the institutions?

Dr. CLEMENTS. Generally, yes.

Senator SCOTT. Is an effort being made in your own State to accomplish that?

Dr. CLEMENTS. We are beginning to try.

We are not doing very well, we need to do a great deal more.

Senator SCOTT. Whose fault is that? Is that the legislature or the Governor or the head of the department of institutions?

I take it that you are in charge of one institution. Is that accurate?

Dr. CLEMENTS. That is correct.

Senator SCOTT. You are not in charge of the whole State and every institution in that State in Georgia?

Dr. CLEMENTS. That is correct.

Senator SCOTT. Do you feel, in your own State, that these conditions you have been describing as existing elsewhere in the country exist in your own State?

Dr. CLEMENTS. I'm afraid that they do.

Senator SCOTT. Has an effort been made to correct them in your own State?

I am assuming you have greater knowledge of what goes on in your own State than you might have in States throughout the country. This seems like a reasonable assumption. A person in his own neighborhood or his own State would have greater knowledge than he would elsewhere.

In your own State, what else could be done?

Dr. CLEMENTS. I think the process, first, needs to be more rapid. We have to take the resources we have been tying up in institutions all of these years—and these are expensive. In my own facility, the average annual cost per person is about $15,000 per year.

Senator SCOTT. To institutionalize and to keep a person full time?

Dr. CLEMENTS. Yes.

Senator SCOTT. That averages $15,000 a year; is that what you're saying?

Dr. CLEMENTS. That is correct

What I'm saying is that we must move much more rapidly to take those resources that are already in hand—the States already have access to—and redistribute those resources and place these people back in the community where they can learn to live in the community. You cannot learn to do this in an institution.

The places where this has grown most rapidly are in the States in which there has been litigation, and the litigation has been successful.

There has been a monitoring mechanism. The States have not had adequate knowledge to go about doing this.

Senator SCOTT. Do the phyisicians of the State of Georgia have the knowledge to know what should be done?

Dr. CLEMENTS. I feel that if we depend on physicians to do this job, it will never get done.

Senator SCOTT. Who do we depend upon?

Dr. CLEMENTS. I think it depends upon the State administrators and officials who are operating these facilities.

Senator SCOTT. I remember a Governor being elected in Virginia a few years ago to a certain extent because he had been around to the mental institutions and had found some deficiencies. And, if elected Governor—and he was elected Governor—he was going to remedy these situations. He did make an effort to do this.

This is out of my field. I don't know the quality of the mental institutions in my own home.

But I just wonder whether you or other physicians or the medical society of the State of Georgia attempted to get proper laws passed within your own State to correct this situation?

Dr. CLEMENTS. The laws do not generally emanate out of medical societies. Physicians traditionally are not trained in this field. More and more are being trained, but physicians ordinarily have not been unusually interested in the field of mental retardation.

Senator SCOTT. We do have other witnesses, and the chairman has just reminded me that there are 10 more witnesses.

But let me just pose one further question, with the indulgence of the Chair.

This bill would give the Attorney General standing in court, so that he could go into Federal court to require things to be done.

It seems to me, and I'm asking for your judgment on this—I realize you have appeared as an expert witness in a number of these Federal cases—but it seems to me that the proper place to start is at the bottom.

I don't believe the Attorney General, if he works night and day and has a large force of Federal employees and Government lawyers working on this, can solve the problem. I think it has to start at the institutional level.

You're attempting to do it in your own institution. You are not entirely meeting with the success you would like, but you are talking about your own State and saying it is not doing as much as it should.

The thrust of my final question is: How can you get the States to do this?

Under our Constitution, we have the right to meet situations like this. It rests in the State government—not the Federal Government. The Federal Government has no police power at all.

This resides in the States.

I am looking for an alternative to this bill. The chairman and I may have a different philosophy on this, but we both have a common desire to improve such situations. If we approached it from some other way, how could we get the States to do the things that need to be done—in your judgment?

Dr. CLEMENTS. In my judgment, the major problem, as I said earlier, was due to a lack of perception of what we were doing to people. That's the reason why people get into institutions.

In order to overcome that, I think the best way at this point is to heighten our sensitivities by pointing out our deficiencies. I think that's the thing that this bill should be directed toward.

Senator SCOTT. Have you attempted to do that in the State of Georgia?

Dr. CLEMENTS. Yes.

Senator SCOTT. And with what success?

Dr. CLEMENTS. With some.

When a Federal judge points out to the States some of the problems that exist in that State, they listen much more carefully to him than they do to me.

Senator SCOTT. Don't you believe that the people of Georgia want good institutions? Do you believe that the people of your own State want people to be mistreated?

Dr. CLEMENTS. I don't think that they want people to be mistreated. I don't think they always understand what the conditions in institutions mean. I think generally they are not knowledgeable of the conditions that exist, and what the results are for people in institutions.

Senator SCOTT. Maybe you could start a crusade in your own area and in your own State of informing people.

We have often heard about the social reformer who has a problem in his or her own home.

It seems to me that you start at home, and then you build from there.

But I appreciate your being here, Doctor, and sharing your thoughts with us.

Senator BAYH. You made a statement that the first need was to get the people out of the institutions that shouldn't be there.

From your personal knowledge, either with the institutions you visited or the ones in your own State, what percentage of patients there do you think would be better treated outside the institution?

Dr. CLEMENTS. If there is a role for institutions, Mr. Chairman, it is to provide those extremely specialized services that cannot be provided elsewhere.

I am responsible, in the so-called northern region of Georgia, for admissions and discharges to institutions. The northern region covers

a population of approximately 2.5 million people, which would be the size of many cities in this Nation.

In that 2.5 million population, there are about 30 people that are currently in institutions in that area who need extraordinary medical and nursing care in order to survive and are in institutions for that purpose.

So I think out of an institutionalized population in that region of 1,000 to 2,000 people, perhaps 30 to 35 need constant medical attention 24 hours per day for a period of time.

Senator BAYH. You're talking about 90 percent that should be out?

Dr. CLEMENTS. At least 90 percent.

Senator BAYH. What has been alarming about this—whether you use the figure 90 or 50—is that all of the professionals who are familiar with this, as you are, stress that fact. Both from the standpoint of treatment applicable to each individual, and from the injustice that is done in putting the people there in the first place, many of your examples went to the process by which people were initially institutionalized.

A good number of people who are in our mental institutions shouldn't be there. What is alarming to me is that I recall my first session of our Indiana General Assembly—which goes way back to 1955—when we were just beginning to crusade, and our State mental health institution was one of the most innovative and active lobby groups during the 8 years I was there.

What you're saying is that despite this effort for this long, we are still way short of the mark.

Dr. CLEMENTS. That's correct.

Senator BAYH. I would appreciate it if I could get from you—are you familiar with the Indiana institutions?

Dr. CLEMENTS. I have visited several.

Senator BAYH. I would appreciate getting a critique of those institutions if you could, please. It can either be confidential or public. I respect your confidence, but I would like to know from a person who is not from the State and who has expertise just how far we have come and how far we have to go.

Do you charge for services like that? If you do, maybe I had better reconsider.

Dr. CLEMENTS. I sometimes get paid—often not.

Senator SCOTT. Let me just follow up the chairman's question very briefly.

You indicated that perhaps 90 percent of people in these institutions should not be there.

Is that true in your own institution where you have the right to discharge patients? What would you do with the people if you discharged 90 percent or more of the people now institutionalized?

Dr. CLEMENTS. It is quite true that there are at least 90 percent of the people, in my opinion, in the Georgia Retardation Center for whom services could be provided better elsewhere. There are many individuals who would not go back to their natural homes, but there are good foster homes. I could take you to places in the United States and show you beautiful examples of how the most severely and profoundly retarded persons are living a useful life.

To me, that is the best situation—a natural home or a foster home.

Indeed, the best situation for a retarded person—particularly, a retarded child—is to be in a home where there are normal children.

One of the problems is that when you put a lot of people together in an institution—we learn behavior from observing behavior—the behavior they learn is abnormal behavior.

Those children need to be in situations where they can observe and learn normal behavior.

Senator SCOTT. Mr. Chairman, I appreciate the witness's responses.

I know of a personal instance when I was a child of a Mongoloid child who grew physically into manhood. He was in a family of, I think, about 10 children. These brothers and sisters were all normal and treated him like any other. The child did die before he was 20 years of age, but I believe he lived a very happy life.

So I can associate myself with your suggestion.

Thank you.

Senator BAYH. Thank you, doctor, for your appearance here today.

[The prepared statement of Dr. James D. Clements follows:]

PREPARED STATEMENT OF DR. JAMES D. CLEMENTS

Much is being said recently about human rights. Human rights and civil rights in the United States are inexorably entertwined, almost indistinguishable one from the other; one is the interstices of the other. Civil rights were not intended as the exclusive privilege of few nor were others to be denied their benefits. People who are mentally retarded, in the United States, are particularly at risk as a minority group subject to suppression and denial of their God-given and Constitutional Rights. They have been stripped of their dignity, exiled, shunned, sterilized, institutionalized, had their liberty, their citizenship, and even their lives capriciously torn from them without plea, or rebuttal. They are indeed our nation's true silent minority.

Thomas Jefferson wrote that all men were created equal. Mr. Jefferson surely intended that equal rights and opportunities should be available to all. Many people who are retarded, by disability or circumstances, are unable on their own part to freely exercise these rights. Decisions are being made for them by institutional superintendents, ward personnel, by doctors, by parents—often conflicting with the desires and needs of the person who is retarded—generally without notice, due process, nor representation by Counsel. Many are not permitted to vote, hold money, own property or marry. Indeed many are involuntarily sterilized and some surgically castrated. The law in its present concept and practice does not now adequately cope with civil, legal and human rights of persons who are mentally retarded.

In 1972, a federal court held that Alabama's mental retardation facilities and mental hospitals were operating unconstitutionally and ordered extensive reforms. The Eastern District Federal Court of New York reached similar conclusions about Willowbrook State School which was, at that time this nation's largest institution for people who are retarded. Federal Courts in Pennsylvania and the District of Columbia have ordered public school systems to provide all children who are retarded suitable educational opportunities. Since that remarkable Decision in Alabama, over 100 suits have been filed relating to denial of people who are retarded of their civil rights.

The enormity of the problem and its solutions is just beginning to surface. The original two trials relating to the Willowbrook facility resulted in over 3,000 hours of expert testimony. Since the Order and its monitoring requirements, there have been 14 hearings. The cost of monitoring by the Court and the State of New York is over $1 million per year. A recent trial in Pennsylvania lasted over 8 weeks. The costs to plaintiffs in mounting such an effort may run well over one half million dollars.

Notwithstanding the enormous costs of preparation and court hearings, choosing and scheduling a host of experts and lawyers is formidable. Presenting evidence in a meaningful fashion to a court unfamiliar to the subject re-

quires extraordinary skill. To maintain years of monitoring of the Order requires conviction, perserverance, and resources.

Recently the U.S. Department of Justice was dismissed from two cases involving the civil rights of people who are retarded because they did not have legislated authority to bring on their own such complaints to the Court. They, the Office of Special Litigation, Civil Rights Division, are the one group that has the expertise, the continuity, the resources, to represent people who are retarded in their struggle to obtain what constitutionally is theirs. I ask you to give them that standing. I plead in support of Senate bill 1393, not for myself but for that silent minority, who waits. I plead not from knowledge of the law but from first hand observations of gross denial of civil and human rights.

Senator BAYH. Our next witness is Dr. Alan Stone, professor of psychiatry, Harvard Medical School, and a joint professor of the school of law.

TESTIMONY OF ALAN A. STONE, M.D., PROFESSOR OF LAW AND PSYCHIATRY, FACULTY OF LAW AND THE FACULTY OF MEDICINE, HARVARD UNIVERSITY

Dr. STONE. Thank you, Mr. Chairman.

I consider it a great kindness of you to invite me, given my opposition to the bill.

Senator SCOTT. Let me add a word of welcome to this gentleman, because I think you're the first one, while I have been here, who has been opposed to the bill.

Senator BAYH. The Senator from Virginia is perfectly free to invite other witnesses if he feels we are not giving him a fair assessment of what the professional community feels on this bill.

Senator SCOTT. I certainly didn't intend to attack the chairman of the subcommittee. I believe he is attempting to do a good job.

I may have some witnesses to suggest to him, however.

Dr. STONE. I want to say that I think Dr. Clements' description of what goes on in many of our institutions is accurate. I have no disagreement about that.

The problem is: What is the proper remedy for that?

I know that you, Senator Bayh, have been interested in conditions in nursing homes, rooming houses, and sheltered settings where the mentally ill and retarded have been moved under pressure of much of this litigation and under the pressure of reform in the State.

During the last 10 years, the population of our State mental institutions has dropped from a high of around 650,000 patients to now below 200,000.

During this same period of time, we have had a rise in nursing homes from something like 100,000 to over 1 million nursing home beds in the United States.

Many of the patients that we're talking about have not moved to the kind of foster homes that Dr. Clements described. They have been deinstitutionalized to welfare hotels and to the worst kind of nursing homes.

I appreciate the importance Dr. Clements places on having the mentally retarded be with normal children as they grow up. There is also the problem of taking a nursing home for older people and adding to it a population of chronic mentally retarded people—people who have been in institutions all their lives—transferred from

the State institution to the nursing home because Federal funds will pick up the money and because their is a court order to deinstitutionalize them.

So I don't think that you should leave these hearings with the idea that there is no price to be paid in terms of the suffering of other people whom you are concerned about.

If we integrate the aged mentally retarded and mentally ill with the aged in our nursing homes, that creates real problems.

Senator BAYH. Is that the only alternative?

Dr. STONE. It certainly is not.

But that raises the other issue. We're talking about this as though it were a bill which would not result in expenditure of funds.

Senator BAYH. This Senator isn't. We are spending money now on an average of about $15,000 per patient per year. I'm not suggesting that by protecting the rights of individuals you can do without cost, but I wonder what you could do in a different setting with $15,000 per human being.

Dr. STONE. My view about that is the following.

In my State it costs over $20,000 a year in an institution to keep a mentally retarded child. It costs more than that for a mentally ill person.

Of course, the appeal of a community facility is great, but I can assure you that it will not be cheaper. If we can find the kind of foster parents Dr. Clements described who are willing to do this, then I can assure you that we can do it cheaper.

What we find are people who are willing to give 1 year to having a person like that in their home and making a really humane effort to provide the kind of life that that person needs, and then they tire of it.

We have talked about the role of the Attorneys General of this Nation but the Justice Department has been in exactly the same situation as to the District of Columbia. They have defended the Federal Government or the district against suits brought about St. Elizabeth's Hospital.

The Justice Department lost that suit. The Federal court found that these patients, exactly the ones we are talking about, were entitled to alternative facilities here in the District of Columbia. That, I think, was over 1 year ago. Those facilities haven't yet been found in the District of Columbia.

Some of the people who have been sent out have asked to return to St. Elizabeth's because the alternative facilities found by the District of Columbia were worse than St. Elizabeth's Hospital.

If you cannot do it here in the District of Columbia—or at least I think you should start by doing it here in the District of Columbia——

Senator BAYH. I think you are proving our point.

You have an institutional structure where, in Washington, the Federal Government is the defendant. That does not exist in every other State.

What you are pointing out is that even when you have the Federal Government as the defendant, you are going to have the kinds of injustices we're after.

Dr. STONE. I quite agree. My point, however, is that once you go to court and once you get a judicial opinion and you move to the implementation stage, you have this situation where the Federal Government or the District of Columbia has not been able to come up with these alternatives.

To the extent, in some instances, where they have, the situation has been worse than the institution.

This leads me to the first point I wanted to make in my prepared testimony.

When we talk about consitutional rights and the Justice Department's involvement—and I have reviewed the record of the Justice Department in the last 5 years and have been following it very carefully—the Supreme Court ruled, for example, that there is a constitutional right of persons not to be confined after they have been found incompetent to stand trial for longer than a reasonable period related to what they have been charged with.

That is a clear holding of our Supreme Court. There are many States which are still not in compliance with what the Supreme Court has declared. It is a clear constitutional right.

To my knowledge, the Justice Department has done very little about that. What they have been involved in— and I understand from all of the young law students I've talked with and many of the lawyers I've worked with—that they are interested in making new law. They're interested in developing new constitutional rights.

So during this period of time, while the Justice Department did not participate in suits asking the States to be in compliance, with *Jackson* v. *Indiana*, they were participating in suits on the right to treatment which the Supreme Court had not yet decided was a right. They also were in conferences with HEW, indicating that they were prepared to challenge States whose commitment statutes did not have as their main criteria dangerousness, although the Supreme Court had not spoken on that subject.

In my view, if it is new constitutional rights that we want the Justice Department to work on, then we're asking them to be an advocacy group. We're asking them to try and implement important policy as to chronic care.

The question is: Do they have a forum which is open to input about the kind of new constitutional rights which are not, as they turn out in these cases, in the form of a simple sentence that you can summarize. These cases end, as you're familiar with, in lengthy decrees as in *Wyatt*. They are practically an administrative formula for the institutions.

The question is: Is the Justice Department open? Does it have a forum to consider the kinds of policies that are going to go in? Are they going to accept Dr. Clements' view that 95 percent of the patients shouldn't be in institutions and proceed on that basis? Or are they going to hear from others who will say that it is closer to 75 percent?

That is going to affect how the consent decree is shaped. The *Wyatt* decree did not provide for the kind of systematic deinstitutionalization that the *Willowbrook* decree provided.

The Justice Department was learning along the way.

But the question was: How did they get that learning? Who are they open to?

I have certainly found, in my own effort to communicate with the Justice Department, that they are not interested in hearing what I have to say. And so far as I know, the Justice Department has not been open during these cases, in looking at the policy matters, to input from citizens or from lawyers.

I would also like to address the question which you have already heard about from Congressman Kastenmeier that the facts do not bear out that the public interest groups are there.

The Justice Department was involved in *Willowbrook.* It had been involved in other cases.

The public interest lawyers have been involved and have done a remarkable job. As someone who reviewed the various appallate briefs from both sides, I can tell you that there is no question that this is not one of those cases and one of those situations where we have a citizens group fighting in court against a powerful vested interest.

The briefs of the attorney generals have been poor, at best, for reasons which I think Dr. Clements aptly described; namely, that the Attorney General has no stomach to defend situations which are clearly indefensible. And I agree they are indefensible.

But if we are fashioning constitutional rights, there need to be balanced adversaries. I'm sure that any lawyer would agree with that.

There have not been balanced adversaries.

The point I want to make, in that regard, is that if the Justice Department participates, what confidence do you have that the Attorneys General can meet that—not so much to defend the conditions, because they are indefensible, but to shape constitutional law that this country can live with for the next 50 or 75 years.

That seems to me to be the crucial issue.

With due respect to the Justice Department, I would say that the most powerful impact they have in these cases is not that they have such great lawyers. The public interest lawyers in this area have been superb. It is because they have the FBI in the discovery stage.

They are able to martial the kind of evidence that the public interest lawyer does not have the capacity to do.

I want to emphasize there is some possibility of providing that kind, after some sort of hearing in the Justice Department, of assistance to public interest lawyers of the discovery phase that might be an alternative to having the Justice Department participate.

As to the Justice Department's participation: They have been, and in the *Wyatt* case they were, invited in. They are now in a case in Ohio which involves the right to treatment. The Justice Department is not uninvolved in these situations.

Not passing this bill does not mean that the Justice Department does not participate. They are participating.

As you correctly noted, these are our benchmark cases. So if they are involved and a precedent is developed, that becomes useful in other States.

So it is not that without this the Justice Department's hands are tied. It is that without this they have to participate as an amicus

with the public interest lawyers who, I repeat, have been doing an excellent job.

There is one last comment I want to make.

If the purpose of this bill is to use the Federal courts to force the States to come up with much, much more money—and that's what we're talking about——

In Georgia, we're talking about one-third of the State budget which goes to the mental health area.

We're talking about doubling that at least.

As I look through the various consent decrees—*Willowbrook* and *Wyatt*—it is quite clear that no one, even where the State agreed—and I have to disagree with Dr. Clements on this—it is not just a lack of knowhow.

I think even when they agreed, they just did not know how much it would cost. They did not know how few foster homes they would be able to find. They did not know how few people they would find who would be willing to work with the mentally retarded in the community. Nor did they know how much it would cost.

But if that is the purpose of the bill, to force through the Federal courts and the State legislature and the Federal Government to come up with more money, then I would have to be for it.

Senator BAYH. I guess we can look at the same piece of legislation and can come to different conclusions. I'm sure you heard our colleague from Wisconsin, and I stressed the same point in the initial hearings, that the purpose of this legislation, as we see it, is not to provide new rights but to make old rights under the Constitution more enforceable.

I would like to find out what we are talking about as far as costs are concerned.

You mentioned foster homes and nursing homes. What has the State been willing to spend per patient in those foster homes and nursing homes?

Dr. STONE. When you start thinking about the budget, you have to think about the situation of the child. If this is a mentally retarded child, and what we're talking about is some kind of nursing care and some kind of educational input and some kind of medical care, which is needed and not provided in a centralized institution, then I must say I am for that.

But the notion that you can take care of a multiple-handicapped person, unless it's the situation described by the Senator from Virginia where there is a family of 10 kids, if the State has to hire people to do that and find people who are willing to do that.

In my State, we tried to solve two of our social problems at once. We have hired the people from our prisons to take care of the mentally retarded. People from our prisons are not necessarily compassionate to our mentally retarded. It was a compassionate program for prisoners; it was not necessarily a compassionate program for the mentally retarded.

The same situation was true at Willowbrook. No one would work there. So anybody who had just come out of jail could get a job there.

The most unimagineable conditions existed.

Now how can the State create multiple-good situations for these youngsters? Where can they find that? How do we go about finding the people?

Part of the problem is that they simply have been unable to find them. They tried to contract it out—find people who would find people for them.

In our State, the computers cannot keep up with the foster children. We don't know what foster child is at what foster home in Massachusetts.

Senator BAYH. What does the State of Massachusetts pay for foster home care?

Dr. STONE. For an older child, less than $300 a month.

Senator BAYH. What for a younger child?

Dr. STONE. Somewhat more. I don't know the exact amount.

Senator BAYH. Is it close to $20,000 a year?

Dr. STONE. No. That does not include the medical attention, the education programs, et cetera.

Senator BAYH. They're not getting much of that in the mental institutions.

No health care and no education; that's pretty much what the picture is.

Dr. STONE. I would agree.

Senator BAYH. I would like to believe we could reach a utopian situation. We are certainly not going to reach it by this bill, nor is that the purpose.

Going back to my days in the State legislature, I am familiar with all the groups competing for the State's limited resources.

You are not going to put frills, or even normal comforts, in a penal institution or a mental institution if, in the process, you take it away from children that represent the majority of the people in the public school setting.

The fact of the matter is you're just not going to do that.

I think what we're talking about here is how we can utilize about the same resources to accomplish more for inmates with less injustice than exists under the present situation.

Dr. STONE. I certainly agree with that, Senator. But when we start talking about carving constitutional rights at the various institutions——

There are suits on the right to refuse treatment. You've heard about the horror of Thorazine. Thorazine, if administered improperly without the proper medical supervision, can be harmful. On the other hand, in my State, a temporary restraining order from the Federal court allowing patients to refuse medical treatment has created a ward in which patients are assulting each other. Nurses are being sexually assaulted. The staff is quitting.

The patients who are there and want to be treated can't be treated because the atmosphere in the institution is impossible to cope with.

Unless you can tell me how you're going to carve out these constitutional rights and how they're going to be defined and unless you can assure me that there's going to be input to the Justice Department so they'll hear the various sides of the case. I am going to be very concerned and troubled about how that process works.

Senator BAYH. I think you are certainly on target to suggest that you, and others in this field who may come to different conclusions, should have a chance to be heard, because this isn't an exact science.

Looking at the *Willowbrook* and the *Wyatt* cases, in your opinion did any good come from those suits?

Dr. STONE. A great deal.

I think Willowbrook was perhaps the largest institution for the mentally retarded in the world and the most horrible institution imaginable. The horrors of Willowbrook are just unthinkable.

Clearly the rhetoric that compares it to a concentration camp is not rhetoric.

So the participation of the Justice Department to do something about that I am totally grateful for.

Senator BAYH. Senator Scott?

Senator SCOTT. Thank you, Mr. Chairman.

Dr. Stone, perhaps my greeting to you was partly in jest, although I certainly welcome you. I did not intend to ruffle the feathers of our chairman at all.

Senator BAYH. Would the record show that the Senator's feathers are not ruffled. He may need a haircut, but it has nothing to do with ruffled feathers.

Senator SCOTT. Doctor, I believe you are the first psychiatrist to have testified while I was present. There may have been others, because I haven't been here.

But we have heard these horror stories. and they have been repeated by former inmates at institutions as well as people who have had a degree of supervision over the institutions.

You indicated initially your opposition to this bill. Let me ask you what alternative you would suggest. Do you consider these horror stories that we've heard to be general conditions in the mental or penal institutions around the country?

Dr. STONE. First, is the question of whether they're general or not.

It's clear that in many of the institutions in some of the Southern States—Alabama where the *Wyatt* case arose had the lowest per patient budget of any State in the country. I think there were even problems with their compliance with the civil rights of patients, and they couldn't be eligible for Federal funds.

The horrors when the *Wyatt* case started, were incredible.

There are such problems generally in the United States. They are worse in some States than others.

The District of Columbia has a problem. I have long urged various groups to bring all of these suits against the District of Columbia and not against the State.

Senator SCOTT. Are you speaking of St. Elizabeths?

Dr. STONE. Yes.

But there are suits against almost every institution providing physical and mental health care for chronic patients.

Senator SCOTT. I don't know the status of St. Elizabeth now. It was a national institution, and there was talk of turning it over to the District of Columbia. As I recall, the District of Columbia did not want it as a district institution where they would have to appropriate funds for it. Is that accurate?

Dr. STONE. Yes; I think they now have it, however.

Senator SCOTT. You're saying that it's now a District of Columbia, rather than a Federal, institution.

Dr. STONE. It's a complicated mixture of responsibility for services. As I understand it now.

Senator SCOTT. What alternatives would you suggest in lieu of this bill?

Dr. STONE. I think it is time to sit back. The reason I say that is that I followed most of the litigation in this area. I think that the flood of litigation is going to continue.

Senator SCOTT. You mean the flood of litigation where it is instituted by the Attorney General?

Dr. STONE. No.

Senator SCOTT. You're saying, without regard to cases brought by the Office of the Attorney General, there will still be a flood of cases.

Dr. STONE. That is quite right.

The Justice Department will be called on in many instances to be amicus during trial.

Senator BAYH. So that the record will be consistent, we are talking about a flood—How large is this? How many cases are we talking about?

Dr. STONE. There are major—let's take my State for example. Almost every institution in the State has a Federal court order or pending litigation as to almost every institution. Every one of the institutions for the mentally retarded—the Boston State Hospital—all of the State hospitals—have had suits. There are new suits.

There is a major suit now which tries to do exactly what Dr. Clements says. There is a 600-bed hospital in Ohio which takes care of chronic patients. It is medicaid approved. There is a right-to-treatment suit—the Justice Department is amicus—which wants them to close 550 beds and reduce it to a 50-bed hospital and make the rest of it into out-patient facilities, just as Dr. Clements suggested, for chronic mental patients and elderly people who have some psychiatric as well as senility problems.

There are lawsuits like that, Senator, going on in most of the States now. I get a bulletin from the Commission on Mental Health.

In Kentucky, Tennessee, Illinois—you name the State—there is a lawsuit going on. There is literally a flood of litigation.

Most commissioners of mental health spend most of their time now responding to litigation.

Senator SCOTT. Going back, I don't believe you answered my basic question. What alternatives would you suggest to this bill?

Dr. STONE. The alternative I'm suggesting is to sit back and wait and see what happens across the country.

I think that I am not as confident as Dr. Clements that I know what's best. I would rather that the various States hassle it out, involving the Federal courts in some instances and involving the State supreme courts in other instances, as is happening, and have a variety of solutions attempted to these problems.

Then when we have had a chance to see the variety of solutions, pick the one that is going to be the best for the country as a whole.

Despite what some of your witnesses have said, I don't think this

is a question of clearcut constitutional rights. The *Willowbrook* decree is not a question of clearcut constitutional rights. The *Wyatt* decree is not. It is a long, complicated administrative formula of how the States should spend money, where it should send patients, how many doctors it should have, et cetera.

Senator BAYH. It is accurate to say, isn't it that these Federal cases that have gone clear to the top do not prescribe the kind of treatment that is provided for in the Constitution. But they do at least imply that there is something that a patient is entitled to. And certainly patients are entitled to protection from the kind of mental and physical abuse that has been levied on them.

Dr. STONE. The *Wyatt* decree was decided on a due-process basis. The *Willowbrook* decree was decided on a right-not-to-be-harmed basis.

None of them have gone to the Supreme Court.

The one important case that went to the court of appeals was *Wyatt*, and the status of *Wyatt* is now uncertain because of the Supreme Court's action in *O'Connor* v. *Donaldson* where, apparently, they indicated that *Wyatt* was not a precedent.

To my knowledge, at this point, there is no clearcut court of appeals decision about the right-to-treatment for either the mentally retarded or the mentally ill.

Senator SCOTT. How long have you been licensed?

Dr. STONE. Since 1956.

Senator SCOTT. That's about 21 years.

I notice you are on the faculty both of the school of medicine and the school of law at Harvard. Do you teach the things that a lawyer should know in the psychiatric field in the law school, or what sort of courses do you teach in the law school?

Dr. STONE. I teach a course called law and medicine, and I teach a course which deals specifically with the litigation we are discussing today.

I teach a number of other courses as well at the law school.

Senator SCOTT. We are glad to have you here.

I heard you say—it sounded like something I didn't want to hear—that the answer was to spend more money. Did I hear that incorrectly that we should spend more money on these institutions?

Dr. STONE. I don't think there is any question but that we have to, Senator Scott.

Senator SCOTT. Dr. Clements said that 90 percent of the inmates in mental institutions should be discharged. To me, that means spending less money.

I would like your comments on that. Do you feel there is anything approaching 90 percent of the inmates in mental institutions who should be discharged? Would you share your thoughts on that?

Dr. STONE. I don't want you to have a simplistic answer to it.

If you take the kind of family that you knew, yourself, and they keep the Mongoloid child at home, there is every reason to expect that that child will, within the limits of its possibilities, flourish. It will be able to do many of the things other children can do—watch television and enjoy it, for instance.

If you take that child and institutionalize it, and it is subjected to the kind of institutional life that you've heard about, by the time

that child is 8 years old, it will be rocking endlessly and be incapable of anything and will not even be toilet trained.

I stand with Dr. Clements. Children like that should never be admitted to institutions.

Senator SCOTT. What is the alternative?

Dr. STONE. To see that no mentally retarded child would ever be admitted to an institution, unless it can be demonstrated that it needs nursing care. The State cannot take responsibility for the family's problems by providing the total institution.

The parents and the family must take the responsibility for their problems.

To the extent we can do that it is critical.

Dr. Clements will tell you, and there is now a case before the Supreme Court from Georgia, on the issue of the confinement of juveniles. He will tell you that many of these kids have been abandoned. They have no family. It's the welfare department which is trying to put them in the institution, and the welfare department has no alternative facilities or resources.

Senator SCOTT. What about foster homes?

Dr. STONE. The foster home issue is a crucial issue. People like Dr. Clements feel it is possible to find foster homes.

Senator SCOTT. You say it is impossible?

Dr. STONE. I believe it is very difficult to find——

When you live in a society where the natural parents don't want to take care of their children, to assume that we will find altruistic people who are willing to take someone else's children is, I think, a Utopian hope.

Senator SCOTT. Perhaps it would be people who would need additional funds. Maybe someone who was single, such as a widow. Would that be an answer?

Dr. STONE. At times it certainly would be, but I think the extent of that possibility is much less than Dr. Clements thinks it is.

Senator SCOTT. Would you disagree with the thought that 90 percent and upward—and I haven't pinned you down on this—Do you agree with Dr. Clements that 90 percent and upward that are now in mental institutions should be discharged?

Dr. STONE. I can't answer it in that way, Senator Scott. I would say that 90 percent of the children admitted to institutions for the mentally retarded should never have been admitted there.

Now, as a result of their institutionalization, they have been so damaged that it is impossible to find a foster home willing or able to deal with them.

As to the mentally ill, I would say that we are at a state in this country, because of the vast changes which have occurred, that the majority of the mentally ill who are institutionalized need to be institutionalized.

Senator SCOTT. Would you say that the longer these individuals are in mental institutions the more unlikely it would be that they could or would be successfully discharged?

Dr. STONE. Absolutely.

I don't think any child should be in an institution for longer than a minimal period of weeks—or a maximum period of weeks.

Senator SCOTT. How about adults? Would you have a different thought on them?

Dr. STONE. The same is true for adults.

Senator SCOTT. Now we are speaking of Federal legislation that would give standing to the Attorney General. Are the States, in your judgment, as concerned about this problem as the Federal Government?

Could the States do the same thing—State attorneys general—as the Federal Attorney General, or do you have any feeling on this?

Dr. STONE. I do have a feeling. It is quite clear to me that the State attorneys general have not taken an active role in this, and they will not take an active role.

Senator SCOTT. Why would this be true?

Dr. STONE. To use the phrase "corporation counsel"—They have not gone in as advocates into the State institutions. I suspect it is because of the budgetary crunch that they all see as theirs.

Senator SCOTT. Did I understand you correctly? I am attempting to.

If a State is going to do something about this, are you saying the chief executive of the State, the Governor's office, would have to be involved in it and would have to give direction to the State institutions?

I'm thinking of them as members of the cabinet of the Governor.

If the Governor, or chief executive of the State, wanted to do something, they could do something about this; if the heads of the mental institutions wanted to do something, they could. Is this what you're saying?

Is it a question of desire to change these things?

Dr. STONE. I would say to you the same thing I have written.

If I were to have a hospital, such as Dr. Clements', I would find a public interest lawyer and ask him to sue me.

There's no way I can do what I want to do because I don't have the funds and I don't have the alternatives. I am locked into a situation where the legislature has decided they would devote a third of their budget to the department of mental health or department of mental retardation; and that's it.

So the head of the institution can go hat in hand to the legislature, as they have done for 15, 20, or 50 years.

Senator SCOTT. I'm not sure that I really have you pigeonholed here, Doctor.

If you will permit me, you are opposed to this bill and yet you don't seem to think that the Governor or the head of the mental institution can solve the problem.

You speak of the public interest lawyers bringing lawsuits in lieu of the Attorney General. Are you telling us that law suits by public interest lawyers is the answer to this?

Dr. STONE. Yes.

I think it has been the most important development in the quality of life in State institutions for the last 10 years.

Senator SCOTT. I would say that is quite an indictment against all America, it seems to me.

It is an indictment against the heads of our State institutions and against the people of the country that somebody has to bring a lawsuit to a nongovernment agency.

It would almost indicate that the people are so callous about this they can't do it without having the court do it for them. Frankly, I can't accept this. I have more confidence.

I know I'm invading your field, and I have no knowledge of psychiatry; but I do know people fairly well, or I wouldn't be in this office I'm in.

I can't believe that the people of our country and the people of the various States—even the Southern States——

I am a Southerner, and I don't believe Massachusetts, or any of the Damn Yankee States, have a better grip on this than Southern States have.

Am I misinterpreting your thoughts?

Dr. STONE. I think the problem is "out of sight, out of mind."

I worked at the Southbury Training School in Connecticut, which had a reputation for being one of the best such institutions for the mentally retarded. I worked at the Fernuld School in Massachusetts, which has a reputation for being one of the best institutions in the world. There were conditions which were horrible in both of those institutions.

Those are both States committed to caring for their citizens. But the cost of caring for citizens in this area is so great and the resources are so huge, that we have for our own convenience put people like this in these institutions and then avoided them.

I think that when you get a Federal judge to come to the institution, or you get a Governor or an attorney general, they will have the reaction that Dr. Clements described.

The judge, after visiting one of our notable institutions—which is wide-recognized because of the various medical papers that have come out of it—said: You don't have to be a constitutional lawyer to know that this is a pigpen.

Senator SCOTT. Mr. Chairman, I'm not going to burden the committee further.

I can think of another personal incident in a family I'm related to where they have a little girl who is now about 5 years old. She can't even sit up. She has some sort of brain damage. That child is with another normal child, and you see nothing but love in that family.

The child is being taken care of in the family. Maybe I live in a different world, but I just can't see that the people in this country are not concerned about situations like this. I see the concern; I don't know the answer, however.

Thank you, Mr. Chairman, and thank you, doctor.

Senator BAYH. I just want to make sure that I understand you correctly.

As I understand it Dr. Stone, you agree with the assessment of the conditions that have been described.

Dr. STONE. Yes.

Senator BAYH. You agree with the assessment that the big bulk of people who are institutionalized, if a decision could be made at the outset, should not be there.

Dr. STONE. Of the mentally retarded?

Senator BAYH. Right.

Dr. STONE. Yes.

Senator BAYH. And you agree that the States have not exercised the capacity, if they have it, to provide a remedy?

Dr. STONE. That's right.

Senator BAYH. So our difference is on the remedy.

Dr. STONE. Absolutely.

The concern I have about the remedy of the Justice Department is that I feel it's very important, given how much litigation is going on and has gone on that we not develop one Federal position and push it all around the country.

Senator BAYH. So you're not even saying the litigation is bad.

Dr. STONE. No; I'm not.

Senator BAYH. In fact, you're really saying that litigation is the only way we're going to remedy the situation which you admit exists and you don't like.

Dr. STONE. Absolutely.

Senator SCOTT. But you're saying litigation brought by private attorneys rather than the Department of Justice.

Dr. STONE. Since I've reviewed most of these cases as they arise, and most of the public interest lawyers—or many of them—are my former students, I have kept abreast of the developments.

I am convinced that there are good lawyers.

Senator SCOTT. You are just trying to provide job opportunities for your former students. Is that accurate?

[Laughter.]

Dr. STONE. Those students could be doing lots better in a large Washington law firm.

Senator BAYH. You point out that one of the assets of the Justice Department, vis-a-vis the public interest law firm, is the discovery mechanism.

Dr. STONE. Absolutely.

And some bill which would allow the Justice Department to hold a hearing of some sort and then allow the FBI to participate in some way.

Senator BAYH. The thing that concerns you most about Justice intervention is that the resolution to the problem that is suggested by the Justice decree, endorsed by the court, may not be realistic.

Dr. STONE. Exactly.

Senator SCOTT. Mr. Chairman, could I pose one further question.

Do you draw a distinction between the inmates in mental and penal institutions; and, if so, in what respect insofar as this bill or the consideration of this committee is concerned?

Do you see a distinction of any kind? Do you see a difference in the penal institutions and mental institutions?

Dr. Stone. The problem in the mental institutions is that the policies in some way have to integrate the complicated issues of how you provide health care.

In the end, they all have had to tackle that problem. They bring 1983 actions, but in the end they come down to formulating policies about health care.

That's why I feel it is terribly important that we not think of this just as a struggle over constitutional rights. It is a question of how

the courts are going to formulate health policy, just as courts have become involved in how they're going to formulate educational policy.

Senator SCOTT. As I understand it, we'd be talking about civil rights in each instance—the civil rights in the mental institutions and those in the penal institutions.

In your opinion, are there differences here? Should it be addressed separately, or do you have any feeling with regard to the overall picture?

I don't believe we are really addressing ourselves to the health care where we are thinking of penal institutions.

Dr. STONE. That is the important difference.

Although we start out with constitutional rights—Judge Judd, a very distinguished, remarkable judge who recently died, who participated in Willowbrook, started out a very conservative man. He started out very cautiously after he saw what was going on in the institution. He moved from a right not to be harmed to that right requiring the remedy of habilitation. And then, as that decree emerged, it was a formulation for all the public care policies for the institution.

There is no way we can reduce this discussion to a simple argument about constitutional rights. It would be unfortunate if we did.

Senator SCOTT. Then you are addressing yourself exclusively, or almost exclusively, to the mental institutions. Is that a fair conclusion?

Dr. STONE. The institutions for the mentally retarded and the institutions for the mentally ill.

Senator SCOTT. Then your testimony does not relate to the civil rights of inmates in penal institutions?

Dr. STONE. No; it does not.

Senator SCOTT. You would separate the two?

Dr. STONE. Yes; I would.

Senator SCOTT. Thank you, Mr. Chairman.

Senator BAYH. Thank you very much, Dr. Stone. I appreciate your contribution.

One last thought, please.

I have been very involved in this area for some period of time. In your opinion, how long will it take before we can hope to have a significant impact on these institutions?

Dr. STONE. I think already in most of these States, it is much harder to put a child in an institution. It is much harder, because there is much more resistance from the hospital to allow the welfare department to simply dump kids in the institution when they have no place else to put them.

That, I think, in a 5 to 10-year period, will significantly reduce the problem which—Most of the problems we are trying to deal with are mistakes of the last generation. Willowbrook and many of these other places are filled with retarded citizens who are old enough to be on medicare.

Senator BAYH. The nursing home figures. Have you had a breakdown to see whether that's a true parallel?

We have tried to get older people out of hospitals and into nursing homes, and we've made more resources available for nursing homes so

that now there may be people in nursing homes who otherwise might not be there.

Dr. STONE. Let me just give you some sense of how I construct that.

When the Congress passed medicare, at that point, in 1964 and 1965, we had 40 percent of the people in our State mental institutions who were over 60. That is 40 percent of 600,000 people—240,000.

We were using our State mental institutions for homes for the aged. There was no question about it. That was an abuse.

The nursing homes opened and have grown, taking all of that population in most of the States. There is no reason the State should pay for it if it can be paid out of medicare.

So there has been this huge transfer of patients from State hospitals, which the Congress for its own reasons—which I think were incorrect—specifically excluded the mental institutions from medicaid.

So the States were paying for it; therefore, they transferred most of these older people to nursing homes.

Seator BAYH. If we were to permit State institutions to be reimbursed under medicare and medicaid, then we could be more certain that in making the determination as to where old people were sent, that the ones who really would cause the cost problem that you emphasized would be kept in the mental institution and the ones that could be treated best in the nursing home would go to the nursing home.

Dr. STONE. Absolutely.

Senator BAYH. Well, thank you, doctor.

I don't think we are as far apart as maybe we were when we started this discussion.

Dr. STONE. I enjoyed the opportunity.

Senator BAYH. Thank you very much.

[The prepared statement of Dr. Alan A. Stone follows:]

PREPARED STATEMENT OF ALAN A. STONE, M.D.

S. 1393 presents, in my opinion, a number of complicated policy questions. It is not a simple legal question of authorizing Justice Department involvement to vindicate constitutional rights.

Five years ago the Supreme Court in *Jackson* v. *Indiana* set out a clearly defined constitutional standard for the continued confinement of persons found incompetent to stand trial. The Justice Department, to my knowledge, made no serious efforts to see that the states were in compliance. Various colleagues have reported to me that many states are still not in compliance, and that the law of the land is being ignored.

In contrast, the Justice Department, during the same period of time, was litigating cases where no constitutional right had been articulated by the court, and where the goal of the litigation was to develop and create constitutional rights that had not heretofore been given the imprimatur of the Supreme Court. Thus, as I reflect on this proposed legislation, the first question that presents itself is: Is it the intention of S. 1393 to give the Justice Department authority to create new constitutional rights, or o enforce righs already clearly defined by the highest court in the land. It is my personal judgment that during the period before *Solomon*, when the standing of the Justice Department was in question, Justice was more interested in creating new constitutional rights than in enforcing constitutional rights of citizens confined in state institutions. Thus, for example, the Justice Department participated in various right to treatment suits where no Supreme Court decision was available to guide them, and staff expressed an interest in challenging any state civil commitment

statute that did not focus on dangerousness, despite the fact that again there was no Supreme Court decision in this area then, nor is there now.

If the intent of S. 1393 is to allow the Justice Department a free hand to participate by initiating suits, and/or by intervening in suits, where no constitutional right has been clearly recognized, then I would conclude that the Justice Department is being encouraged to play an adversary, reformist role that, given the nature of the problem, will be guided not be clearcut legal considerations, but by social and health policy judgments. Whether the Justice Department is the proper agency for the formulation of such social and health policy judgments is in my view open to question. It has not been my personal experience in the past that the Justice Department had a process or forum to consider alternative or conflicting policy judgments in this area.

The second issue that S. 1393 presents relates to the first. The participation of the Justice Department in suits brought to enforce constitutional and federal statutory rights of persons confined in state institutions has resulted in court decrees requiring the expenditure of vast sums of money. Ironically, the *Solomon* litigation arose at a time when essential federal funds had been impounded and major cutbacks in federal funds to train staff had occurred. Thus, the federal government was in the rather bizarre position of demanding that the state improve the institutional living conditions, while at the same time cutting off those federal funds and programs necessary to assist the states to do what the Justice Department was demanding.

If the covert intention of S. 1393 is to allow the Justice Department to use the federal courts as a forum to create constitutional rights that force the Congress and the state legislatures to allocate larger sums of money for citizens confined in institutions, then I personally would support it. But I would want the Subcommittee to know what they are doing and to be convinced that this is the only way to squeeze money out of Congress and the state legislatures.

My third and fourth points will address specifically the past litigation, since one might look to the past track record of the Justice Department as indicative of what it might do in the future.

What has been the law that has developed out of Justice Department participation in litigation brought to develop constitutional rights of persons confined in state institutions? Many of our state instituions are abominable, and the conditions therein are unacceptable by any standard, be it constitutional, moral or social. The Justice Department's intervention has resulted in much that has been important and helpful in the way of improvements. The Justice Department, for example, was helpful in dismantling Willowbrook in New York, the largest institution for the mentally retarded in the world, and an institution where human degradation was the prevailing condition. Similarly, the Justice Department's participation in Alabama was helpful in forcing considerable improvement in the state institutions there. The Justice Department's participation is particularly helpful, but not necessarily because of its legal talent, but because of its ability to use the FBI and other investigatory channels during the discovery process leading up to trial.

These remarks are meant, then as an introduction to my third and fourth points.

As one studies the litigation that has resulted, it becomes clear that the development of constitutional rights of persons confined in state institutions has not been the result of balanced adversaries. At least that is this observer's opinion. The activists and reformers have produced careful scholarly argument, and this is particularly reflected in appellate briefs. The states have not matched that performance by a wide margin. This has not been the typical situation of much public interest law where the public interest lawyer faces powerful legal adversaries subsidized by vested interests with enormous wealth at their disposal. In many states mental health litigation is handed over to the newest Assistant Attorney General with little legal back-up and wih little motivation. It is easy to understand why a young lawyer would have little interest in defending conditions in institutions where human degradation is the spirit of the day. However, without balanced adversarial presentations to the court, the emerging law is apt to be short-sighted, particularly when it addresses the problems of implementation of new health policy.

When S. 1393 throws the Justice Department in on the side of the plaintiffs, it does nothing to remedy this profound problem of adversarial imbalance. In at least two states, one where the Justice Department is involved and one

where they are not, the doctor-defendants have considered attempts to raise funds to hire private attorneys rather than depend on the efforts of the state Attorney General's office. This response is precipitated both for selfish and unselfish reasons. Many of the suits brought on behalf of patients in the area of developing constitutional rights have demanded monetary damages under § 1983. Thus, physician-defendants have been concerned about the possibility of personal financial hardship that, since it is brought under a civil rights action, may not be compensable through malpractice insurance. The unselfish considerations are that the effort of the federal courts to develop the constitutional rights of citizens confined in institutions without adequate adversarial consideration has resulted in temporary restraining orders, judicial decrees, and consent decrees that have seriously compromised the ongoing treatment efforts in many institutions. In Massachusetts, for example, a temporary restraining order giving patients in a state mental institution the right to refuse medication, and setting limits on the use of resraints and seclusion, has led to chaos with a proliferation of physical and sexual assaults, injury to staff and patients, and a rather serious and profound disruption of the morale of the treatment staff. This situation inevitably disrupts and even destroys the possibility of treatment of all the patients in that facility, including those desirous of treatment.

What all of this suggests is that serious consideration should be given by this Subcommittee to the resources and capacity of the states to deal with litigation initiated in the Justice Department, particularly if that litigation is as I have indicated in my first point, an effort to develop new constitutional rights rather than enforce constitutional rights recognized by the Supreme Court. All of us would agree, I assume, that the development of new constitutional law ought to be the product of good legal argument on both sides.

The fourth issue I want to bring to the Subcommittee's attention also arises directly out of my evaluation of the recent litigation attempting to develop constitutional rights of persons confined in state institutions. The pattern this litigation has now taken is not so much the development of individual constitutional rights in any traditional sense; rather, much of the litigation looks to the particular state institution under consideration and the plaintiff and defendant essentially are forced to develop policy for that instituion. That policy does not take into account the will of the state legislature, the fiscal status of the state, the needs of other institutions not covered in the litigation, or the needs of other mentally disabled persons who do not happen to be in institutions at the time the litigation is brought. What I mean to emphasize is the litigation has taken the form not of arguing specific constitutional rights of all citizens, but rather what one sees is the development of massive consent decrees that set standards and structure every aspect of capital investment, personnel hiring practices, living conditions, etc., in a particular institution. These court standards may or may not be compatible with standards set by HEW, or by the Joint Commission on Accreditation of Hospitals. Essentially, the court ends up taking on the policy decision making role that is supposedly the province of the state Commissioner of Mental Health. Unfortunately, the judge may not feel responsible for all of the state institutions, and thus litigation may result in distortions and gross inequities with money being taken from some institutions to cover improvements mandated by the court in other institutions.

The basic point I want to emphasize here is that the result of this litigation is to usurp from the executive and legislative branches of state government the policy making role for mental health services. S. 1393, as I read it, will heighten that trend.

Senator BAYH. I would like to ask our next three witnesses, if they would, to serve as a panel.

Kenneth Schoen, I think it is fair to say, is one of the most progressive prison administrators in the country, with 20 years experience in the field of corrections. I think the State of Minnesota is one of those States that has been on the point of reasonable change.

Anthony Travisono, executive director of the American Correctional Association, is here delivering testimony for Mr. William

Leeke, who is commissioner of the South Carolina Department of Corrections.

Mr. Irving Segal of the American Bar Association's Commission on Correctional Facilities and Services is accompanied by Mr. Melvin Axilbund staff director of the commission.

I appreciate very much your being here.

We intended to have Mr. William Nagel, executive vice president of the American Foundation, Incorporated. In light of the testimony we had yesterday, we were looking forward to his being here. Unfortunately, he was subjected to a train derailment.

TESTIMONY OF KENNETH F. SCHOEN, COMMISSIONER, MINNESOTA DEPARTMENT OF CORRECTIONS

Mr. SCHOEN. Thank you, Mr. Chairman.

I am Kenneth Schoen. I am the commissioner of corrections for Minnesota.

I have a prepared statement to which I'll make a few additions today. Essentially, what I am saying in the statement is that I am in support of this bill.

I have been in the position of corrections commissioner for 4½ years and in the business of corrections for approximately 20 years.

The department includes both adults and juveniles, incidentally, which is not always the case in each State.

We have had a number of suits, as most administrators in the position that I hold have experienced, based upon the alleged violation of the constitutional rights of inmates in prison. They have come principally from a State-subsidized local organization called Legal Aid to Minnesota Prisoners, LAMP.

From the standpoint of a corrections commissioner, I do not sit in my office looking forward to these kinds of documents that are delivered by the Federal marshals. But they do arrive.

I think, ultimately, the result has been an improvement in the prison conditions and in the institutional settings for juveniles.

There are a number of areas that they have addressed themselves to, ranging from medical care to access to visitors. A most recent suit dealt with the process by which we segregated what were viewed to be obstreperous inmates into separate living quarters. In the process of litigation we found procedures which were indeed unconstitutional as well as being, I think, out of line with good correctional practice. As a result changes were made underscoring the value of legal intervention.

The question of cost comes up. The end result has not been particularly high. I think probably the largest cost has been in the litigation process itself, that is the attorneys that we employ and the defendants' attorneys. In Minnesota, they are largely paid for by the State.

Senator BAYH. When the suits are brought, could some of these costs of litigation be dispensed with, as a result of this negotiating process, to accomplish the goal that the suit or the intervention was designed to accomplish in the first place?

Mr. SCHOEN. Probably not much more than we already have. In all cases, we have ended up negotiating in reaching a settlement outside of the court, which we then bring into court.

I am not a lawyer; my background is sociology. The cost problem, as I see it, is that because there is a suit brought—frequently with money damages attached to it—it is important that we have quality, well-qualified lawyers representing us, so, when we go through the process and end up with a result via negotiation or trial it is one that is legally viable. I have not stated an amount of money this costs and I cannot. But I do know, of course, that the cost of having lawyers representing us is considerably more than what it was some years ago when the whole process never took place in the first place.

So, I guess my answer to your question is that there is an additional cost. I think we are going to have to agree that it is going to be necessary to carry on these kinds of improvements in the system in the legal atmosphere using resources not previously required.

As far as the cost to the State to implement the findings or the negotiated findings, the cost there has not been particularly great.

In Minnesota, we incarcerate per capita very few people, at least in comparison to the national average. We incarcerate about 43 or 44 per 100,000; the national average is something in excess of 100. This means that we spend more per capita in prison but probably not as much per capita in Minnesota.

Senator BAYH. What is the crime rate in Minnesota?

Mr. SCHOEN. The crime rate in Minnesota for violent crime is lower than the national average; the property crime is about average.

Senator BAYH. So you have incarcerated half as many people; this fact has not resulted in twice as many crimes?

Mr. SCHOEN. I think, Senator, we can say pretty pointblank there is no relationship between the number of people incarcerated in the State and the Nation and the crime rate. It is more a result of practice and custom than it is a relationship to the amount of crime that exists.

Therefore, when we make alterations in what we are doing based upon whatever decree may result from the litigation, it has not resulted in a major cost in the operation of the institutions.

From the standpoint of the inmates, inmates are particularly sensitive and have a keen sense of justice, getting to the point of even being paranoid somewhat on that subject. I frankly think the primary quality of a correctional institution, be it juvenile or adult, must be that of justice. That has to be the prevailing theme.

If we accomplish that better through litigation and through the judicial process, I think we are better off. I think, as a result of our experience in Minnesota, we have been better off.

When a sense of justice is felt by inmates to be violated, we end up with a situation in prison that is less than stable. There has been riot, disorder, and violence which has its roots in that perceived injustice. Therefore, from the standpoint of people that are working in the prison on a day-to-day basis, when justice is improved, their working conditions improve.

From my standpoint, of course, and those of us who are at a more distant position, from the line officer, to have the prisons operating smoothly is a desired condition, you can be sure.

I think there has been a good deal of discussion in recent years as to the rehabilitative capabilities of prisons. Personally, I take the stance that prisons serve a primary function of being the symbol by which we make known to the public at large that certain laws must not be violated and that, if they are, we will put people in prison.

However, I think there is one thing we can teach inmates in prison. That is what justice, fairness, and constitutionality are all about. Certainly, that quality should exist in a prison as much as—if even not more so—than on the streets throughout Minnesota and this country.

In conclusion, I think that the constitution of this country, the Bill of Rights, are very important foundations upon which this country was built.

As far as the Department of Justice getting involved—and I want to relate to some of the testimony heard this morning—it certainly is not going to be the cure-all for all problems in correctional institutions.

However, I think it is important that the States not be in a position to be able to opt to enforce the precepts and concepts of the Constitution. I think the Justice Department should be enabled to bring suit against States when it is felt that the Constitution and Bill of Rights are being violated.

I therefore support this bill.

Senator BAYH. Thank you very much, sir.

Without objection, your entire statement will be inserted in the record.

[The prepared statement of Kenneth F. Schoen follows:]

PREPARED STATEMENT OF KENNETH F. SCHOEN

I am pleased to have this opportunity to appear before the Senate Subcommittee on the Constitution and testify on behalf of S.1393. This legislation provides authority to the Attorney General of the United States to redress deprivations of federally protected rights of institutionalized persons, including those in jails, prisons or other correctional facilities, with which I am most familiar. My comments will be addressed to that population.

Minnesota is considered to be one of the more progressive correctional agencies in the United States. As the Commissioner of that Department of 4½ years and as a corrections professional for 20 years I have been well aware of the increased intervention of the courts on behalf of incarcerated individuals. During the last 10 to 15 years a multitude of suits have been brought by various inmate rights groups throughout the country, and the success of these groups has had a major impact upon reform and improvements.

Cases alleging unequal protection of the law, cruel and unusual punishment, or abuses of administrative discretion have resulted in numerous suits, which I believe have upgraded correctional institutions and the development of procedural safeguards regarding basic constitutional rights. There is no question in my mind that had such court intervention not taken place, these fundamental improvements would not have occurred.

In my home state of Minnesota, an organization exists that has sued our department with some degree of regularity. Since its inception in 1972 this legal assistance program has filed over 35 suits. None of these suits has come all the way to a jury trial as we have negotiated to reach equitable settlements.

The net result of this activity has been what we would consider rational and improved administrative practices, including those in the area of due process, inmate mail, furloughs, medical care, visiting rights and elimination of administrative segregation. Minnesota has established policies far beyond what the federal courts have mandated as minimal requirements.

While I do not intend to imply here that I sit expectantly at my desk each week awaiting news of another impending suit, I do recognize that unless my agency consistently deals fairly with those incarcerated in our institutions we will be held judicially accountable.

Correctional officials and particularly institutional administrators have traditionally had nearly unquestioned authority. Practices and policies of institution management are generally developed for administrative convenience, and while these policies do not necessarily reflect intentional oppression of the rights of the confined, that consideration has generally been one of a secondary nature. Correctional institutions by their very nature are inward looking and under constant strain and stress in order to maintain control. Practices that were initially designed as a control measure can easily evolve into punitive and cruel techniques having nothing to do with maintaining control and custody. These procedures, once established, can become virtually impossible to revise as they become ingrained into the very administrative procedures of the agency or institution. The symptom of this process is usualy riot and rebellion, with the net result of imposing often even more control. Prisons are not like the human body in being self-healing rather, unless interrupted, their tendency is operationally to move in the direction of tyranny and caprice. This causes a still poorer environment in which to work, and the cycle perpetuates itself.

Rarely, then, has reform or change emerged from within the walls.

Yet reforms have occurred. As I have indicated, the last decade has seen a variety of organized groups, outside the prison walls, emerge to defend the rights of those within the fortress. Why, then, is there a need for S.1393? If there are already various groups throughout the country engaged in filing these suits, why should we pursue legislation that will afford the Federal Government, through its Department of Justice, legal standing to enforce such constitutional rights?

The answer, I believe, is as much philosophical as it is legal.

Procedures for treatment, physical conditions and rights of persons confined in correctional institutions are not equal throughout our country, in spite of a constitution which speaks of equal protection. Some states have such serious prison overcrowding that inmates are bunked 4 and 5 and 6 to a single 4 x 8 foot cell—and remain there 16 hours per day, while other states have established standards requiring 70 square feet of cell space per inmate; some states have segregation facilities in their prisons with no lights, no running water and no beds—others provide the same physical amenities in their isolation areas as they do in their general population. The gamut runs wide; uniformality of treatment and equal justice under the law are merely slogans, not realities.

Justice must be the prevailing theme of a correctional system. Prisoners have rights which administrators must carefully protect. And if we believe all prisoners deserve equal justice, if we believe that the federal government must protect the rights of all its citizens, if we believe that all citizens should enjoy equal protection and should receive equal treatment, we must then ensure that within the federal government there is a federal agency that can assist in the enforcement of these rights; there must be provided an effective enforcement mechanism for securing these guarantees.

S. 1393 does this. It creates no new rights, it creates no new agencies. It does nothing more than statutorily give the federal government, through its Justice Department, legal standing to institute civil actions in cases where there has been a systematic, widespread pattern of deprivations of rights, privilages or immunities secured by the Constitution or laws of the United States. Recent case law makes it clear that such legislation is needed to ensure the continuation of an orderly and sustained effort towards providing equal protection under the Constitution for all confined persons.

S. 1393 will do this—and do it well.

There are some limitations. The impact of judicial intervention can be limited, or even substantially aborted, by foot dragging administrators. While their activities might be forced to comply with the spirit of the law, there is a good deal they could do to interrupt or diminish this spirit, yet still be in compliance. On the opposite side, laudatory purposes could be manipulated by overzealous activist lawyers who have a personal cause far beyond the intent of the legislation. If we do not, in administering the process, maintain continued

vigilance against this, the antagonists to the legislation would have legitimate reason to move for its demise.

S. 1393 is a good bill. Its potential long range impact, the establishment of equitable standards for confined persons, is badly needed.

Yet S. 1393 may not be the total answer. The question arises: "Assuming its passage, assuming the Federal Government's intervention, assuming court orders for improved institutional conditions—what will be the outcome?" Many of the problems and inequities in institutions are related to financial problems—growing prison populations, limited and antiquated physical facilities, inadequate staff to inmate ratios. If all we do by passage of this bill is create situations where the only answer is more jails, more prisons, more cells—even though they will be better jails, better prisons and better cells—we have not solved the real problem. Nor have addressed the politicians—and the citizens—constant question: "Who will pay?"

We must ask ourselves—is building more places of confinement the solution? Or rather, must not the more basic question "who is locked up—and why" also be resolved, if the how of that confinement is to be properly corrected?

This issue is likely far too broad for consideration under S. 1393. Yet it is no small matter. We must recognize that if we believe philosophically that the Federal Government has the power to enforce equal rights and equal protection, we must also admit that the Federal Government has the duty, the responsibility and the obligation to provide assistance in the promotion, development and funding of programs and practices that will ensure a constant continuation of these efforts. And we cannot pass legislation to do the first, without knowing that the second must be close at hand.

I would urge both your support of S. 1393 and your continued review of the broader issues that it raises.

STATEMENT OF WILLIAM D. LEEKE, COMMISSIONER, SOUTH CAROLINA DEPARTMENT OF CORRECTIONS, PRESENTED BY ANTHONY P. TRAVISONO

Mr. TRAVISONO. Senator Bayh, Mr. Leeke, whom I represent this morning, regrets that he is not able to be with you to share his thoughts. He has asked me to do that for him.

Mr. Leeke is also a veteran career specialist in the field of corrections, having served almost 20 years. He expresses his deep appreciation to you for your collective interest in the development and reform of our Nation's penal and postadjudicatory systems. He is currently the commissioner of corrections in South Carolina. He also serves as president of our American Correctional Association, of which I am the executive director.

We do have 10,000 to 12,000 correctional professionals throughout the United States and Canada within our membership, which includes adult and juvenile services; institutional, transitional, and community programs; probation, parole, and pardon services; related academic areas; corrections volunteers; and a whole host of services in this field.

He is testifying today basically as the commissioner of South Carolina, although he has been in contact with several other commissioners who, perhaps, expressed the views that he wishes to express to you today.

The Federal district courts of this country have been deluged with prison-related lawsuits. The volume of litigation has caused a great number of substantive and procedural problems. This bulk of litigation has increased greatly the length of time between the institution of suit and final determination. Prolonged confusion con-

cerning proper prison administration follows. Moreover, the exponential increase in prisoner petitions, especially the 42 U.S.C.A. 1983 actions, has taxed the limited resources of State correctional systems.

The need for the creation and implementation of a process by which vital constitutional issues will be litigated and, to a greater extent, resolved is paramount. So long as the constitutional parameters governing corrections management remain either unclear or unresolved, the effect will be detrimental to both inmate and correctional staff morale.

Any conscientious correctional administrator is deeply concerned about and dedicated to the protection of the civil rights of the inmates charged to his custody and care. However, this can be a most difficult task as we are faced with the vicissitudes of correctional case law. Though Mr. Leeke is uncertain as to the public utility of this legislation, he would urge your consideration of two recommendations should enactment of the bill be contemplated.

Two modifications to strengthen and provide greater utility to this proposed legislation would be: (1), to require that exhaustion of State administrative and/or judicial remedies be had prior to implementation of action under the auspices of this bill; and, (2), upon notice of intent by the Attorney General to the respective State officials, the bill provide that a period of time be granted the State officials so that they may review the case and take whatever remedial and/or affirmative action indicated, if such may be applicable, to obtain redress for the alleged violations.

Such recommendations are offered as it is felt more desirable for the State to act on its own initiative and not on judicial fiat.

Provision for administrative exhaustion of State remedies in section 1 of the bill would recognize the fundamental tenet that the most effective resolutions are those accepted by both inmates and the institutional staff. As outlined in improved grievance procedures: A technical assistance manual, prepared by the Bar Association Support To Improve Correctional Services, a properly functioning administrative grievance mechanism should and can be a manifest component of conflict resolution. Among other benefits, inmates are provided regular formalized procedures in bringing forward their complaints as to conditions and policies to the correctional administration as well as affording the inmates with input in suggesting improvements. Tension between inmates and staff is reduced as the two groups work together to find mutually agreeable solutions to problems.

It is not my intent to endorse a specific grievance mechanism over another procedure. Nevertheless, I wish to outline to the subcommittee commonly implemented procedures which could be applied, as such administrative remedies do exist and it is felt should be exhausted prior to the Attorney General's invocation of the jurisdiction of this bill.

One is the ombudsman model.

Senator BAYH. Could we just submit those models for the record without going into all the details, so we can have a chance to study them, sir?

Mr. TRAVISONO. Certainly.

I will conclude, Senator, with a summary of Mr. Leeke's position.

Correctional administrators are currently forced to operate in an atmosphere of confusion and stress created in part by severe fiscal constraints and burdensome litigation. The numbers of suits challenging the policies and practices of administrators is ever increasing.

Realistically, the volume of petitions will not decrease in the near future. Furthermore, Mr. Leeke is not convinced that the enactment of S. 1393 would result in a decrease in litigation; and, as commissioner of the South Carolina Department of Corrections, he is concerned that his administration will become less effective as these challenges proceed through the judicial system.

However, despite his concerns, should S. 1393 be enacted, he would urge inclusion of the modifications proposed to, one, require the exhaustion of available State administrative procedures and/or judicial remedies and, two, allow for a reasonable period of time to permit the States to act, once notified.

Thank you, Senator.

Senator BAYH. Thank you, Mr. Travisono.

Without objection, the entire statement of Mr. Leeke will be inserted in the record.

Senator BAYH. Mr. Travisono, I realize that you were presenting Mr. Leeke's views. Perhaps you are not in a position to respond to questions directed at that statement. If you do not feel comfortable answering the following questions, please say so.

I note that Mr. Leeke is concerned about the question of an exhaustion requirement. He feels that any individual should have to exhaust State remedies before suing.

He also refers to the bar association comment, almost as if it is in support of that position.

Is he aware, or are you aware that the bar association is going to be strongly in opposition to the requirement of exhaustion before the suit?

Mr. TRAVISONO. I cannot speak that he is aware of that position.

Senator BAYH. You might call that to his attention.

Mr. TRAVISONO. I certainly will, Senator.

Senator BAYH. Also, in assessing the right of individuals generally to sue to protect their civil rights, the courts have pretty consistently ruled that plaintiffs do not have to exhaust State remedies.

So, if you are going to single out individuals who happen to be institutionalized and apply a different standard to them than the court has so far applied to everyone else, there may be a question of the constitutionality of that.

Mr. TRAVISONO. Again, I cannot express his views, but I think it would relate to the section where he indicates that the evolving correctional law is still very unclear as it relates to the problems in the criminal justice system of corrections and that, perhaps, many of these problems could be worked on and solved at the local level, if given the opportunity.

Senator BAYH. Perhaps Mr. Segal can speak to that.

You are aware, I am sure, that there are institutions for the mentally ill, the retarded, the aged, the juveniles that are also included in this?

Mr. TRAVISONO. Oh, yes.

Senator BAYH. Do your concerns about exhaustion go strictly to penal inmates, or are you speaking of inmates who are patients at other institutions?

Mr. TRAVISONO. I believe Mr. Leeke would be speaking for inmates of penal institutions only.

Senator BAYH. I think it is fair to say that Mr. Leeke's testimony reflects a concern for the increasing number of lawsuits filed by prisoners. He implies that the measures in S. 1393 would exacerbate this problem.

Judge Johnson, in looking at the question of Alabama prisoners, did consolidate numerous cases. In the Rhode Island case, there were 150 individual cases tried together.

Is there any reason, if S. 1393 becomes law, that the judge wouldn't do the same thing as he has in the past?

Mr. TRAVISONO. I do not believe there is, from my point of view, Senator. I think the judge would take that under advisement.

Senator BAYH. We might just ask.

Mr. TRAVISONO. I will ask Mr. Leeke.

Senator BAYH. Thank you.

[The prepared statement of William D. Leeke, submitted by Mr. Travisono, was marked "Exhibit No. 13" and is as follows:]

[EXHIBIT NO. 13]

PREPARED STATEMENT OF WILLIAM D. LEEKE, COMMISSIONER, SOUTH CAROLINA DEPARTMENT OF CORRECTIONS

Mr. Chairman and members of the Subcommittee on the Constitution of the United States Senate Committee on the Judiciary:

OPENING REMARKS

I am honored that you have invited me to testify before you concerning S. 1393. Unfortunately, due to scheduling conflicts I am unable to personally appear. Therefore, I have requested that Mr. Anthony P. Travisono, Executive Director of the American Correctional Association, appear in my stead and present my testimony.

As one who has been actively working in the corrections area of the criminal justice system for almost twenty years, may I express my deep appreciation to you for your collective interest in the development and reform of our nation's penal and post-adjudicatory systems. I am currently Commissioner of the South Carolina Department of Corrections and am serving as the President of the American Correctional Association, an organization composed of between 10,000 and 12,000 members from throughout the United States and Canada and represents all aspects of correctional work, including adult and juvenile services; institutional, transitional, and community programs; probation, parole, and pardon services; related academic areas; corrections volunteers; and other interested individuals, agencies, and private firms and groups. During my career in corrections I have served as past-President of both the Southern States Correctional Association and the National Association of State Correctional Administrators.

Although I am testifying today as he Commissioner of the South Carolina Department of Corrections, I have, nevertheless, been in contact with several other state correctional administrators and am confident that the views hereafter expressed are shared by the majority of my fellow correctional administrators.

As you are aware, the federal district courts of this country are deluged with prison related law suits. The volume of litigation has caused a great number of substantive and procedural problems. This bulb of litigation has increased

greatly the length of time between the institution of suit and final determination. Prolonged confusion concerning proper prison administration follows. Moreover, the exponential increase in prisoner petitions, especially the 42 U.S.C.A. 1983 actions, has taxed the limited resources of state correctional systems.

The need for the creation and implementation of a process by which vital constitutional issues will be litigated and, to a greater extent, resolved is paramount. So long as the constitutional parameters governing corrections management remain either unclear or unresolved the effect will be detrimental to both inmate and correctional staff morale.

STATEMENT

Any conscientious correctional administrator is deeply concerned about and dedicated to the protection of the civil rights of the inmates charged to his custody and care. However, this can be a most difficult task as we are faced with the vicissitudes of correctional case law .Though I am uncertain as to the public utility of this legislation, I would urge your consideration of two recommendations should enactment of this Bill be contemplated.

Two modifications to strengthen and provide greater utility to this proposed legislation would be: (1) To require that exhaustion of state administrative and/or judicial remedies be had prior to implementation of action under the auspices of this Bill; and (2) Upon notice of intent by the Attorney General to the respective state officials the Bill provides that a period of time be granted the state officials so that they may review the case and take whatever remedial and/or affirmative action indicated, if such may be applicable, to obtain redress for the alleged violations. Such recommendations are offered as it is felt more desirable for the state to act on its own initiative and not on judicial fiat.

Provision for administrative exhaustion of state remedies in Section One of the Bill would recognize the fundamental tenet that the most effective resolutions are those accepted by both inmates and the institutional staff. As outlined in "Improved Grievance Procedures: A Technical Assistance Manual" prepared by the Bar Association Support To Improve Correctional Services (BASICS), a properly functioning administrative grievance mechanism should and can be a manifest component of conflict resolution. Among other benefits, inmates are provided regular formalized procedures in bringing forward their complaints as to conditions and policies to the correctional administration as well as affording the inmates with input in suggesting improvements. Tension between inmates and staff is reduced as the two groups work together to find mutually agreeable solutions to problems.

It is not my intent to endorse a specific grievance mechanism over another procedure. Nevertheless, I wish to outline to the Subcommittee commonly implemented procedures which could be applied, as such administrative remedies do exist and it is felt should be exhausted prior to the Attorney General's invocation of the jurisdiction of this Bill.

1. Ombudsman Model: Traditionally, the ombudsman is an independent agent, usually appointed by the state's legislative body. The ombudsman has the authority to investigate and mediate between individuals or groups and the correctional agency. In the majority of situations the ombudsman is not empowered to enforce recommendations proffered by his office but must rely first on the good faith intent and good will of the agency involved. The major facet of this type of ombudsman program is the inherent independence of the agency under investigation.

A variation of the ombudsman model is the departmentally created ombudsman's office. Typically, the director of the agency appoints the ombudsman to receive and investigate complaints from the correctional facilities. The ombudsman is an employee of the agency, directly responsible to that agency. The ombudsman's office has access to files, documents, and records and is required to investigate each complaint and present recommended solutions to its superior. In effect, the director creates a staff position assigned the specific duty of investigating inmate complaints.

2. Grievance Procedures: As stated in "The Grievance Mechanism In Correctional Institutions," published by the Law Enforcement Assistance Administration and the National Institute of Law Enforcement and Criminal Justice, "Grievance procedures in correctional institutions generally have taken the

form of a multi-level appeal process. At the institutional level, a designated individual or committee considers complaints that are submitted in writing and usually makes recommendations to a decision maker, i.e., the superintendent. If the grievant is dissatisfied with the response, he usually may appeal for a review of the decision at a higher level, usually within the department of corrections. In some instances, he may appeal the departmental decision to some form of external review which is advisory to the superintendent or departmental director."

The procedures utilized in a typical grievance procedure model include the imposition of time limits at every level of the complaint and appeal, that each grievance must be addressed in writing together with an explanation of facts in the event that the petition is denied, special provisos for handling emergencies, and a hearing at some specified stage of the appeal process.

Through implementation of this type of grievance model the possibility of increased inmate participation exists for the resolution of difficulties. As a general rule, the greater the level of participation by inmates, the higher the level of credibility attributed to such a procedure.

3. The New Jersey Model: The Office of Inmate Advocacy was created in the State of New Jersey as a part of the Department of the Public Advocate. One of this office's many responsibilities is to process prisoner's class action suits against the state, county, and local governments. The scope of this office is set out in the enabling legislation in that the office represents "the interest of inmates in such disputes and litigation, as will, in the discretion of the Public Defender, best advance the interest of inmates as a class . . . and may act as representative of inmates with any principal department or other instrumentality of state, county or local government."

The Inmate Advocacy section is staffed by two attorneys and other clerical assistants. The office serves all state penal institutions as well as the local jails. Both attorneys and investigators acquire cases during their visits with inmates at the various facilities as well as via mailed requests for assistance. All staff members are trained to attempt informal resolution of complaints. The attorneys look for patterns in the grievance filed to determine which subjects might be ripe for class action.

Admittedly, these various models are not to be measured as panaceas, either individually or together, in the area of inmates' grievances. However, it is my firm belief that these procedures or whatever administrative process the various state departments of corrections have developed first be exhausted prior to the Attorney General instituting action. The rationale is two-fold. First, any solution that is formulated on the state level, especially that arrived at by both administration and inmate residents, is preferable to intervention by the courts. Second, the need to preserve the integrity of the administrative procedure is of paramount importance as the resolution of conflicts ultimately rests in this process.

Moreover, it is felt that consideration should be given to a requirement that state judicial proceedings by exhausted prior to institution of action by the Attorney General under this proposed legislation in that state courts are uniquely familiar with local prison conditions and, therefore, should be qualified to effect meaningful judicial remedies. Admittedly, the Supreme Court has held in *Monroe* v. *Pape*, 365 U.S. 167, 81 S. Ct. 473 (1961), that exhaustion of state remedy is not constitutionally required. Nevertheless, I feel that statutorily the state judiciary should be given priority to fashion appropriate remedies.

It is further recommended that Section Two be amended to allow that a reasonable period of time be designated after notification of the state officials by the Attorney General to allow institution by state officials of any action deemed appropriate or otherwise indicated. Should the state grant relief sought by the Attorney General, the cost of litigation would automatically be avoided and the issue made moot. Additionally, as a matter of respect to the state, a period of time should be set out in which the state may take whatever remedial or affirmative action it decides is appropriate. If subsequent to the notification of appropriate state officials by the Attorney General and after a reasonable period of time the state had decided not to grant the relief sought, the Attorney General should at that time commence action under the auspices of this Bill.

CONCLUSION

Correctional administrators are currently forced to operate in an atmosphere of confusion and stress created in part by severe fiscal constraints and burdensome litigation. The numbers of suits challenging the policies and practices of administrators is ever-increasing. Realistically, the volume of petitions will not decrease in the near future. Furthermore, I am not convinced that the enactment of S. 1393 would result in a decrease in litigation; and as Commissioner of the South Carolina Department of Corrections I am concerned that our administration will become less effective as these challenges proceed through the judicial system. However, despite our concerns, should S. 1393 be enacted we would urge inclusion of the modifications proposed to (1) require the exhaustion of available state administrative procedures and/or judicial remedies and (2) allow for a reasonable period of time to permit the states to act.

TESTIMONY OF IRVING R. SEGAL, COMMISSION ON CORRECTIONAL FACILITIES AND SERVICES, AMERICAN BAR ASSOCIATION; ACCOMPANIED BY MELVIN T. AXILBUND, STAFF DIRECTOR

Mr. SEGAL. Mr. Chairman, I am Irving R. Segal.

This oral statement supplements my prepared statement already submitted.

I have, since 1971, been a member of the American Bar Association's Commission on Correctional Facilities and Services. Melvin Axilbund is my mentor. He is the staff director of that organization.

The commission was formed in 1970, as I am sure you know, pursuant to the invitation of Chief Justice Burger, that the bar become a leader in the field of correctional improvement, if not reform. I believe that the commission has promoted excellent programs—at one time as many as a dozen with a staff of perhaps 35. It could be said that the commission is phasing out now.

In that period of time it has been a kind of instigator of movements in this field. That is the capacity in which I speak. I have Mr. Axilbund here because I am not anything like the kind of expert you have heard today; except I have, for close to 40 years, been in the courts. I am going to direct my remarks to what I gather will be the experience of the Attorney General in the courts.

I am not going to address myself to my prepared statement here at all, Senator. I have spent my lifetime telling witnesses that they should not read the statements that have already been submitted, and I am not going to violate that rule.

Senator BAYH. I think it is fair for me to say that the ABA Commission on Correctional Facilities and Services has served as a sort of lightning rod of conscience to try to get public awareness and official reaction to some of these critical problems. We are all in your debt.

Mr. SEGAL. Thank you, Senator, it seems to me that perhaps I could best proceed by mentioning three points; they will not take me very long.

The first is, in preparing for testifying here in an area in which I have already said that I am not an expert, I focused on the objective of S. 1393. I think it is important, as we approach the end of your hearing day, to focus on it again.

As I understand it, its objective is to protect rights, privileges, immunities secured by the Constitution or laws of the United States

with respect to people who find themselves in kinds of institutions the bill describes. As I understand it, Senator, it is not a cure-all for every evil which we necessarily know exists in both penal and mental institutions and perhaps retirement homes and other institutions described in the bill.

I found myself somewhat confused because I do not think, Senator, your bill is intended to cure a situation such as the horrible death of a child who was killed by hot water internally injected into his body, as described by the good doctor from Georgia. I doubt very much if that would be—except in the long run—aided by the Attorney General's participation in litigation.

Senator BAYH. Unfortunately, there is no legislative remedy that is failsafe.

Mr. SEGAL. That's right.

Senator BAYH. Whatever we do is subject to the imperfection of human beings. What we are trying to do is provide an environment in which the number of malfunctions can be significantly diminished.

Mr. SEGAL. The Senator mentioned the resolution of the American Bar Association passed by the House of Delegates in August 1976. It speaks of the very same words that are in this bill. It speaks of the full enjoyment of rights, privileges, or immunities secured or protected by the Constitution or laws of the United States with respect to prisoners and inmates of mental institutions and other institutions.

It is that aspect of this bill that the American Bar Association supports. I am here at the request of the president of the American Bar Association to support the bill in its present form.

The second point I wanted to make—and it is not in my prepared statement—was called to mind by Dr. Stone's testimony. It is that, as a practicing lawyer with and against the Government in many cases over a lifetime of litigation, I need not assure you, sir, but I wish to assure the record, that I have found that the resources of the Attorney General's office are enormous, both with respect to the capabilities of the fine lawyers that find their way into that organization and with respect to its ability to command attention, to command witnesses nationwide, to commend studies that have been produced nationwide.

Dr. Stone—I agree with the Senator—was not in real disagreement with the objectives of this bill. He, it seems to me, would prefer, however, to let it take the course of normal litigation by civil rights lawyers—and they are some of the best lawyers in the country in that field; I agree with that, too—and then rely on the chance invitation directed to the Attorney General to participate as an amicus in those civil cases.

While it is true that the Attorney General has been permitted to participate in some of those cases, in more than the normal amicus capacity, but, rather, in the litigant capacity, nonetheless, it is a totally different matter to have the Attorney General have the ability to pick and choose those key situations in which he can instigate litigation, command the litigation, direct it, direct the settlement which the Senator spoke of earlier today, the accommodations that can be reached in settlement of litigation, and in general make it "United

States versus" instead of "A versus B," with the United States Attorney General as an amicus.

I think as a litigant I can assure you there is all the difference in the world in the impression on the court and on the public. The United States as the litigant attracts the attention of the press. The Assistant United States Attorney General, as I understand it, testified a month ago before the House. He estimated that, under this S. 1393, the Attorney General would participate or institute 7 to 10 cases a year.

That is what I concede to be—and I think the American Bar Association concedes to be—a proper function of the Attorney General: To pick out major spots in which attention can be riveted nationally and a precedent established nationally that would then affect the type of situation the Senator's subcommittee has heard from many witnesses.

Senator BAYH. I assume you are painfully aware of the condition of the dockets of many of our Federal courts as far as crowding is concerned. You are as desirous as anybody is to see that the cases are expedited.

Is it fair to assume that, by giving the Justice Department the right to pick and choose and not just to respond, that you indeed might accomplish what we are trying to accomplish with no additional intervention and perhaps even less intervention because of the ability to pick those cases that have the greatest consequence and cover the greatest field of abuse?

Mr. SEGAL. I do indeed think so, Senator.

In addition to that, it is pointed out in my prepared statement that something over 5 percent of all the civil actions of all the Federal district courts in the United States are inmate petitions, primarily on civil rights matters.

Senator BAYH. Five percent?

Mr. SEGAL. Over 5 percent.

In the back of my statement, Mr. Axilbund has provided a chart which shows that that 5 percent is something like 7,000 cases. It would seem to me that if the Attorney General, in this picking and choosing—you and I have used that term, and I think it is the right term—I think the bill directs the Attorney General to pick and choose by the standards it creates—I think a lot of those cases would vanish. If the inmates of these institutions could see a major case in Pennsylvania or in the Northern District of California that takes up his rights and focuses nationally on his rights that he, in his handwritten fashion, has tried to bring before that court in a kind of amateurish and painfully slow and unattractive—in the legal sense—procedure. He does not command the judge's attention. He gets kind of shoveled around, but he does his best.

I think, Senator, that if inmates see this happening, the number of these cases in the courts will diminish. You will have a bigger case, sure. But it will be well directed, well tried.

I heard today about a case—Senator Scott said it would take 2 years to present expert testimony. I have never seen such a case in my whole life, and I have been in some of the longest cases in America.

But if that happens in the kind of case that now exists, I tell you the Attorney General, in his 7 to 10 cases a year, will not have that kind of procedure. It will be a well-honed case.

I think you will diminish the number of these petitions in the courts that Chief Justice Burger talked to the Bar Association about in 1969; that has to be reduced in order to relieve the burden on the courts.

I think the effect of S. 1393 might very well be to reduce litigation, not to increase it.

So, I call the attention of the subcommittee to the resources of the Attorney General, which I think are a very important part of the program which the American Bar Association is in favor of and that it thinks will be augmented by your bill.

The final point is on this exhaustion of remedies. Senator Bayh, I think you have largely covered that. But let me stress the fact that the American Bar Association resolution to which I referred ends up by saying:

> Any such legislation should continue existing law and not require involuntarily confined persons to exhaust state administrative remedies as a condition precedent to securing relief under section 1979 of the revised statute, 42 U.S.C. section 1983.

That resolution directs itself to a possible amendment of existing law with regard to the general civil rights field. I understand there is one bill before the House that as a kind of appendage to the bill, which in other respects is similar to yours, would amend the laws of the United States with respect to the inmates of penal institutions and other institutions.

We are unalterably opposed to that.

But, in addition, we are opposed to any provision in S. 1393 that would make it a condition of the Attorney General's institution of, or intervention into, a suit that there be an exhaustion of State remedies. The bill now expressly says the contrary. We think that is the right direction of the bill and that it would impede the objective of the bill immeasurably to insert any exhaustion of remedies requirement, either with respect to the actions this bill is directed to or—even more important—section 1983 actions in general.

As the Senator has pointed out, it would be a change in existing law against a certain class of citizen and, in my view, would be intolerable.

Senator BAYH. Would it be sustained, do you suppose, by the courts?

Mr. SEGAL. Well, I think there is a serious constitutional question. I have not focused on that aspect of it. I think there is serious doubt as to the constitutionality of——

Senator BAYH. If you have not focused on that, I will not ask you to respond.

Mr. SEGAL. I have not focused on it, but my impression would be—I am not unfamiliar with the constitutional principles involved—it would be a very serious constitutional question.

That, Senator, completes the remarks I wanted to make that are not in my prepared statement.

Senator BAYH. Your statement will be inserted.

Gentlemen, your statements speak for themselves. Thank you very much. I appreciate the inconvenience to which you have been put.

I appreciate the contribution you have made to our study. I hope you will feel free to let us have any additional thoughts you might have as you give this more thought and as we proceed with our study.

Mr. SEGAL. Thank you.

Senator BAYH. Thank you very much.

[The prepared statement and supplementary materials submitted by Irving R. Segal follows:]

PREPARED STATEMENT OF IRVING R. SEGAL ON BEHALF OF THE AMERICAN BAR ASSOCIATION

Mr. Chairman and members of the subcommittee, I am Irving R. Segal. Since 1971 I have been a member of the American Bar Association's Commission on Correctional Facilities and Services. I am pleased to appear before you today at the request of President Justin A. Stanley to present the Association views with respect to S. 1393. The American Bar Association supports the principles of this measure.

Our Commission was created in 1970 in response to Chief Justice Warren E. Burger's challenge to lawyers to assume a leadership role in examining America's correctional system and advancing innovative programs which would improve that system. Since beginning its work in earnest in 1971, our Commission has started over a dozen staffed programs. We have also sponsored and successfully urged the ABA to adopt a variety of policy positions to further our mission.

Most pertinent to the legislation now before you, in 1972 the Commission created the Resource Center on Correctional Law and Legal Services. The two principal goals of the Resource Center were to encourage the broader provision of legal services to confined offenders and to encourage the development of grievance mechanisms for prisoners to serve as an alternative to the litigation process. Since 1974, fostering these mechanisms has been a priority of the Commission's BASICS* program. Through BASICS, over $60,000 has been spent on grants and technical assistance to state and local bar associations to allow them to work with local correctional officials to develop grievance mechanisms.[1] Thus, the Commission has been concerned for five years with the issues that are before us today.

At the Association's 1976 Annual Meeting last August, our House of Delegates adopted a resolution calling on all states to develop formal grievance mechanisms for prisoners as a supplement to existing judicial remedies. The resolution also supported the principles of legislation such as S. 1393. In my remarks this morning, I would like to explain the basis for our position, and I would of course be pleased to respond to your questions at any point.

In summary, we believe that the record is clear that the rights of confined citizens have often been ignored or violated in local and state correctional systems. That is the judgment of our courts,[2] that is the judgment of such legislative agencies as the General Accounting Office,[3] and that is the judgment of

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* Basic stands for Bar Association Support to Improve Correctional Services.

[1] One of these bars was The Association of the Bar of the City of New York. Based on an initial study performed under a $3500 BASICS grant, a state-wide inmate grievance system has been designed and is being implemented. An additional BASICS grant of $15,000 was made to facilitate implementation. Federal and private funds of $580,000 were attracted by this small "seed money" investment. The conception and implementation of this program are described in the attached article reprinted from The Record of The Association of the Bar of the City of New York, May/June 1977.

[2] See the cases collected in Merritt, *Correctional Law Digest: Major Cases Reported in 1976* (ABA Commission on Correctional Facilities and Services, 1977); Merritt, *Correctional Law Digest: Major Cases Reported in 1975* (ABA Commission on Correctional Facilities and Services, 1976); ABA Resource Center on Correctional Law and Legal Services, *Prisoners' Legal Rights: A Bibliography of Cases and Articles (2 ed.)*, (ABA Prison Law Reporter, 1974); Singer *Prisoners' Legal Rights: A Bibliography of Cases and Articles* (Warren, Gorham & Lamant, Inc., 1971).

[3] See the Comptroller General's 1976 report, *Conditions in Local Jails Remain Inadequate Despite Federal Funding for Improvements* (No. GGP-76-36). The General Accounting Office also critized state and local probation systems in 1976 (GGD-76-27), and halfway houses in 1975 (GGD-75-70).

the executive branch of the federal government.[4] And we believe it is a judgment with which many state correctional officials would also agree. It also appears reasonably clear that the existing methods for lessening these violations of individual rights, of human rights, if you will, have not been fully effective. While there are a wide variety of measures we should take, and are taking, to rectify this situation, it is appropriate that the Congress consider and enact legislation such as S. 1393 to provide an additional means by which at least the most serious problems can be addressed. It is worth noting, too, that while this bill is directed toward improving conditions in correctional institutions, among others, it may afford a means whereby some of the burden of prisoners' rights litigation may be lifted from the shoulders of the district court judges, on whom it has largely fallen.[5]

It seems unnecessary this morning to spend much time establishing that prisoners in fact have been deprived of constitutional rights in correctional institutions. From press accounts I know you have had first person testimony regarding the sorry conditions which exist in state-run institutions for the mentally disabled. Prisoners could tell many similar tales. Violations have been established in numerous cases concerning religion, speech, unreasonable searches, cruel and unusual punishments, denial of the equal protection of the laws, and deprivation of due process. The voting rights of detainees have been limited, and unconvicted persons have often been subjected to conditions more onerous than those provided sentenced prisoners in the same state.

Prisoners have often been forced, as they see it, to resort to violence in order to protest prison and jail conditions. Correctional officials see the seeds of violence in any concerted action by prisoners and they have, therefore, generally not countenanced group action. Prison riots, of course, have many causes. The American Correctional Association accepts the reality that these include inept management, inadequate personnel practices, inadequate facilities, insufficient constructive, meaningful activity, and insufficient legitimate rewards for good behavior and efforts at selfimprovement.[6]

A variety of preventive measures are suggested directly by these shortcomings. Our immediate concern, however, is with techniques for making prisoners' complaints known and resolving them. These techniques may be of two types, administrative and judicial. The range of administrative mechanisms includes everything from a simple suggestion box approach to monitoring of grievances by an ombudsman.[7]

Of 209 state correctional institutions responding to a 1973 survey,[8] 77 percent reported an existing formal grievance mechanism, 71 percent indicated there was a legal services program for dealing with prisoner complaints, and 56 percent reported inmate councils through which complaints could be resolved. Sixty-four institutions (31 percent) also indicated they were serviced by an ombudsman and 21 percent reported a prior effort to form an inmate union of some sort.

This is an impressive record, and, as already mentioned, the ABA Corrections Commission has encouraged and continues to encourage developments along these lines. A closer look at the details of particular programs reveals that while individual systems can be lumped into a few main categories, there is considerable variety among the programs of each type. The programs have in common the assumption that at least some prisoner grievances are legitimate.[9]

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[4] A review of litigation supportive of this conclusion was provided to this subcommittee on June 17, 1977, by Assistant Attorney General Drew S. Days. III. See, also, the series of reports on state correctional systems presented to the U.S. Commission on Civil Rights by its state advisory committees for Nebraska (August, 1974). Colorado (September, 1974), Alabama and Delaware (November, 1974), and Kansas, New York, and Arizona (December, 1974).

[5] By virtue of the Supremacy Clause, state court judges have the power to hear cases which arise under the 1871 Civil Rights Act. 42 U.S.C. §1983. For an example of a recent case confirming this parallel jurisdiction, see *Kish* v. *Wright*, ——Utah——, 21 Crim. L. Rptr. 2108 (Mar. 30 1977). However, there is no evidence that a substantial volume of such cases have been heard in state court systems under that Act, or under specific state legislation,, such as §79-c of the New York Civil Rights Act.

[6] American Correctional Association, "Riots and Disturbances in Correctional Institutions," 1 (1970).

[7] Penal Ombudsman Legislation had been proposed. See H.R. 7568 (95th Cong., 1st Session).

[8] McArthur, Inmate Grievance Mechanisms: A Survey of 209 American Prisons, 38 Fed. Probation 41, 42 (1974).

[9] Under New York's new system, 65% of inmate complaints have been found to have merit.

They also have in common a feature which may account for the failure of these relatively new programs to reduce prisoners' reliance on the courts as a primary source of relief. That feature is that administrative procedures rely, either originally or ultimately, on a correctional official deciding to take corrective action. While it is entirely proper—and probably best—that the initiative for change should come from those most familiar with the particular situation or institution, it is not surprising that prisoners do not place great faith in these grievance procedures. There is little evidence in our correctional history that correctional officials are capable of providing meaningful relief to prisoners when major expenditures or substantial changes are required. Nevertheless, the American Bar Association believes there is value in continuing and expanding the correctional officials' existing efforts. In the Association's "Tentative Draft of Standards Relating to the Legal Status of Prisoners," released in April a comprehensive program for the settlement of disputes is outlined.[10]

We do not envision, however, that individually or *in toto* the recommended measures will quickly change prisoners' perceptions of correctional officials as adversaries. Nor will the procedures reach the major issues likely to attract the notice of the Attorney General. Consequently, we find appealing the approach of S. 1393 to resolving inmate civil rights complaints.

State prisoner civil rights petitions heavily burden the District Courts. Last year such cases accounted for 5.32% of all civil action filings.[11] However, in looking at the frequency of these cases, it is well to remember that the last few years have been a period of unprecedented growth in state prisoner populations. Since construction of new correctional facilities has not kept pace with the prisoner influx, more persons have been crowded into the existing, already inadequate, correctional plant. If there is a surprise in the filings data, it is that last year there were actually fewer petitions filed per 1,000 prisoners than in 1975, despite a 14% population rise in the same period. According to the Federal Judicial Center,[12] these cases are especially difficult to handle, in part because most are brought by the inmate without benefit of counsel, the petitions are frequently handwritten, and they often contain a large variety of allegations which are difficult to separate and evaluate. The report also notes, as have most persons familiar with prisoner civil rights litigation, that many frivolous complaints are included in the total filed.

This fact does not lessen the validity of prisoners' seeking judicial redress for violations of their rights. Rather, it suggests that new efforts be made to improve the conditions underlying these complaints and that new techniques be employed to facilitate judicial resolution of the cases brought before the courts. The simplified forms, and other case handling techniques, outlined by the Federal Judicial Center appear to be worthy of careful consideration.

The provisions of S. 1393 are equally appropriate for consideration. Presently the District Judge has little basis to differentiate the frivolous complaint from the meritorious one, or the valid individual claim from those of general significance. Sections 1 and 3 of S. 1393 provide a technique by which the Department of Justice can advise the court that it has before it something more than a run-of-the-mill case. This should facilitate the allocation of judicial resources to the most important of these complaints. And, because the relief sought by the Attorney General would apply throughout a correctional institution or system and serve as precedent for the nation, these provisions should obviate the need for often repetitive individual claims.

Just as these provisions could save judicial effort, they could help the responsible state officials. It is entirely reasonable to expect that upon being notified by the Attorney General that a pattern or practice of violation of rights has been detected, the state officials concerned will be activated to invesigate and implement remedial measures, and avoid the need for litigation. It seems sensible as well for the press to treat as more serious than the ordinary case those relatively few cases in which the Attorney General will become involved. The coverage accorded these serious cases will bring to the attention of correctional officials everywhere information which will enable them to anticipate, and thereby avoid, local problems. Those cases not settled through pretrial negotiation, pursuant to the requirement that the Attorney

[10] See Standards in Part VIII, 14 *Am. Crim. L. Rev.* 377, 405 (1977).
[11] See Table 1.
[12] Federal Judicial Center, "Tentative Report: Recommended Procedures for Handling Prisoner Civil Rights Cases in the Federal Courts" 13 (1976).

94-420 O - 77 - 28

General provide advance notice of an intent to litigate, would probably be carefully developed by both sides. And this would, in turn, regardless of the outcome, contribute substantially to the development of constitutional standards for corrections. The potential contribution of S. 1393 to improved prison conditions through the involvement of the Department of Justice, is not hard to envision. On May 18, 1977, Assistant Attorney General Drew S. Days, III, wrote Congressman Kastenmeier, Chairman of the House Judiciary subcommittee considering legislation comparable to S. 1393. Mr. Days estimated that the number of new prison and jail cases which might be filed pursuant to H.R. 2439 or H.R. 5791 would be in the range of 7 to 10 per year. That total would not burden the federal court system nor overwhelm the states. But it could produce substantial benefits for the fair administration of our correctional system, and that is why the American Bar Association supports S. 1393.

TABLE 1.—PRISONER CIVIL RIGHTS PETITIONS FILED IN U.S. DISTRICT COURTS, FISCAL YEARS 1972-1976

	1972	1973	1974	1975	1976
State prisoner population (estimated for June 30)[1]	175, 600	177, 900	188, 600	207, 200	236, 800
State prisoner civil rights petitions[2] (for the Federal fiscal years ending June 30)	3, 358	4, 174	5, 236	6, 128	6, 958
Rate of filings per 1,000 prisoners	19. 07	23. 46	27. 76	29. 58	29. 38
State prisoner civil rights petitions as a percentage of total district court civil filings	3. 48	4. 23	5. 05	5. 22	5. 32

[1] Population data is derived from the Law Enforcement Assistance Administration series, National Prisoner Statistics. To achieve comparability with filing data, which is reported on a Federal fiscal year basis, the NPS year-end counts for adjacent calendar years were averaged and rounded to produce the numbers shown. Jail inmates are excluded for all years because their numbers are known only for 1970 (160,900 on Mar. 15) and 1972 (141,600 at midyear). Inclusion of jail inmates in the State prisoner population would substantially reduce the rate at which State prisoners appear to file petitions for civil rights reviews by increasing the divisor of the equation.

[2] 1976 Annual Report of the Director of the Administrative Office of the United States Courts 94, 96.

[EXHIBIT No. 14]

THE ASSOCIATION OF THE BAR
OF THE CITY OF NEW YORK
42 West 44th Street, New York 10036

Grievance Procedures in the Correctional Facilities of New York State Instituted Under the Auspices of the Association

By THE SPECIAL COMMITTEE ON PENOLOGY

In July 1974 the Edna McConnell Clark Foundation approved a grant program to the American Bar Association for studies in the field of corrections to be conducted by local Bar groups. Studies approved by the ABA were to be followed by "action" grants to implement those programs considered practical and worthwhile. The ABA effort, "Bar Association Support to Improve Correctional Services," is popularly known by the acronym "BASICS."

The Association of the Bar of the City of New York was fortunate to receive a grant to study the adequacy of grievance procedures in the correctional institutions of the New York State. As a result of that study, the Association received an action grant to implement new grievance procedures. This report describes that effort and the result so far.

INTRODUCTION

New York State's inmate population hovers around 18,000, sometimes exceeding and sometimes just below more populous California. Almost all of those inmates re-enter society.

Mindful of the Association's traditions and its responsibilities, as members of the legal profession, to that population, the Committee decided to concentrate on inmate grievance procedures in the correctional system. It was aware, when it began the effort, that most correctional systems, including New York, lacked formal grievance mechanisms and that this absence of the rule of law in prison had broad implications for the criminal justice system and society as a whole. It also believed that the introduction of a rational grievance process would be beneficial to inmates and administrators alike, as well as the general public.

The purpose of the Association's action grant, approved by BASICS in July, 1975, was to "initiate an experimental inmate grievance procedure in the New York State Correction system providing for inmate and line staff participation and impartial arbitration as a final step."

The grant request, for $15,000 was "to pay for fees and expenses of professional lawyer/arbitrators who would agree to serve in the project." System

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design, training and evaluation expenses, totaling $145,000 were to be provided through governmental and private foundation sources.*

In sum, the project, which began as an experiment, has exceeded its goals. An inmate grievance procedure, now mandated by statute, is in place in every state correctional facility in New York. As will be discussed below, the grievance mechanism is not without difficulties, but it is in place, and, with care and commitment, can make a significant contribution toward resolving the problem the Association sought to address.

A. *SUMMARY OF THE PLANNING/STUDY PHASE*

The correctional problem which the Association and its Special Committee on Penology proposed to study was whether or not existing institutional methods of responding to and resolving inmate grievances in New York State Correctional facilities were "adequate, responsive and fair."

The impetus for the study was the McKay Commission Report and the Report of the Select Committee on Correctional Institutions and Programs. Both had deplored the lack of formal grievance procedures and strongly urged their adoption, the McKay Commission noting that the lack of an effective grievance procedure was one of the root causes of the Attica uprising.

In early 1975, more than three years after Attica, New York had three complaint systems, all internal—an Inspector General, Inmate Councils (some active, others not), and a means by which inmates could write directly to the Commissioner of Correctional Services.

Aided by the consulting services of CCJ, the Association surveyed three selected New York prisons (minimum, medium & maximum security) and found those three "systems" woefully inadequate. The key conclusions of those visits as reported to newly-appointed Commissioner Benjamin Ward on April 17, 1975 were:

> "1. The Inmate Liaison Committees are not designed to handle individual inmate problems and are generally not regarded as effective by the inmate population.
> 2. There is considerable ignorance and confusion regarding the Department's Inspector General and the role of his office.
> 3. The only institutional recourse for an inmate with an individual complaint is a highly individualized and informal non-system dependent about the good graces of particular officers who have the interest and concern to react to problems.
> 4. None of the institutions have formal written systems with time limits, written responses, response guarantees, appropriate hearing procedures, independent review of other normal elements characteristic of a grievance procedure."

At the same meeting, the Association recommended the implementation of a more formal grievance procedure at one of the visited institutions on

* The recipient of these funds was the Center for Correctional Justice (now known as the Center for Community Justice) in Washington, D.C. As this report indicates, CCJ played a vital role in this project.

a carefully-planned, phased basis with a high level of inmate and staff participation in the design of the procedure itself. We further recommended that design and implementation be similarly phased in other institutions after the procedure at the first institution became operative. The reason for this approach was quite simple—prior experience had indicated that promulgated procedures—unaccompanied by design participation, implementation participation, and training and orientation would fail.

We identified the following elements as essential for an effective grievance procedure in a correctional setting:

- participation by elected inmates and by line staff in designing procedures and in resolving grievances;
- availability to all inmates with guarantees against reprisal;
- guaranteed written responses to all grievances with reasons stated;
- speed; time limits for receipt of all responses and for any action putting responses into effect, with special provisions for emergencies;
- appeal to some sort of independent review outside the department;
- monitoring of all procedures; and
- some impartial method of determining whether a complaint falls within the procedure.

The independent review most seriously discussed was arbitration by individuals not connected with the State's correctional agency.

In May of 1975, some days after the Association's Planning/Study Grant Final Report, but before the Action application, Commissioner Ward agreed with the Association's recommendations. Green Haven, an 1800-man maximum security facility in Stormville, New York was selected as the pilot project. CCJ agreed to commit one-quarter of a proposed two year Law Enforcement Assistance Administration (LEAA)/private foundation grant of $580,000 to design, training and evaluation activities in New York, and the Association, having been instrumental in generating that commitment, decided that Action funds would be needed only to finance the fees or expenses of arbitrators.

B. *MAY TO OCTOBER 1975*

At the Association's request, the Action grant was not effective until October 1, 1975. Since the pilot program was not expected to be operative until that time and since the purpose of the grant was to pay arbitrators who would be hearing grievances as a final procedural step, an earlier effective date would have been inappropriate. Nevertheless, critical work took place between May and October on both the institutional and legislative levels and this report would be incomplete without a description of it.

It was decided that the procedure would be initiated in a single cell block, holding 200 men. After discussions with Green Haven Officials and inmates, F Block was chosen. The next step was the formation of an Inmate/Staff Design Committee. Inmates on F Block elected their representatives and the Superintendent selected the staff. That Committee, eight in number, then met with representatives of the Association, CCJ and the New York-based

Institute for Mediation and Conflict Resolution. The "Outsiders," acting as advisors, discussed the principles set forth on page 3 of this Report and assisted the Design Committee in its formulation of the procedure. It was agreed that the Committee's deliberations would be open to an Observers Committee, representing all major groups in the prison (Sunni Muslims, Hispanic Alliance, The Italian American League, etc.) so that the population could be kept up to date on the Committee's activities. After a number of meetings, in which many issues of design and implementation were discussed, the Committee completed its work. By unanimous agreement, it decided on a first level, equal voice—equal vote inmate/staff committee and final step outside review through impartial advisory arbitration. The procedure had tight time limits (5 days for a decision at the first level, 14 days for the last), provisions for full hearings with rights of representation and cross-examination, written responses with reasons stated, guarantees against reprisals, grievance administration by inmate clerks, and a "grievance" definition broad enough to encompass policy questions as well as complaints that non-contested policies were being arbitrarily or erroneously applied.

As stated, the first level committee was to consist of four persons (2 staff and 2 inmates), each with a vote. A fifth person was added to function as a non-voting, Chairman/Mediator. Each of these elements, including the existence of the committee itself, was important. Methods of resolving complaints in other jurisdictions were characterized by the non-involvement of both inmates and line staff in the prison. Based on the investigative or ombudsman model, they afforded no role for inmates except that as complaint-makers and no role whatever for line staff. This non-involvement accounts, in large measure, for the non-use of those procedures and their failure. The Green Haven model was designed to remedy that glaring defect by giving inmates and line staff roles as decision-makers. The thought was that most grievances could be resolved at the first level and that inmate and staff, though having different interests and perspectives could agree on acceptable resolutions when faced with specific cases. The equal vote procedure was designed to give both inmates and staff a status they did not presently possess, and the absence of a tie-breaker vote and the substitution of a non-voting Chairman/Mediator was designed to induce reasonable compromise. It may be a matter of interest that the Committee decided that the Chairman could be a staff member, an inmate or a citizen volunteer otherwise associated with the prison's programs, and later when it came time to decide who those Chairmen would be, the Committee on its own, adopted a unique method of selecting them. Inmate members nominated 10 persons whom they considered fair and objective and staff members did the same. Then the inmates selected three persons from the staff list and staff selected three from the inmate list. In that way, the chairmen took office with backing from both sides.

It was also determined that if the Grievance Committee could not agree on a solution acceptable to the complaining inmate, or even if the Committee could agree but the question involved an institutional or departmental policy, that the matter would go to the Superintendent for his disposition. Appeals of his decisions would go to the Commissioner, as did matters requesting changes in departmental policy. As a final step, the original design,

thereafter affected by legislation, provided for advisory review of the Commissioner's decisions by independent arbitrators. Advisory review, rather than binding review, was dictated by the fact that the grievance procedure allowed policies themselves to be challenged as well as applications of policy, and while some consideration was given to binding review of the latter, the Department would not accept binding review of the former.

As the Design Committee was completing its work in May and June of 1975, the New York Legislature began considering a grievance procedure bill. The bill mandated inmate/staff committees consisting of one inmate and an unlimited number of staff members. It also ignored the use of arbitration and left advisory review to the Commission of Correction, a "watch dog" agency independent of the Department of Correctional Services. When asked our views, we suggested that the bill be shelved. Our argument was that any bill freezing procedures or the composition of grievance committees was premature and that the pilot program should have a period of trial and adjustment before legislative enactment. We pointed out that the pilot program was the first of its kind in a U.S. adult correctional system, that the prototype California Youth Authority system had been allowed to mature slowly with a carefully planned and phased build-up, that training and orientation of both inmates and staff was necessary, and that a uniformly-imposed early mandate on a penal system the size of New York would pose extremely difficult problems of acceptance and implementation.

It became clear, despite these arguments, that the legislative leaders intended to act. Nevertheless, the final version of the bill, Section 139 of the Correction Law, signed by the Governor on August 5, 1975, remedied the initial bill's unbalanced committee structure and adopted the Green Haven 2–1–1 model. It also permitted the Commission of Correction to "delegate its advisory review function to an independent arbitrator." However, it also ordered that grievance committees be in place and functioning in all twenty-five institutions no later than 180 days after enactment of the law. At the time of the bill's signing, Green Haven, which was designed as an experimental pilot program, had not heard a single case.

A companion bill, adopted at the same time, restructured the Commission of Correction, changing it from a part-time, nine-member body to a full-time, three-member commission. This was to cause additional problems as time went on, both because the Commission members and many of the staff were new and because the Commission's Chairman, through no real fault of his, became involved in a bitter confrontation battle which, in 1976, ended in his rejection by the New York State Senate.

Training of the F Block Inmate/Staff Grievance Committee, the Inmate Grievance Clerks and the non-voting Chairmen took place during the last week of July, 1975. It was conducted by the Association's BASIC's subcommittee Chairman George Nicolau, Albert Rivera of IMCR, and Michael Keating, Deputy Director, and Michael Lewis, staff member, of CCJ. The training, which covered the conduct of a hearing, mediation techniques, and grievance processing, was experimental in format, featuring simulated grievance sessions that were video taped and then played back for review and analysis. By the time the training was concluded, the Committee members were ready to put the procedure into effect.

During the same period, steps were taken to enlist the first group of volunteer arbitrators. The BASICS subcommittee chairman, who is a member of the National Academy of Arbitrators, personally contacted fifteen Academy members, including such experienced practitioners as Michael Sovern, Dean of Columbia Law School, Professors Tom Christensen and Dan Collins of N.Y.U. (all Association members) and Peter Seitz of baseball fame. Twelve of the fifteen agreed to serve.

The Green Haven procedure became operational on August 1, 1975, and the first arbitration hearing was conducted in early October by Joel Douglas, Professor of Labor Relations at Westchester Community College.

C. *THE ACTION PHASE*

As the Association continued to monitor the pilot program, CCJ and IMCR agreed to assist the Department and the Commission in their preparations for the expansion of the procedure into the rest of the system.

Elections were held, design committees were aided, an expanded Training Manual was completed, and training was provided for Department staff so that it, in turn, could carry on training programs in the Department's smaller facilities. In addition, CCJ and IMCR, at the request of the Department, trained the Grievance Committees at three other institutions, Attica and Great Meadow, both maximum security, and the women's facility at Bedford Hills. (CCJ has continued to monitor those facilities, as well as Green Haven up to the present time.)

The training was conducted in December 1975 and January 1976, and, in February, the grievance committees (now known as Inmate Grievance Resolution Committees or IGRC's) went to work.

As they began, the Association turned to the creation of a state-wide arbitration panel. Under the legislative mandate, advisory review of departmental decisions became the province of the Commission of Correction, with a right to delegate that function to arbitrators in particular cases if it so chose. Because it had this ultimate responsibility for delegation decisions, the Commission decided that it would take over the process of selecting arbitrators, scheduling cases, etc., a function that had previously been performed on a volunteer basis by the BASICS subcommittee Chairman. To expand the list from the small pilot cadre and to make it state-wide in order that it might serve all facilities, three routes were followed. Association members with arbitration experience were contacted, and if willing, were added. The American Arbitration Association, the largest private sector arbitration agency in the country, was asked for and supplied nominees. Assistance was also requested from Harold Newman, the Director of Conciliation of the New York State Public Employee Relations Board. The latter, which has jurisdiction over public sector disputes, maintains a roster of independent arbitrators which it utilizes in labor-management conflict. At the Commission's request, it asked those arbitrators, many of them lawyers and Association members, to volunteer for service. The response to Mr. Newman's appeal was impressive, and as a result of these efforts, over 100 arbitrators are available to hear cases on a state-wide basis.

1. *The Experience to Date and the Problems*

With the implementation of the procedure in all facilities and the creation of a state-wide panel, the Association had accomplished what it had set out to do—foster a major correctional reform in this state's penal system. Thereafter, the Association's formal role became ministerial, paying the fees or expenses of arbitrators as approved by the Commission. Nevertheless, the Association is aware that reforms initiated are not necessarily reforms completed, and the Special Committee on Penology continues to monitor the procedure and offer advice for its improvement. Additionally its progress will be the subject of formal evaluations by Professor James Laue and his colleagues from the Center of Community and Metropolitan Studies at the University of Missouri—St. Louis.

Each institution now has an Inmate Grievance Resolution Committee (IGRC). It consists of two inmates and two staff, each with a vote, and a non-voting Chairman. These Chairmen, who may be inmates, staff or volunteers, rotate on a regular schedule. Each institution also has an Inmate Grievance Clerk who administers the procedure. (The Clerk is selected by the IGRC, and in large institutions there may be many assistants.) If an inmate has a complaint which he cannot resolve, he can file a formal grievance. The Committee and the Clerk have a few days to attempt informal resolution, but failing that a hearing must be held. The inmate appears, with a representative if he desires, and presents his case. Involved staff is also present. After the hearing, the IGRC attempts to decide the issues. If the matter is an individual conflict and is not a challenge to institutional or departmental policy, the IGRC decision is binding unless appealed. Appeals and questions of institutional or departmental policy go to the Superintendent, with the IGRC's recommendations. Institutional matters stop there unless appealed, but matters of departmental policy must go to Central Headquarters in Albany. The next step is the Central Office Review Committee, consisting of the Deputy Commisioners. Appeals from decisions of that body go to the Commission of Correction, which can review the case on its own or delegate its advisory review authority to outside arbitrators. Those advisory opinions go back to the Commissioner of Correctional Services, who has the final word. However, if he rejects an advisory recommendation he must give his reasons and make the opinion and his rejection statement public.

Experience to date indicates that the system works. It is working best at the local level. There are problems at that level and more significant problems at the various review stages, but if those problems are resolved, as we anticipate they will be, the procedure will fulfill its potential and work significant changes in prison life.

The procedure was designed to resolve grievances, and our hope was that those grievances would be resolved at the lowest possible level, preferably the first level committee or the institution. Outside review was part of the mechanism, not in the expectation that it would hear all cases, but to serve as a check on the other levels and to assure inmates of the system's basic fairness and objectivity. Cynics told us, however, that inmates and staff would never agree on anything, that the differences in perspective were too vast and the

peer pressures too great for agreements to be achieved. The fact is that 81% of the 8116 grievances filed up to September 30, 1976 were resolved at the institutional level, with almost 40% resolved informally. In most of the cases, the committee's recommendations were unanimous. Interviews with committee members, both inmate and staff, reveal that each now considers the other fair, objective and worthy of trust. Those on the IGRCs, many of whom first viewed their common venture with suspicion, are now the foremost advocates of this reform. This experience led one Commission staffer to write in August 1976 . . . "Commission analysis . . . indicates that the IGRC is the finest and most creative force for the resolution of conflicts and grievances and for the inspiration and motivation to change."

This is not to say there are no problems at the committee level. There are. IGRC meeting schedules are often subject to other staff needs and are thus delayed. In some institutions, staff positions on the IGRC are subject to seniority bidding under the Union agreement, and inmates at some facilities are not given access to necessary information as readily as staff members. Moreover, the procedure is not yet fully available to inmates in lock-up status. But these problems are soluble with effort and they are insignificant in comparison to problems that have and, in some instances, continue to exist above the committee level. The latter problems affected the procedure's credibility at a time when the procedure was still in its infancy, and still affect it now.

The most important problem was and is that of time. As paradoxical as it may seem, time is important to those who are serving it. This stems from a long history of institutions "looking into" complaints, but never supplying answers. The procedure's time limits were made short so that problems would not fester or lie unanswered. They were also made self-enforcing, so that a failure to respond within a time limit automatically moved the grievance to a higher level of appeal unless the grievant elected otherwise. Those time limits are—5 days for a decision at the Committee level, 5 days for the Superintendent's response, 20 days for Central Office, and 10 days for the Commissioner. Unfortunately, these time limits have been exceeded more often than not, particularly at the Superintendent's level and above. There are three major causes for this—shortage of staff, a failure on the part of some to take the procedure seriously and appreciate its administrative and managerial benefits, and structural inadequacies.

In some cases, the self-enforcement mechanism has led to grievances going to Albany without their being considered either by the Committee or the Superintendent. This deprives those at the end of the process of input from those at the beginning and frustrates one of procedure's main goals—resolution at local levels. Self-enforcement thus is not a substitute for adherence to deadlines. We know that Superintendents are busy, often overworked men. Nevertheless, a smooth and responsive procedure is of benefit to them as well as inmates, and we have urged the Department to make a major effort to stress the importance of time limits and swift institutional response.

The Central Office, too, has had great difficulty with time limits. While there are obvious staffing inadequacies at this level, the problem here is primarily structural. In the original design, departmental policy grievances or grievances unresolved at the local level went directly to the Commissioner

and then to outside review. The Commissioner decided, for policy reasons, to create an interim step—the Central Office Review Committee (CORC). The Committee, consisting of deputy and assistant commissioners, was to decide all appealed matters. Appeals of those decisions would then be taken to outside review. That advisory opinion, either of the Commission or an arbitrator, would then be sent back to the Department for the Commissioner's acceptance or rejection. In this way, the Commissioner would not have to be in the position of reversing himself, an understandable objective. Another virtue of the CORC system is that it compels top staff to concentrate on and seriously consider inmate complaints. Unfortunately, however, the CORC system has created substantial delays. Because its members are burdened with other problems, the scheduling of CORC meetings has been very difficult, and months have gone by before some appeals are considered. As often happens when a legislature mandates a process, the Department was not geared up for what was about to occur and, as a result, a substantial backlog of cases developed. Recently, though, the Department has added new staff, and the Office of Inmate Grievances, which was established to process the grievance flow, is beginning to make a dent in the CORC's casefile. Nevertheless, there is some doubt that the CORC system can ever respond within the time limits now established. The Commissioner and his Executive Deputy are powerfully aware of the problem and trying to overcome it. Perhaps the only solution is the abandonment of the CORC and the assumption of appeal responsibilities by individual deputies, but the question is whether adequate steps can be taken swiftly enough to maintain the credibility which the "response from Albany" problem now erodes.

Until recently, the Commission's response record has been no better. In fact, the Commission, which was legislatively responsible for its end of the procedure, has never even set a time limit for its responses. Again, the fault is not attributable to one individual. Rather, it is a combination of factors and events. At the time the Commission was given the advisory review responsibility, it was brand new. Its enabling statute also gave it significant new responsibilities to set minimum standards for all penal institutions, including county and local jails and little staff to perform all its functions. At one point in the fall of 1975, it was operating with a single, unconfirmed Commissioner and newly-hired staff. At the critical point in February 1976 when the grievance procedure went statewide, Commission Chairman Herman Schwartz was in a confirmation battle sparked by the Commission's issuance of minimum local standards the month before. At the same time, one of the Commission members became incapacitated as the result of an accidental injury, and the third member, who had been Superintendent of Green Haven during part of the pilot program, expressed a desire to return to the Department of Correctional Services. Needless to say, the Commission barely survived these severe operational difficulties.

In March, 1976 the New York Senate rejected Professor Schwartz's nomination. It was not until August, 1976 that a new Chairman, Stephen J. Chinlund, was appointed, and he, understandably cautious, moved slowly pending his *own* confirmation. Through all of this, an undermanned staff, often only one person, struggled unsuccessfully to keep up with the volume of grievances reaching the Commission's office.

All of this could have been avoided if these many unforeseen events had not occurred, and more to the point, if the Legislature had evinced a more realistic appreciation of implementation problems inherent in the hurried adoption of a new method of grievance handling in an 18,000 inmate system. But the problems did occur and the question now is whether they are being overcome quickly enough to preserve the procedure's credibility. The Commission, after a period of indecision, embarked upon an analysis of its backlog of 250 cases, consolidating those involving like issues. It reinstated the assignment of cases to arbitrators, which had been virtually dormant for close to a year, and decided to permit all but the most important of the cases retained by the Commission itself to be decided by a single Commissioner, rather than the entire Commission. It has not yet made a decision on increased staff, but its necessity is obvious.

Through these efforts, the Commission's backlog has been reduced to less than 100. As of March, 1977, it established a regularized referral procedure for arbitration and in that month scheduled more than 20 arbitration hearings, exceeding by 3 the number of cases referred to arbitration in all of 1976.

Another problem, which still exists, is the keeping of records and statistical analysis. Try as it might, the Department, though it publishes a Quarterly Index of Decisions, has not begun to approach the sophisticated data gathering pioneered by the California Youth Authority. In CYA, the Director, by reading the Summary reports, can spot problems at a glance, whether they be time lags or a spate of similar problems at particular institutions, and move to correct them administratively. In New York, however, the Department has yet to appreciate fully the procedure's value as a management tool.

There is also great concern in the Department over the quality of some CORC and Superintendent decisions. In the case of the CORC, decisions are often one-liners, affirming a Superintendent's decision and merely reciting what that decision was. Some Superintendent decisions often reflect irritation at a particular complaint or a casual attitude toward the procedure itself. There are enough of these kinds of decisions, at both levels, to indicate that the procedure is not yet taken as seriously by middle management as it is by those at the very top or those handling the bulk of the work, the IGRCs.

Despite these problems, the procedure's chances for survival are good. Commissioner Ward and his Executive Deputy Commissioner Lewis Douglas are committed to its improvement, and have strongly urged other states to adopt similar systems. They see value not only in the decisions made, but in the decision-making process as well. Though skeptics said that the system would be flooded with frivolous and invalid complaints, that has not turned out to be the case. IGRCs, consisting of both inmates and staff, have found merit in fully 65% of the cases. Even the CORC, which does not enjoy the best reputation among inmates, has, according to the Department's figures, sustained, in whole or in part, about 40% of the the appeals it has heard. And, of great importance, the Commissioner has accepted almost all of the outside advisory recommendations made to him, even when they suggested changes in long-standing policy. Those recommendations, though still few in number (28, about evenly divided between the Commission and arbitrators), have resulted in some significant policy shifts. Some examples follow.

1. Mail policy has been changed to permit sealed outgoing correspondence in all cases.
2. Inmate Legal Assistants are now permitted to attend and assist in conferences between inmates and attorneys. Previously, an Inmate Legal Assistant was forbidden any further role after an attorney had been appointed.
3. The opportunity to take showers was increased at one institution from one to three times a week.
4. The Commission approved a recommendation that all grievance decisions, including those from outside review, be kept up to date on each cell block, to provide inmates easy access to them.
5. Sunni Muslims were permitted to wear beards on religious grounds.
6. Also on religious grounds, Native American Indians were permitted to wear head bands at all times, rather than just at religious services.
7. Visiting policies were changed to permit visitors to visit more than one inmate at a time.
8. Visiting room policies were liberalized at Attica to permit the wearing of non-state issue "colored" shirts.

Additionally, the CORC has relaxed hair length and mustache standards for minimum security facilities, permitted transistor radios at Attica, restructured the Work Release Program so that approved applicants would not be taken out of turn, and generally followed through on complaints of unsanitary conditions or inadequate food.

Though, for all the reasons cited in this Report, there have been only a small number of arbitrations, they have had an impact beyond their number. Hearings conducted by impartial outsiders at Attica and Green Haven have resulted in systemwide changes, a fact not lost on the prison population. The conduct of the arbitrators—considerate, judicious, mindful of the need to educate both sides in the grievance process, taking the time to develop all the facts and to give everyone a full opportunity to be heard—has had an effect on grievance committees and prison officials, as we had hoped from the beginning. Greater activity, which has now begun, should increase that beneficial effect.

2. *Expenditures*

In its grant application, the Association noted that it would be difficult to predict the number of arbitrations which might result from the procedure since there was no base line data from which to draw. Ideally, the great bulk of the cases should be settled at the lower levels, with perhaps one to two per cent going to the "outside." (This has been the CYA experience.) In New York, the figure, so far, has been much less, primarily because of the Commission's difficulties and its long periods of inactivity. It and the CORC, for the reasons outlined in this report, have simply not kept up with the volume. Those difficulties appear to be over, and we can expect that a substantial number of the cases in the Commission's backlog and many of those in the CORC's backlog will be sent to the panel. When this occurs, the cases referred to the "outside" will exceed 2%.

As of this date, grant expeditures have been low. Arbitrators have responded magnificently to our request that they consider their work in these initial stages as public service. No arbitrator who has heard a case (and some have heard more than one) has asked for a fee, and some have not even asked for expenses. We cannot expect this level of dedication to be sustained, particularly now as the Commission and the CORC finally begin to tackle their backlogs and the Commission delegates an increasing number of cases to the arbitration panel.

As this Report indicates, a major correctional reform has been initiated with a minimum of expense. We fully expect that the State, as the procedure takes hold, will take steps at some stage to allocate funds for arbitrator's fees and expenses. That stage has not been reached for obvious reasons. Therefore, the BASICS program has extended the Association's Action Grant for an extended period up to December 31, 1977. This extension may be able to carry the program until state funds are available. If it cannot, the State and the Association expect to seek interim funds from other sources.

C. *CONCLUSION*

Though the inmate grievance procedure in New York corrections is far from perfect and not yet at the point where its success is assured, the Association and its Special Committee on Penology are proud of the part they have played in its development. The Association had only hoped to foster an experiment. That experiment is now embodied in legislation. Other states, South Carolina and Colorado, have adopted the concept administratively and inaugurated similar programs. And it may be that the New York experience will point the way for others.

Respectfully Submitted by

THE SPECIAL COMMITTEE ON PENOLOGY
OF THE ASSOCIATION OF THE BAR
OF THE CITY OF NEW YORK

BERNARD H. GOLDSTEIN, *Chairman*
GEORGE NICOLAU, *Chairman*, BASICS Subcommittee

May 5, 1977

[EXHIBIT 15]

SUPPLEMENTAL STATEMENT OF IRVING R. SEGAL ON BEHALF OF THE AMERICAN BAR ASSOCIATION REGARDING EXHAUSTION OF STATE ADMINISTRATIVE REMEDIES AS A CONDITION PRECEDENT TO DISTRICT COURT JURISDICTION OVER 42 U.S.C. § 1983 CASES

S. 1393 (95th Cong., 1st Sess.) does not require prisoners to exhaust state administrative remedies before filing suit under the Civil Rights Act, 42 U.S.C. § 1983. However, counterpart legislation proposed by Mr. Railsback in the House of Representatives, H.R. 5791 (95th Cong., 1st Sess.) has such a requirement as its proposed Section 4. The American Bar Association opposes legislation such as Mr. Railsback's proposed section, which would change the current law.

It is our belief that it is inappropriate at this time, when our concern is speeding the improvement of conditions in prisons, jails and other institutions, to amend the Civil Rights Act to require some citizens to exhaust state remedies. If there is to be a fundamental change in the way citizens may seek redress for violations of their Constitutionally protected rights—and recourse to the federal courts for this purpose was provided over a century ago—then that change ought to be considered carefully and separately on its own merits and not as a subordinate provision of other legislation proporting to extend civil rights rather than restrict their enforcement.

When he introduced the predecessor of H.R. 5791 on February 19, 1976, Congressman Railsback said: "A major purpose of the draft bill is to encourage States to adopt effective inmate grievance procedures."[1] The American Bar Association shares that objective. On the motion of the ABA commission on Correctional Facilities and Services, we urged in 1976 that all states "implement effective administrative procedures for resolving grievances arising out of and concerning the confinement of prisoners . . ." But we went on to state our view that supplementary measures are needed, not procedures which would supplant the basic judicial remedies provided by existing law.[2]

It strikes us as strange and somewhat disingenuous to "encourage" state governments to be more protective of the rights of their citizens by depriving those citizens of protections the law already affords. It is not a mysterious lurking presence which has allowed our jails and prisons to fall into disrepair. It is not some foreign or secret organization which prevents pretrial detainees from touching their loved ones, or which fails to provide basic physical security in jails and prisons, or which racially segregates inmates while, too often, confining juveniles with more hardened, older inmates in violation of state laws prohibiting such commingling. These acts of misconduct—and many more which could be spread on the record—are the acts of some states and their agents. 42 U.S.C. §1983 provides protection against action taken "under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory." Some states have often failed to discharge their basic obligations as custodians of prisoners and, until they show a willingness and capability to meet their responsibilities, they should not be given any new powers to delay or foreclose access to the courts. See *Bounds* v. *Smith*, 430 U.S.—(April 27, 1977).

Moreover, it appears to us that the states already have ample incentives to create effective grievance machinery, as some already have. Among those incentives are savings in the cost of defending litigation and savings in the time of correctional personnel at all levels. As the law stands today, any state with a sincere interest in realizing these savings can do so. A variety of models exist for grievance mechanisms and an array of organizations have expertise and publications which are relevant. Every examination of prison problems in the last decade has found a need for effective grievance procedures. In view of this consensus, the availability of technical assistance, and financial aid as well, we are compelled to give little weight to any claim that incentives have been inadequate.

A number of states have done their job. Minnesota was the first state to enact a correctional ombudsman statute. Connecticut was the first state to con-

[1] Congressional Record H. 1190 (Feb. 19, 1976).
[2] Report No. 121A to the House of Delegates, by the Commission on Correctional Facilities and Services and the Commission on the Mentally Disabled, "Grievance Mechanisms for the Mentally Disabled Prisoners," approved, August 1976.

tract for ombudsman services from a private, outside organization. The Association of the Bar of the City of New York has been working for two years to assist New York State to implement a grievance procedure which begins with inmates and staff jointly reviewing prisoner complaints. There is substantial experimentation underway, and some quite promising developments.

What those who would require exhaustion of remedies fail to recognize is that all such procedures merely present opportunities to resolve complaints; they do not guarantee that result. And when, as has occurred, the state creates a procedure but fails to commit itself to paying attention to it, or stacks the deck against success, it should be no surprise that the potential benefits of a grievance procedure—which include avoidance of legal actions—are not realized.

If Congress were to enact an exhaustion requirement now, it would be legislating in a virtual factual vacuum. While there is substantial literature expressive of the principles on which sound inmate grievance procedures should be founded, and while there are many descriptions of individual programs, there has been no comparative evaluation of existing programs. Hence, we do not know the impact an exhaustion requirement would have. It is easy to see how an exhaustion requirement imposed against this backdrop would expand rather than lessen litigation. Until each institution's grievance system had been tested and found "plain, speedy, and efficient," inmates of the particular jail or prison would to some degree continue to file their grievances directly with the appropriate District Court. The first issue in each such case, clearly requiring factual development through ordinary procedures, would be whether exhaustion was required or not. After this determination was made, in cases where the state remedy was found to meet the basic criteria specified in Section 4 of H.R. 5791, a further determination might be needed whether "there exist circumstances rendering such administrative remedy ineffective" in the particular inmate's case. Neither of the mini-trials necessary to decide these issues would deal with the merits of the complaint, but each would consume one of the least available judicial resources we have—time. At least until we know more about the effectiveness and collateral effects of the procedures inmates might be required to exhaust, it seems preferable on balance to devote judicial effort to substantive rather than procedural concerns.

We are concerned about including an exhaustion requirement for a final, independent reason. In the century since the Civil Rights Act was enacted, its full benefits have extended, on the face of the statute, equally to all citizens. However, until quite recenty the judiciary held to a "handsoff" policy which in fact deprived prisoners of the benefits of this general legislation. With the partial abrogation of that doctrine in the last decade or so, courts have come to consider correctional problems. In this process, we have discovered that prisoners have been subjected to conditions which "shock the conscience" of our courts. This has been a painful but important lesson. Overcrowding has worsened conditions in many correctional institutions over the last few years, in effect making confinement sentences more severe. We should not ignore that reality and impose new procedural penalties on inmates as a unique class.

Reflecting on the changes recently made in corrections as a result of judicial intervention, Federal Bureau of Prisons Director Norman A. Carlson recently wrote:

"A new balance has been struck, and while as an administrator of the federal prison system I would question some of the individual decisions, there is no doubt that, on the whole, judicial influence has been constructive. The judiciary has compelled penal administrators, executive officials, and legislators at all levels of our society to face squarely the problems associated with treatment of offenders and has spurred constructive action to resolve these problems. As we move into the third century of this nation's history, it is virtually certain that the courts will take further steps to awaken all Americans to the need for less crowded, more humane penal institutions, which are secure enough to protect society without creating conditions that threaten the basic rights of inmates and which permit both inmates and prison staff to work and live with a larger degree of safety and dignity." [3]

It clearly is not in our interest to abandon a system which has produced and can continue to produce such beneficial results. Therefore, exhaustion of state remedies should not be required in prisoner civil rights cases.

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[3] Carlson, Corrections in the United States Today: A Balance has been Struck, 13 Am. Crim. L. Rev. 615 646 (1976).

[Exhibit No. 16]

American Bar Association Report to the House of Delegates Commission on Correctional Facilities and Services and the Commission on the Mentally Disabled

GRIEVANCE MECHANISMS FOR THE MENTALLY DISABLED AND PRISONERS—RECOMMENDATIONS

The Commission on Correctional Facilities and Services and the Commission on the Mentally Disabled recommend adoption of the following resolution

Resolved, that the American Bar Association urges all states to implement effective administrative procedures for resolving grievances arising out of and concerning the confinement of prisoners and the involuntary residents of mental hospitals or institutions for mentally retarded persons. Such procedures should supplement but not supplant existing judicial procedures for remedying such matters.

Further resolved, that the American Bar Association endorses legislation designed to allow the Attorney General of the United States to institute suit, or intervene in pending litigation, to secure to prisoners, the mentally disabled, and others involuntarily confined the full enjoyment of rights, privileges, or immunities secured or protected by the Constitution or laws of the United States, provided, however, that any such legislation should continue existing law and not require involuntarily confined persons to exhaust state administrative remedies as a condition precedent to securing relief under Section 1979 of the Revised Statutes, 42 U.S.C. § 1983.

Further Resolved, that the President of the Association or a designee may present the views of the Association on this matter to the appropriate committees of the Congress and to other appropriate government officials.

REPORT

A few cataclysmic prison upheavals in recent years have underscored the extent to which prisoners believe that the procedures and conditions to which they are subjected do not adequately recognize their rights as citizens. An enormous number of recent court decisions, directed at both particular correctional institutions and entire state systems, substantiate the validity of prisoners' claims in this regard. The same is true of our nation's public mental health and mental retardation facilities, which have also been the subject of an avalanche of lawsuits and widespread adverse publicity.

A widely held and apparently growing body of opinion, with which the Commission on Correctional Facilities and Services and the Commission on the Mentally Disabled tend to agree, is that the courts are not necessarily the best forum for resolving prisoners' complaints about the physical and other conditions of their confinement, or for deciding the appropriateness of particular treatment modalities or other professional and administrative decisions in mental institutions. The courts have been drawn into these areas, at least in part, because of the absence of any effective internal mechanisms for the resolution of such matters. In recent years there has been substantial experimentation at both the state and federal levels which has demonstrated the efficacy of administrative procedures for dealing with a substantial portion of the complaints which prisoners have. Although the relatively inarticulate nature of some mentally disabled individuals raises special problems, state mental institutions have also been exploring the utility o fvarious types of internal ombudsman and advocacy programs. The purpose of the first resolution is to call this recent experience to the attention of all states and to encourage them to adopt the systems which in their judgment seem most viable in their particularized circumstances.

The second resolution has two aims. First, it supports giving the United States a statutory role in resolving questions regarding the rights and status of involuntarily confined individuals. Bills such as H.R. 12008 and H.R. 12230, 94th Cong., 2nd Sess., copies of which are attached, are examples of legislation, the principles of which are supported in part. Each authorizes the Attorney General, after attempting to resolve problems administratively, to file a civil action to resist a pattern or practice of denial of civil rights to prisoners, the

institutionalized mentally disabled, and other involuntarily confined persons. Where litigation has already begun, the United States could intervene in its own right if the Attorney General certifies that the case is of general public importance. So much of each bill is supported. The resolution's second aim, however, is to oppose provisions such has those set forth in Section 4 of the bills. These provisions would diminish rather than expand existing avenues for peacefully resolving important grievances. This result would be accomplished by denying prisoners, the mentally disabled, and other involuntarily confined people in a variety of institutions (including some nursing homes and facilities for the chronically physical ill or handicapped, and juvenile detention and treatment institutions) the right to fie their own civil rights suits unless they first exhaust state administrative procedures. (Each bill would provide an escape from its exhaustion requirement when circumstances exist which render administrative remedies ineffective to protect an individual's rights, or the remedy is not plain, speedy, or efficient.)

The final resolution authorizes the President of the Association or his representative to articulate these views in appropriate forums.

In its Standards for Criminal Justice, the American Bar Association has provided for the substantive and procedural rights of prisoners respecting appellate and collateral review of their convictions. Consequently, those matters are not dealt with by the instant resolutions.

What is at issue here are the procedures and conditions—classification, discipline, transfers between institutions, grant and denial of furloughs, the amount of exercise available, the quantity and quality of food, the adequacy of heat, light and ventilation, the prevalence of assaults by staff and other inmates forced application of physical and chemical restraints, and similar matters—which are a fact of life in America's prisons and mental institutions. Because they are involuntarily confined, prisoners and mentally disabled individuals cannot take, without great danger to themselves (and others), the self-help measures available to free citizens to change conditions in their environment which they do not like or which they feel are unlawful. The riot at Attica in September, 1971, was unfortunate proof that prisoners would pursue any means to raise grievances. The revelations of scandalous conditions at the Willowbrook State School in New York and at Alabama's mental health and mental retardation facilities in 1971 and 1972 were similarly tragic evidence of the voicelessness and helplessness of persons confined to mental institutions.[1] These events underscored the need successfully to conclude an effort already underway to find peaceful and effective forums for airing and resolving grievances of institutionalized individuals.

The effort to expand the channels for resolving such complaints has attracted the interest and personal support of the Chief Justice of the United States. It appears to have been a major focus of attention at the National Conference on the Causes of Popular Dissatisfaction with the Administration of Justice which the American Bar Association sponsored with the Chief Justice in April. Earlier, the Commission on Correctional Facilities and Services highlighted the grievance resolution problem through a number of its publications and through production and dissemination of a documentary film version of the final report of the New York State Special Commission on Attica. Subsequent to its nation-wide telecast in 1972, the Attica report has been made available for over 2400 showings to a variety of professional, civic and educational groups. It has also been widely used for training purposes by correctional agencies. Through its BASICS Program (Bar Association Support to Improve Correctional Services), the Commission has given financial aid to state and local bars to assist in development of effective grievance procedures.

In the mental disability field, Congress has already mandated the provision of advocacy services in state developmental disability programs (Pub. L. 94–103), and is considering expansion of this requirement to state mental health systems as well (H.R. 10827). The Commission on the Mentally Disabled, through a contract with the State of Pennsylvania, is currently testing an advocacy model at the Norristown State Hospital near Philadelphia.

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[1] See *NYSARC and Parisi* v. *Carey*, 357 F. Supp. 752 (E.D. N.Y. 1973), 393 F. Supp. 715 (E.D. N.Y. 1975); *Wyatt* v. *Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 and 387 (M.D. Ala. 1972), aff'd 503 F. 2d 1305 (5th Cir. 1974).

It will be noted that the first resolution does not call for adoption of a particular form of procedure by the states. There is too much diversity in their correctional and mental disability systems for uniformity in this area (what may be appropriate for a single-institution state might have little or no applicability to a multi-institution state). Also, states which operate extensive community-based mental disability programs may wish to go beyond the institutional model and adopt a more expansive approach to advocacy and resolution of grievances. Encouraging a single model would also fail to recognize the variety in existing programs. Of 209 state correctional institutions responding on a 1973 survey,[2] 77 percent reported an existing formal grievance mechanism, 71 percent indicated there was a legal services program for dealing with prisoner complaints, and 56 percent reported inmate councils through which complaints could be resolved. Sixty-four institutions (31 percent) also indicated they were serviced by an ombudsman and 21 percent reported a prior effort to form an inmate union of some sort. About one-third of the legal services programs and half the ombudsman and grievance procedures are only four years old.[3] It is still too soon to measure the relative effectiveness of existing procedures.

Although it is too early to focus on a single approach, it is possible to glean from the correctional experience and that of related fields the central principles on which sound approaches can be built:

1. Simplicity. It must be possible to initiate consideration of a complaint in a manner which can be understood and utilized by all prisoners, mental patients, and institution residents. Assistance must be made available to those who lack the competence to act for themselves.

2. Responsiveness. The procedure must deal with problems while they are still meaningful to the person involved.

3. Confidence. This is a multi-faceted consideration. Prisoners, patients and residents must view the procedure as one through which they can get action on complaints without fear of reprisals. Staff must view the procedures as one in which their interests will not be ignored. (Perhaps the best way to meld the interests of these two groups is to involve them jointly in the grievance resolution process.) Top administrators must trust the system to produce workable response to real problems, and give it their support.

The second resolution endorses the principle of federal government involvement in resolving confined individuals' grievances about institutional conditions which "deprive them of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States" when "such deprivation is pursuant to a pattern or practice of resistance to the full enjoyment of such rights, privileges, or immunities." Prior to initiating civil actions in such cases, the Attorney General must notify appropriate institutional authorities and grant them a reasonable time to correct alleged deficiencies. (The "reasonableness" of the time allowed for corrective action would, we assume, vary with the urgency or life-threatening nature of the situation.) He must also certify that suit by the United States "is in the public interest." As to cases already commenced, the Attorney General may intervene upon certifying that the case "is of general public importance." Support for legislation containing such principles is founded on several considerations. As Congressman Railsback stated on introducing H.R. 12008,[4] it "would operate to upgrade State prison conditions. It would thereby help to eliminate the current distortion in the sentencing process and the breeding of career criminals" which results from judicial reluctance to confine offenders in bad institutions. Conditions in mental institutions would be similarly improved. The principal way this objective would be achieved is through the prophylatic measures states might take to avoid suits prosecuted by the Attorney General to correct deficient institutions and practices. Similarly, suits by the United States in the public interest would attract greater attention than suits by individuals, hastening dissemination of information concerning proper institutional conditions. It is also reasonable to expect that such suits would substantially contribute to the development of needed national standards. Realization of these benefits

[2] McArthur, Inmate Grievance Mechanisms: A Survey of 209 American Prisons, 38 Fed. Probation 41, 42 (1974).
[3] Id., at 42.
[4] Congressional Record H. 1190 (February 19, 1976).

should reduce the current volume of institutional litigation, particularly suits brought by or on behalf of individual prisoners.

In recent years, the U.S. Department of Justice has brought suits to remedy serious and large-scale institutional abuses on a number of occasions without specific statutory authority.[5] Legislation of the instant type would reduce the procedural barriers to continuation of this practice.

The second resolution would also reiterate the Association's opposition[6] to requiring prisoners to exhaust state administrative procedures before they may bring civil rights actions. Sections 4 of H.R. 12008 and H.R. 12230 contain such requirements. The basis for that earlier position—that creating an exhaustion requirement applicable to prisoners would make them in essence second class citizens, since other Americans face no similar obstacles to bringing federal suits to secure federally protected rights—remains valid and applies with equal force to other institutionalized groups of persons. The extension of an exhaustion requirement to involuntarily confined mentally disabled persons exacerbates the harm of such provisions by applying them to many persons who have done nothing voluntarily to set themselves apart from the population at large.

In addition to being legally infirm, legislation such as the proposed Sections 4 would represent too high a price for the welcome involvement of the Attorney General in relatively few suits. According to Congressman Railsback, prisoner suits under 42 U.S.C. § 1983 are being filed at a rate of 6,000 per year, approximately five percent of the District Court civil caseload. This is a heavy volume of litigation, but the results which have been achieved have been substantial. Even though the resources available to the Department of Justice far outstrip those to which prisoners (or the mentally disabled) have access, with or without counsel, it is unlikely the Department could devote enough resources to this area to obviate the need for all these suits. Nevertheless, under the proposed Sections 4, all prisoners and other involuntarily confined persons would be foreclosed from federal court until state remedies were exhausted.

Congressman Railsback also said: "a major purpose of the draft bill is to encourage States to adopt effective inmate grievance procedures. Under current law, States have little incentive to establish such procedures because inmates can bypass them in filing section 1983 suits."[7]

There are at least two answers to this. First, where there are effective procedures, prisoners use them. Since his office was created in 1972, Minnesota's correctional ombudsman has developed inmate confidence in his ability to resolve grievances. The legislature gave the office a statutory mandate in 1975.[8] In fiscal year 1975, the Minnesota correctional ombudsman received 1300 inmate complaints.[9] Over 70 percent were resolved within a month. It should also be noted that the Legal Assistance to Minnesota Prisoners program assures prisoners assistant in pursuing judicial resolution of grievances.[10] The Ward Grievance Procedure of the California Youth Authority, recently accorded Exemplary Project status by LEAA's National Institute of Law Enforcement and Criminal Justice, represents another mechanism used because it works, not because there is compulsion. While there is less hard evidence with regard to such pro-

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[5] At the present time, the Department's Civil Rights Division is involved as plaintiff or plaintiff-intervenor in 16 cases involving prisons, jails, mental health and mental retardation facilities and institutions for juveniles. The Department has also participated in a number of cases as amicus curiae, otfen with the right to conduct discovery and present evidence and arguments as if a party to the case.

[6] This position was originally articulated in the Association's amicus curiae brief in the case of *Preiser* v. *Rodriguez,* 411 U.S. 475 (1973). In deciding the case, the Supreme Court held that a suit for equitable restoration of allegedly unconstitutional forfeited good conduct time cridits was within the "core" of habeas corpus, and that the rules respecting habeas litigation would therefore apply. So holding the Court did not disturb its prior decisions that "if a remedy under the Civil Rights Act is available, a plaintiff need not first seek redress in a state forum."

[7] Congressional Record H. 1190 (February 19, 1976).

[8] Chapter 553, 1973 Laws of Minnesota.

[9] Ombudsman for Corrections, 1974–1975 Annual Report 14 (1975).

[10] While a variety of factors in addition to its ombudsman program undoubtedly played some role, the federal court in Minnesota is called upon to adjudicate few prisoner grievances. In 1973, Minnesota accounted for 0.76 percent of all state prisoners. But the 11 civil rights actions brought by its prisoners represented only 0.26 percent of the 4174 such petitions filed in all U.S. District Courts. Prisoner data from Law Enforcement Assistance Administration, "Prisoners in State and Federal Institutions on December 31, 1971, 1972 and 1973" (May 1975). Courts data from "1973 Annual Report of the Director of the Administrative Office of the United States Courts," Table C–3, p. 337.

grams serving the mentally disabled and while the preliminary indications are mixed, it seems likely that effective grievance procedures will reduce the current volume of court actions to some extent.

The second answer is that Section 4 would officially sanction an acknowledged, regrettable phenomenon.

"It is no accident that all these nonjudicial methods of attempting to bring the rule of law into the administration of the correction system have been implemented at a time when the officials of that system feel themselves beseiged by the courts. It is apparent that some of the procedures have been designed primarily to lift the seige rather than to achieve meaningful penal reform or assure to inmates the full enjoyment of their constitutional rights." [11]

It should not be necessary to take away an individual's right to access to federal courts in order for him to secure the enjoyment of other constitutionally protected rights.

The third resolution simply authorizes the expression of the Association's views before concerned congressional committees and other government officials.

Respectfully submitted,

ROBERT B. MCKAY,
Chairman, Commission on Correctional Facilities and Services.
JEROME J. SHESTACK,
Chairman, Commission on the Mentally Disabled.

August 1976.

Senator BAYH. I wonder if the next three witnesses would come to the table together so we can try to expedite this. I assure them that we are not putting less emphasis on their testimony. It is just that we are in a real time bind.

Dr. Stanley Brodsky is a professor of psychology at the University of Alabama. I understand he is going to be testifying on behalf of the American Psychological Association.

Mr. Harry Rubin is chairman of the litigation panel of the Mental Health Association.

Mr. Morton Posner is executive director of the Federation of Parents Organizations for the New York State Mental Institutions. He is also a member of the New York State Council for Mental Hygiene Planning, and a delegate to the White House Conference on Handicapped Individuals.

Welcome.

TESTIMONY OF STANLEY BRODSKY, AMERICAN PSYCHOLOGICAL ASSOCIATION

Mr. BRODSKY. Mr. Chairman, I welcome the opportunity to appear before you today. The views that I will be presenting are both mine and those of the American Psychological Association and the Association for the Advancement of Psychology.

We fully support S. 1393 as a needed step to insure the availability of the resources and expertise of the Justice Department in both initiating and aiding in class action suits against institutions that harm and dehumanize their confined clients.

Most of my work has been with penal and mental health institutions. In a half dozen States in the last 5 years, I have been involved in class action suits filed on behalf of the resident. I subsequently testified about the psychological impact of the treatment, of the facilities, and the programmatic decisions.

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[11] Singer and Keating, The Courts and the Prisons: A Crisis of Confrontation, 9 Crim. L. Bull. 337, 347 (1973).

The kinds of institutions against which Dorothea Dix railed 100 years ago are still abundant, sustained by low priorities for funding, by little attention from State legislatures and by underlying assumptions about the potential of confined people to benefit or improve.

Ambrose Bierce once defined the ostrich as a strange creature with an exceedingly long neck and wings that don't work; however, Bierce observed, the absence of functional wings represents no handicap since the ostrich can't fly anyway. So it is with the underlying rationale for deprivation of many institutionalized individuals; they don't need their rights and their societal benefits, because they can't use them anyway.

When Burton Blatt wrote of the retarded girl who had seven healthy teeth pulled because she was chewing on the dayroom rug in her ward, he captured the essence of institutions putting their operations and maintenance first, their residents last. Every such institution can recite the altruistic goals for which it was founded, and the ambitious plans for the future when resources, staff, and facilities are available.

Yet, it is the present that concerns us and that calls for intervention:

> The essence of a situation is in the means not the ends. The ends are what has happened and what will happen. The means are what is happening.—Burton Blatt

Let me share some happenings which I have observed in institutions against which suits have been filed. In a ward in one State hospital, 30 men share a dimly lit combination dormitory/dayroom which has no furniture other than beds and two benches, in which the perpetually running television is locked behind a screen, in which the men spend years without treatment, without work, without recreation, and without review of their commitment or status.

In another ward in the same institution, I got a quick glimpse of a crew of patients scurrying away, mops over their shoulders, just as I entered the building. The erratic, quick, sideways scurrying reminded me of fiddler crabs on the ocean front on a summer night. And when I inquired about the patients I saw, I was assured that there may have been one patient on clean-up duty, but that no effort was made to impress me.

In one prison that was the subject of a class action suit, about half of the prisoners were locked up 21 hours a day. The rest were supposed to be working, but the work assignments were mythical and only a handful were truly employed. The rest lingered restlessly, feeling useless, worthless, experiencing the malevolent transformation in which they come to see themselves as victims and subsequently are embittered and alienated, sometimes vengeful.

In the Baltimore City Jail, which I just inspected 3 weeks ago, over 1,700 men are confined in an institution that has room for 971. The six-by-eight-foot cells are double-bunked and hold two men who have little to do, many of whom spend many months awaiting transfer or trial.

The sight of human beings locked in screened cages surrounded by their own feces still disturbs me, and indeed degrades all of us.

And the 14-year-old boys in a training school who are locked for weeks in an "intensive treatment unit" are in truth in a punishment building in stripped rooms, barren tile covered rooms without mattress or furniture, in which they are further punished for talking. In a very recent decision, these last conditions have been declared to be unconstitutional.

In my home State of Alabama we have seen several class action suits filed on behalf of the institutionalized. In *Wyatt* v. *Stickney* in 1972, the Justice Department joined two other groups in a successful suit against the Alabama Department of Mental Health. Among other dramatic counsequences of this action, living conditions for the patients have greatly improved, staff-to-patient ratios have risen, and, perhaps most important, a deinstitutionalization program has resulted in many patients being released to their home communities. Now, 1,800 patients are in residence at the State hospital, whereas 5 years ago 5,800 persons were confined. Per patient expenditures have risen sixfold and a court-created human rights committee monitors the continued efforts to meet minimum treatment and living standards for the patients.

The State used to brag at one time that it spent $4 per day per person in terms of the economy of running its operation. The Department of Mental Health is now proud that it spends $36 per day.

Senator BAYH. That is a remarkable deinstitutionalization. What has happened to those people? Have they been handled in such a way that the cost of society is greater because they have been commingled with citizens on the outside who are now being abused by those who, prior to this base, were in the mental institutions?

Mr. BRODSKY. Many have been transferred into nursing homes that are not the best nursing homes. Others have been sent to schools for the retarded.

One of the key things they did was to restrict the flow in. It is much harder to get committed by family or friends to a hospital in Alabama now than it was.

Senator BAYH. It is attrition in reverse.

Mr. BRODSKY. Yes.

There has been an explicit objective to reduce the number of patients in the hospitals. Hospital personnel have gone into communities and have found placements for patients.

We are by no means happy with what has happened to them; that is, we have a long way to go yet. But compared to what it was like 5 years ago, it is quite good.

Senator BAYH. Dr. Stone mentioned that some of those who had been institutionalized were now in nursing homes.

Has this had a detrimental effect on the other people in the nursing home?

Mr. BRODSKY. I do not know. We have not followed up people sufficiently well to be able to answer that.

I know that a number of nursing homes and aftercare homes have been established exclusively for the people who have been released from the hospitals. They have been able to serve these people far better than in the huge institutional setting.

Once upon a time, at the beginning of the 19th century, we believed that large institutions were the way to solve social problems. It is only now that we have discovered that the large institution is not the way. Class action suits have caused this to be given up.

Senator BAYH. I remember from my State legislature day that the fashionable thing to do was to spend money on new institutions. Without major changes, they were doomed to new failures instead of old failures.

What about costs?

Mr. BRODSKY. The State of Alabama is spending much more money now than it did before. Our budget is close to $100 million for this coming year for care of the retarded and mentally ill in the State. That is much more than we paid before. The legislature has allocated this and has given a relatively high priority to it. I have no sense of resentment on their part for doing this in a poor State.

Senator BAYH. If it had not have been for the *Wyatt* case, would you have gotten those resources?

Mr. BRODSKY. Absolutely not.

Senator BAYH. Please proceed.

Mr. BRODSKY. There is a parallel suit against the State correctional system which resulted in a 1976 court order by Judge Frank M. Johnson, Jr., identifying 11 constitutional rights of inmates. Most were straightforward and common sense in nature.

One was the right to sanitary conditions; rodent hairs and droppings and insect fragments were frequent among the food and the sewage system fell well below health standards. A right not to be harmed was in effect identified, and my colleagues and I engaged in an extensive effort to classify inmates according to potential harmfulness, so that the violent and aggressive ones could be maintained in single cells, and not prey on the others. The court had ruled that no classification system had been in effect previously, which corresponded with our observations.

In all of these inspection and assessment experiences, I have become more aware of the noxious effects many such total institutions have on people's adjustments and lives. There are indeed institutions that respect the dignity of their clients, but in others the clientele may be predicted to leave far worse than they arrived, in terms of their psychological functioning and physical well-being.

The evidence is consistent: high rates of attempted suicide among clients, a staggering incidence of physical and phychophysiological ailments, violence and the fear of it everywhere, and psychological deterioration and disorder.

Class action suits change perspectives. The attention of the public, the newspapers, the legislature all become riveted on the problem areas. A court decision following the trial may not be issued for up to 2 years, and sometimes, even in these circumstances, the offending conditions may be remedied in the interim. Priorities do become reassessed and the class action suit is a swift vehicle for social change.

A central question regarding this legislation is why should the Department of Justice and the Attorney General be involved in initiating and/or participating in such civil suits?

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A central question regarding this legislation is why should the Department of Justice and the Attorney General be involved in initiating and/or participating in such civil suits?

Senator BAYH. You think that is a key question, where Dr. Stone and you might come down on opposite sides. Why bring the Attorney General in on this on the basis of initiation rather than joinder? Why not let public interest lawyers direct this litigation?

I think that is one of the key bones of contention.

Mr. BRODSKY. I have worked with both groups. One of the things that happens is almost every public service attorney—and they are just an idealistic, dedicated, bright, and talented group of people—must carry case loads in which they work with the poor and indigent of their communities.

More than this, every person who is a public service attorney starts afresh in his first-class action suit. The attorney has not had the expertise of filing briefs before, being involved in cases of this sort, and simply does not have the centralized expertise and knowledge that the Department of Justice attorneys do.

Senator BAYH. Is that always the case? Aren't there a few public service lawyers that are sort of out on the point whenever some of these cases come up?

Mr. BRODSKY. Well these lawyers start at the beginning as originators of a number of them. But now there are so many suits available that the "point men" are involved in somewhat of an advisory capacity. They simply are not doing it all themselves anymore.

Almost every State has a technical legal assistance group or a legal resources office that are pursuing class actions on their own. What the experienced attorneys do now is simply offer some advice by telephone. But they are not involved by any means in a substantial number of the cases anymore.

The second problem is not only the expertise but the financial resources. The attorneys who are doing this operate on tiny budgets.

I was just speaking to an attorney who is filing a suit in Baltimore against the Maryland penitentiary. He has $1,800 available for this suit. It is similar to the Alabama prison suit, which probably ran about a quarter of a million dollars. He has asked me and other witnesses to donate our time, which we will, and to see who we can get to come without traveling a long distance. But local expert witnesses are reluctant to testify against the State.

Senator BAYH. It is your experience that, contrary to what Dr. Stone said, you do not have a whole phalanx of dedicated, idealistic public service lawyers at all times arrayed against the inefficient, half-hearted efforts of the State's attorney general?

That may be an exaggeration of what he said, but that's the impression I got.

Mr. BRODSKY. There are lots of lawyers filing suits; there is no question about that. In terms of their resources to be able to do it and do it well, I have some concerns.

The legal resources in public service cases are variable. There are some who are able and who mobilize State and local resources well. But there are a large number who are doing it on skimpy budgets, part time, and who simply are not in a position to be able to do it well the way they want to and should.

So, I do disagree with Dr. Stone. I would add that I agree with him on the other part; many superintendents of schools have more

than welcomed such suits. They see it as an action designed to allow them to do what they would like to do anyway.

There is need for a central source of legal expertise regarding the rights of institutionalized individuals and for fiscal and manpower resources to be able to start and sustain such actions.

The local attorneys with whom I have worked on patient and prisoner rights suits have much in common. They are young, idealistic, dedicated people working 10 to 15 hours every day. They usually are affiliated with a local legal aid office and simultaneously offering aid to the poor and the indigent. In some cases they have not litigated a class action suit before and have to start afresh in learning the area. And they have little money for the case.

The U.S. Government and the Justice Department have an important role here. In the past, the Justice Department has worked side by side with these local attorneys and should be allowed to in the future. This combination of locally initiated civil class actions and Federal Government's central knowledge, resources, and participation is important in insuring the rights of the helpless and institutionalized in our society.

In standing by the ocean, one hears first the foreground noises of the crashing of the waves, the rushing of the water onto the sand, the gurgling-hissing as the wave recedes, rolling the sand with it. It is only later, listening attentively, that one hears the background rumble and roar that seems to come from everywhere, of many waves, of the earth itself breathing and pulsing.

And so, in class action suits for the institutionalized, we hear the foreground noises first, the immediate cries of abuse and deprivation, of weakened bodies and failing minds, of insensitivity and deterioration. The background sound has to be listened for, but then it is loud and everywhere; it is that for those fellow citizens in so-called helping institutions, that their problems are the Nation's problems, that when they suffer, we all suffer, and that the rumble and roar of this Nation's voice is that we will not accept psychological mistreatment or physical harm done to them.

The U.S. Government and the Department of Justice should be heard and loud in this chorus for citizens' rights. I urge the subcommittee to act favorably on S. 1393 and to help this process take place.

Thank you for the opportunity to testify before you today.

Senator Bayh. Thank you very much, Doctor, not only for what you give us here today, but for the contributions you have made in actions in this area which have resulted in significant change.

You are of the opinion that the *Wyatt* case has resulted in significant improvements in the State of Alabama?

Mr. Brodsky. Enormous improvements.

Senator Bayh. Have you found, in traveling over the country, that there still remain significant violations occurring of individual rights in institutions?

Mr. Brodsky. I do not think there is a State in the country that does not have some institutions that significantly violate constitutional rights of their inmates. I see it happening in both penal and mental health centers.

Senator BAYH. Senator Hatch suggested that there are widely varying opinions among mental health professionals as to what treatment should be used on whom and when, and that in one instance certain treatment might be considered punitive but in another instance it might be considered therapeutic. Could you give us your judgment as to whether there is, in the medical profession, psychiatric profession, a wide variety of thought as to what is punishment, what is treatment, and what constitutes a violation of a person's constitutional rights in a mental institution?

Mr. BRODSKY. In terms of the lack of consensus—it is certainly true.

Perhaps psychology, psychiatry have been called—with some accuracy—the queens of the inexact sciences.

Senator BAYH. I am sorry I interchanged those words; I do that once in a while.

Mr. BRODSKY. In terms of our views in terms of treatment and punishment, I suspect that psychology and psychiatry have some very similar patterns.

The issue of treatment versus punishment is, by and large, resolved by people outside who serve as an accountability factor. The programs that have been developed that have been accused of being punishment primarily are the behavior modification and psychosurgery programs. I have no doubt that these programs can be used to coerce people, particularly in penal institutions, to conform to institutional rules. It may be something that may make it easier for an institution to run, but may not at all be in the best interest of the individuals involved.

Senator BAYH. Let me clarify the question. What I think I am looking for here is a lay answer, not a professional answer.

Given the kind of situation we have had, of a young man strapped spread eagle to a bed, covered with a sheet with nothing but a slit for his eyes and mouth, over a period of years; a woman kept in a straitjacket for 6 years; people having their toenails removed; 50 girls in a ward tied spread eagle to their beds: That kind of thing clearly constitutes to a layman an abuse of those human rights that ought to be guaranteed to everyone regardless of where they are in life.

Putting into institutions under questionable circumstances large numbers of people who either do not belong there at all or could be treated under better circumstances is another area.

If you lined 100 psychologists or psychiatrists up here and you took a poll of them and you confronted them with the kind of continual disclosures that we have had, how many of them would say that you should not do it differently?

Mr. BRODSKY. I would think and hope that 100 would say that we should do it differently and that calling that treatment is just euphemistic; it is punishment and harmful. It is just these kinds of practices that sometimes go on that we try to mobilize efforts against.

I think all of them would say that it was harmful and punishment.

Senator BAYH. Thank you. I appreciate very much your contribution and the fact that the American Psychological Association is

making a significant contribution throughout the country in our efforts.

Mr. Rubin is our next witness. Welcome.

TESTIMONY OF HARRY J. RUBIN, CHAIRMAN, LITIGATION PANEL MEMBER, BOARD OF DIRECTORS, MENTAL HEALTH ASSOCIATION

Mr. Rubin. Thank you, Mr. Chairman.

In the interest of time, I am not going to read my prepared statement.

Senator Bayh. I have read it, and it is excellent.

The Mental Health Association and associations in the individual States have made a significant contribution in the past. I would hope we could continue to rely on the lay and the professional support that exists out there and that is necessary for any kind of legislative change.

Mr. Rubin. Senator, the association primarily likes to think of itself as a consumer of mental health services in the sense that we are all consumers of those services. We are primarily a lay organization with a sprinkling of professionals in the organization.

We have been interested in the problems of promoting mental health, preventing mental illness. We have encouraged legislation to that effect. We have encouraged appropriations to that effect. In recent years, our Public Affairs Committee and our litigation panel have been developed because we see certain other areas of activity, one of which is litigation, which have become necessary in order to effectively do something for the mentally ill of our society.

We have, in that respect, been a client of mental health services. We have been involved in litigation in which others have represented our interest on behalf of consumers. For example, we have appeared as amicus in the *Wyatt* case, being represented by the mental health law project here in Washington as our attorneys, and so forth.

We really believe, as has already been stated to you today, that conditions in our institutions are sufficiently deplorable, have been sufficiently deplorable, and will remain that way unless something is done about that, that the type of legislation that you are proposing is absolutely essential.

It is absolutely essential not because the work can't be done in some other way—I think Dr. Stone was correct when he said there is a great deal of activity out in the field, by an awful lot of very capable people who are interested in doing something—but because, when the Justice Department gets involved on behalf of the United States of America, as the bar association has pointed out, that adds something to the impact of that litigation.

Dr. Brodsky pointed out to you that the *Wyatt* case had a great impact in Alabama. I can tell you that the *Wyatt* case had a great impact in Pennsylvania. I suspect the *Wyatt* case has probably had some impact in every State of the Union simply because of the publicity, the personal ideas that Judge Johnson brought to his decision, the interest he has shown in it, and the involvement of all of the persons involved, including the Justice Department, which gave it nationwide significance.

We have some unusual situations. I have not heard anyone talk about mental institutions as not requiring help. Everyone who is here today agreed that conditions are terrible. But we do have people who are going to be in those institutions, and we do have a need to continue to promote the care and the rights of those persons. It seems to us that only through this type of process are we going to be able to secure those rights for them.

For example, let me speak of Pennsylvania. Pennsylvania has 19 mental hospitals.

Senator BAYH. Excuse me.

I have just been told that I have about 4 minutes to get over to the floor. It is not going to take too long to dispose of that. I am going to ask Ms. Manella to go ahead here.

I will ask you if you could give us some insight on the Farview situation. A witness yesterday was very dissatisfied with the continuing situation there. I am sure that your organization is concerned about this kind of thing. Perhaps, in addressing the impact of *Wyatt* on Pennsylvania, you can broaden our scope of knowledge on that particular institution.

I am going to try to get back here.

Before I leave, if there is no objection, your entire statement will be inserted into the record

I really appreciate the concern of both of you gentlemen as well as the organizations you represent and your interest in what we are doing here.

Ms. MANELLA. Please continue.

Mr. RUBIN I was going to point out that in Pennsylvania I think we see an example of the nature of the problem. Although I was not here to hear the testimony about Farview that the reporters gave and that Dr. Maguire gave, I read enough about the Farview situation and heard enough about it from those who were involved to have some idea of what they must have said.

Twenty years ago, Pennsylvania had 19 mental institutions and approximately 40,000 patients. Today, Pennsylvania has 19 mental institutions and approximately 12,000 patients. If I were predicting, I would say in about 10 years Pennsylvania will have about 6,000 or 7,000 patients; and that might be an ultimate residue of patients that will have to be kept in the institutions. I am going to say they will still have 19 mental institutions.

But the fact of the matter is that it is just as possible that they will have 19 as not. The dismantling of the institutional scene has proved to be a particularly difficult bureaucratic effort.

I think that much of the problem that you see in a situation like Farview is attributable to that type of situation just as much as it is to the more horrible aspects of the Farview problem. The stories of the abuses at Farview, the problems that have been run into by well-meaning professionals are undoubtedly true. They have been carefully documented in a way that cannot be refuted.

But why is not something really done about it? Something really is not done about it because the bureaucratic approach to dealing with the problems seems ill designed for taking the type of action that is necessary within a State. That is where litigation comes in,

in my opinion. That is where litigation is the single most effective way of dealing with a continuing inertia among State bureaucracies, and the single most effective litigant—not because I think it ought to be involved in every case—is the U.S. Department of Justice.

Ms. MANELLA. So, what you are saying is that the States do not seem to be able to solve these problems absent the impetus provided by this litigation?

Mr. RUBIN. I agree with everything we have heard today; there are persons within the State system that want to solve the problems and absolutely welcome the litigation as being the salvation to their problem. It is the only way it is going to be done.

Ms. MANELLA. Do you feel that, even following the litigation, the implementation is difficult and often far from ideal?

Mr. RUBIN. Of course the implementation is difficult.

Pennsylvania, for example again, spends upward of $300 million in its mental health system. Perhaps $250 million of that goes for the maintenance of those 10 institutions, the remainder for the conduct of a community program. It is the community program, we think, that has been highly developed in Pennsylvania that offers opportunities for real progress in this field. Most of these patients can be treated in the community program, although we do believe that the ongoing oversight on the community program is just as important as oversight of the institutions.

Ms. MANELLA. And do you believe that those community programs would have evolved without the litigation?

Mr. RUBIN. I think the community mental health movement was well under way before the present era of litigation began. I think it was an inevitable consequence of just general revulsion at institutional practices.

But the development of constitutional rights for persons who have been caught in the system goes hand in hand, in our opinion, with the community mental health movement. The two together, I think, offer real hope, from the standpoint of our association, for doing something about what Dr. Stone has called the out of sight, out of mind factor, which is the critical factor in getting anyone to move within the States.

Pennsylvania is an exhibit of another problem of this nature. We do have patients in institutions yet, and there will be patient in those institutions for some time to come. Those patients deserve to live in a humane, decent environment, getting whatever treatment is possible for them. In some cases, that may not be a great deal.

How do you protect them? Pennsylvania decided, under the impetus of some of the litigation, that it ought to develop a set of patients' rights by regulation if not by statute. Statute, again, was a difficult route; so, they decided to work on regulations.

It has taken 4 years and approximately five drafts of proposed regulations; each set of proposed regulations being successively watered down under protest by bureaucratic and institutional forces, to get anything at all on the books in Pennsylvania which purports to extend the most elemental types of living rights to patients in institutions. These include the right to receive a visitor, the right to make a telephone call, the right to have some form of decent health facility.

That is not to say that some of these things were not available in these institutions. It is to say that they were not stated. Therefore, if you got them, it was simply because someone in the institution was willing to make them available to you, not because it was your right to have them.

The terrible effort that it took to get anything, I think, is indicative of the need for continuing litigation surveillance and a continuing involvement of the outside force the Justice Department represents.

I happen to have spent 4 years myself, at an earlier stage in my life, as a deputy attorney general of Pennsylvania. I think there are two things that I would apply from that experience to what I have heard today.

First, I think State attorneys general today, as they did 20 years ago, are still caught up in what they think is a conflict between States rights and constitutional rights. The conflict was in a different form 20 years ago; it had nothing to do with the rights of patients or inmates of institutions. But the same language was being heard from the same group of State attorneys general.

It is not because they are not in favor of doing these things. It is because they somehow sense that some form of their power is being eroded when the U.S. courts and the U.S. Justice Department become involved.

I happen to have worked for two attorneys general who did not feel that way in Pennsylvania and who took a stand at attorneys general's meeting the other way. It was a very lonely minority. There could not have been more than half a dozen attorneys general throughout the Nation who felt that way.

Nevertheless, there was a point of view that was expressed. I remember—just for the record I ought to add—two other attorneys general who did feel that way. One is now Senator Javits of New York. One was the former Governor Edmund Brown of California. They, too, agreed that States rights were not really the core of the problem; there were things that had to be done. If the Federal courts could do it, then that was the place to do it.

The second part of the problem, I think, is also something that has been alluded to today. That is, within attorneys general's offices, there is probably a natural reluctance to defend strongly practices that deputies in these offices realize are improper and not defensible. I think that what has been said about that is probably true. I do not agree, however, with Dr. Stone that the answer is to try to redress the balance of adversaries. As an attorney, I know only too well that in too many law cases the balance of the adversaries is not exactly balanced; there is an imbalance. I do not think that that is the critical problem.

I think it is true that public interest lawyers today who are really good in this field are few and far between and need the help of the Justice Department. I think it is true that many State attorneys general will welcome not having to defend too hard. I do not think it is absolutely necessary. I do not agree at all with Dr. Stone that there is something wrong with making national policy in this field. One hundred years of bad institutional practices is long enough to

wait for the States to have sorted out the problems for themselves. A national policy on the rights of patients in institutions is what is called for. If that is what will happen if the Justice Department intervenes, then I think it is time to let the Justice Department have the statutory authority to participate in these suits and to help set a national policy.

I could go on, but I will stop at that point because I have made the major points that I want to make. I had been prepared to say more about Dr. Stone's views, having read his testimony. But after listening to his testimony, I am not sure that there is a great deal of difference between his position and anyone else's here today except for that very small point as to whether or not the Justice Department should be involved. I have expressed the association's views on that point.

Thank you.

Ms. MANELLA. Thank you very much.

[The prepared statement of Harry J. Rubin follows:]

PREPARED STATEMENT OF HARRY J. RUBIN

SUMMARY OF FULL STATEMENT

The Mental Health Association wholeheartedly supports S. 1393. Patients in mental institutions often have very little contact with the outside world, sometimes due to the neglect of relatives and friends, and often due to the policies of the institution in which they reside. This has frequently resulted in the inability of private citizens to discover and document in court the widespread abuses of patients' rights in many mental institutions. The Mental Health Association, having been involved in a number of cases in which the courts have found a pattern and practice of patient abuse, has seen much improvement resulting from litigation, but realizes the limitations of suits initiated by private parties. We anticipate that the number of court cases filed by mental patients will actually be reduced if this bill is enacted, because the need for individual suits will be reduced as states respond to Justice Department suits alleging patterns and practices of abuse. The Association also anticipates that the need for greater oversight will become even more acute in the future, becaust as more patients leave state instituions for treatment facilities in community settings, only the most seriously ill will generally be left in the large state institutions.

I. Information on Harry J. Rubin and the Mental Health Association, Inc.

Mr. Chairman and members of the subcommittee, my name is Harry Rubin and I am an attorney residing in York, Pennsylvania. I am appearing today on behalf of the Mental Health Association (MHA). I have been active in the Mental Health Association in Pennsylvania since 1966, having served on its Board of Directors and as Chairman of that Board, and on its Public Affairs Committee and as Chairman of that Committee. Since 1972 I have served on the National Board of Directors of the Mental Health Association. In addition, I have served on the Association's National Public Affairs Committee and Litigation Panel, and am currently Chairman of that panel.

The Mental Health Association is the national citizens' voluntary organization of one million members representing the consumers of mental health services, and working toward improved methods and services in research, prevention, detection, diagnosis, and treatment of mental illness; and for the promotion of mental health. We have long been involved in efforts to improve conditions in mental institutions; in fact, an organized mental health movement was founded in 1908 by Clifford Beers, who had personally suffered many abuses during his long confinement in several mental institutions.

II. Rights of patients in mental institutions

In supporting S.1393, the first issue I would like to address concerns the rights that institutionalized patients are allowed by state statutes or regula-

tions. Perhaps fifteen to twenty states, for example, have visitation rights clearly spelled out, while the rest have only vague statutes or regulations which allow the directors of institutions the discretion to choose when and how many—if any—visitors a patient may see. Whenever patients' rights of any kind are not clearly elucidated by statute or regulation, each patient must negotiate for his rights each time he wishes to assert them, and this often results in a denial of Constitutional rights to patietns.

Pennsylvania, whose institutions and policies I am most familiar with because of my residency, has until recently not even had proposed guidelines specifying patients' rights. Only grand jury and state senate pressure resulting from a Philadelphia Inquirer expose of Farview State Hospital (for the criminally insane) has prompted the state to issue temporary regulations. At Farview, patients were exposed to a systematic pattern of abuse by guards, and ofaen had no legal recourse because they were denied access to legal counsel. The following examples, taken from a letter to the national office of the Mental Health Association from Mary Ellen McMillen, Director of the Berks County MHA (June 8, 1977), serve to illustrate the abuses which have occurred because of the lack of patients' rights:

"One patient was held at Farview illegally for four months. It took us six weeks to get him out; the facility, regional office and Department acknowledges to us that he was being held without authority. The man was not allowed to call an attorney, he was not permitted to receive calls or send and receive letters. He was brutalized by patients and guards. His mother had filed criminal charges for a minor offense to get her son help, but she dropped the charges when she was unable to communicate with her son. The young man never committed a violent act. The mother tried to have her son released, but she was unable to get public or private legal counsel. She came to us in desperation.

"One man is still at Farview. I met him three years ago when I was visiting a Berks County patient who had been sent to Farview illegally. He was charged with a crime, found incompetent to stand trial and sent to Farview. He wants to stand trial and he needs an attorney. We arranged for an independent psychiatric examination where he was found competent to stand trial and not in need of maximum security, however, shortly after the examination Farview claimed that he had regressed and is no longer competent to stand trial. We have not been able to secure legal counsel for this man for three years.

"We are working with a man who was just transferred to our state hospital from Farview. He is 80 years old and was placed at Farview in 1921 for burning down an outhouse. He said they would not let him call an attorney."

Without proper regulations, patients are often exposed to abuses by personnel against whom no substantive disciplinary action can be taken. A committee in charge of developing state regulations in Pennsylvania wrote the State Secretary of Public Welfare on July 22, 1976, in a memo on "Abuse Policy and Proposed Regulations," that

"A Superintendent/Director of a facility having learned of and investigated a reported case of abuse has taken disciplinary action against an employee only to later learn that an action may be reversed by the office of Administration or an arbitrator due to a lack of regulations regarding abuse. Cases heard before arbitrators have been decided either in favor of the employee or modified in favor of the employee because of the void in our personnel procedures on discipline in abusive situations."

Due to pressure created by the Philadelphia Inquirer series, Pennsylvania has finally begun the process of adopting permanent regulations which would help to eliminate some of these abuses. But as I have noted, most states do not have comprehensive regulations which specify the rights that mental patients have. Moreover, the adoption of state regulations does by no means guarantee that patient abuses will stop, or that the standard of care in an institution will meet minimum standards of decency. The amount of actual treatment patients receive at most state institutions in minimal, resulting in purely custodial care for the majority of patients in state mental insitutions.[1]

[1] Bruce Ennis, "The Implications of *O'Conner v. Donaldson*," unpublished paper presented to the 1975 ADAMHA annual conference, p. 9.

The nutrition provided patients is frequently inadequate, and the living conditions unsanitary and unsafe. These conditions have been highlighted by court cases in several states, the most well-known of which is *Wyatt* v. *Stickney*, dealing with institutions for the mentally ill and mentally retarded in Alabama. The Mental Health Association filed as amicus curiae in that case.

III. The effect of litigation

Not all mental institutions are operated in such a way that deprives patients of their Constitutional rights. Of course, these insttiutions and the states which operate them would not have to fear the initiation of a suit by the Justice Department. However, it is our view, resulting primarily from our involvement as amicus curiae in a number of cases, that litigation is a very effective way of prompting those states with inadequate standards and commitment procedures to upgrade their standards and procedures. This was accomplished in Alabama by issuing new regulations and spending more money on the institutions. In Pennsylvania, the Association filed as amicus in the case of *Bartley* v. *Kremens*, in which the District Court found then-existing state commitment procedures unconstitutional, as they deprived minors of due process.[2] Although the state of Pennsylvania appealed this decision, it also changed its statutes in a way which conformed to the District Court's judgment. And finally, the Supreme Court's decision in the *O'Connor* v. *Donaldson* case—in which the Mental Health Association filed as amicus—has had and will continue to have a profound effect on the ability of mental institutions to keep patients against their will.

The Court held unanimously that a "finding of 'mental illness' alone cannot justify a State's locking a person up agaisnt his will and keeping him indefinitely in simple custodial confinement."[3] The Mental Health Association, then, recognizes the great potential for progress through litigation. However, we are also well aware of the severe constraints, due to a lack of legal resources, placed on the initiation of suits by private parties.

Without the authority to initiate suits that this bill would grant the Justice Department, many institutions across the nation will be allowed to continue practices which deny the Constitutional rights of their patients. I need not discussed the negative impact of the *Solomon* and *Mattson* decisions, as those cases provided the impetus for the introduction of this bill. Let me add, however, that the need for Justice Department initiation of suits is growing as the number of qualified attorneys willing or able to take such cases grows smaller. Again, I refer to my own experience in Pennsylvania. We have found that few public or private attorneys have the time and resources to pursue extensive litigation on behalf of patients' groups. Community legal services associations have seen their funds shrink significantly, and they have discontinued the few legal services they had formerly provided to institutionalized persons. In sum, it is the belief of the Association that without additional legal and investigative resources used in behalf of institutionalized persons, many institutions across the country which deprive their patients of Constitutional rights will be allowed to continue their practices without any legal sanctions.

IV. The effect of S.1393 on the courts

No one can really predict how many suits the Attorney General would initiate if this bill were passed. However, we feel that the bill has adequate safeguards against "fishing expeditions" by the Department. The Attorney General must feel that the alleged abuses are widespread and serious enough to warrant a suit initiated in the public interest. We believe that the legislation would deal only with the most aggrevious situations, where the treatment provided by the facility is clearly deficient.

We also support the contention that the number of individual lawsuits will be reduced if this bill is enacted. Experience has already shown, in the Estelle case involving prisons in Texas, that individual suits can be consolidated if the Justice Department intervenes. If the Department could initiate suits, individual cases which might arise from an insttiution could be averted in many instances. In addition, as more states adopt new regulations and standards in

[2] *Bartley* v. *Kremens*, 402 F. Supp. 1039 (E. D. Pa. 1975).
[3] *O'Connor* v. *Donaldson*, 45 L. Ed. 2d at 406–407.

response to Justice Department pressure and court rulings, the need for litigation in those states will be reduced. The notification of state mental health officials before suits are filed (called for in Section 2) might frequently stimulate the institutions in question to upgrade their standards and procedures in order to avoid a legal battle with the Justice Department.

V. The shift to community care

I would like to make one final point bearing on this bill. Over the past two decades, there has been a dramatic shift in the patient population, from large state mental institutions to smaller, community-based treatment facilities, a shift for which the Mental Health Association has worked diligently. Largely because of Community Mental Health Centers and other community facilities, the number of patients in state mental hospitals has dropped from 559,000 in 1955 to fewer than 250,000 today, a decrease of more than 50%. This trend raises two issues. First, as the patient population in state institutions declines, those patients remaining will tend to be only the most severely ill in the society. These are precisely the patients for whom greater oversight is a necessity, as they are least able to fend for themselves. Second, it is important that community facilities not be exempt from Justice Department investigation and action if the need arises, because those facilities are where an increasing proportion of the patients will be. Therefore, we endorse the language in S.1393 which defines an institution as "any treatment facility for mentally ill, disabled, or retarded persons."

In conclusion, I wish to thank the Subcommittee for extending to me this opportunity to testify, and Senator Bayh for introducing S.1393 which the Mental Health Association wholeheartedly supports.

Ms. MANELLA. Mr. Posner, we have your statement. As Senator Bayh mentioned, he has read it.

You may be in a uniquely favorable position to comment on one of the points that has been raised today. I hope you will address yourself specifically to the inability of the State administrative and legislative processes to deal with these problems.

As you know, much of the opposition to this bill comes, not from any objection to its stated goals, but from the notion that these problems could best be resolved by the individual States, and by the State and local officials most familiar with the problem in their own institutions.

I hope you will address yourself to the difficulties in achieving reform within the States.

Mr. POSNER. Yes; I am pretty sure that, in the course of what I am about to say, that particular issue is going to rise.

First of all, I would like my testimony, as presented in writing, accepted as part of this testimony.

Second, I could say that, in putting my constituency's face forward, you saved the best for last. Everyone who has testified to date, with the exception of those who were former patients, are very detached personally, although not philosophically or ideologically or morally, from the problems and from the constituency who would be protected by the enactment and implementation of S. 1393.

TESTIMONY OF MORTON POSNER, EXECUTIVE DIRECTOR, FEDERATION OF PARENTS ORGANIZATIONS FOR THE NEW YORK STATE MENTAL INSTITUTIONS, INC.

Mr. POSNER. It is we who are parents and relatives who have the greatest vested interest in what goes on in the State institutions where our loved ones reside or are incarcerated or whatever. It is we who

see on a daily basis, and I in my professional capacity as executive director of the Federation, hear every day, almost every hour of every day, instances of abuse. It is abuse that is physical, and then there is the insidious abuse that is psychological and social in nature.

It is not a random thing with the Federation or with myself in dealing with these incidents. It is not to bring a case here or a case there. We hear it. We see it. We feel it. We taste it. We smell it. We touch it every day of our lives.

We, too, however, have played our part in the legal action taken. We were parties in the *Willowbrook* case and the various other smaller actions. Our problems stem from the fact that there just is not sufficient money. Those who are affected most severely are generally the most indigent and least capable of even putting forth a few hundred dollars, let alone several thousand dollars that it takes to open up a case.

I want to say for the record it should have been a preponderance of former patients and parents and parent advocates who testified on this bill, not professionals——

Ms. MANELLA. Excuse me for interrupting, Mr. Posner.

It might interest and comfort you to know that last Friday we had a full day of hearings in which, with the exception of the Assistant Attorney General in charge of the Civil Rights Division, all of the witnesses who testified were former patients.

Mr. POSNER. I was actually leading up to a point. I was not leaning on that particular issue as a concluding statement.

Ms. MANELLA. Please proceed.

Mr. POSNER. The point that I wanted to make was that psychiatrists have had their day. They have had 150 years on their day. I do not know where the figure 100 comes from; the institution system is over 150 years with us in this country.

Psychiatrists have had all of that time, and they have failed in their mission. I do not say they have failed through bad intent. Nonetheless, they have failed.

It is the consumer movement, made up of parents, relatives, and former patients, who had to yell and scream and do all sorts of socially unacceptable things in this society to bring the inequities and the depths of degradation to society's attention. It has been through the use of the courts and the use of the news media.

I agree with a former witness who said that one of the benefits of having the Justice Department intervene would be that it certainly would be more newsworthy and be more sexy—as they say in the news business—than the kinds of things that are brought on local court levels today, which do not seem to get anybody's attention.

There is another problem with the news media that I would like to point out. That is, after a while, they get turned off to the same thing being done. With the U.S. Department of Justice able to come in on major cases, uncovering major issues, it would not be the same thing over and over again.

I should also like to point out that one of our most serious problems is the fact that, while a Dr. Stone talks about a flood of litigation—which does not exist; there are not a lot of cases being brought.

Here am I representing the largest percentage of institutionalized patients and residents in the United States; almost one-third of all of those patients reside in the State of New York institutions. Yet, we do not have a single major case against the psychiatric institutions, against the Governor and department of mental hygiene because we do not have the wherewithal to bring it.

We have lost Bruce Dennis to Washington. We are losing Chris Hanson. We have lost half of the mental health law project staff. Their financial base has diminished to a point of where it virtually is nonexistent. They are practically out of business in September of this year.

My federation is out of money because many of the foundations on whose largesse we exist have seen fit to put their funding elsewhere.

So, if it is not the Justice Department bringing cases, intervening in cases, initiating cases—who else is going to do it? I submit that Dr. Stone is not a credible witness on that particular issue because, without the Justice Department they won't be brought and our people will continue to suffer and die.

We cannot wait. We cannot sit back, as Dr. Stone recommends. As Mr. Rubin just pointed out, it has been 150 years. Our people, our mothers and brothers and fathers and sisters and aunts and uncles, are dying now; they are suffering now. They need the help now. They cannot wait.

Ms. MANELLA. Mr. Posner, earlier today, Senator Scott indicated he found it difficult to believe that, if more people knew about conditions in institutions, they would not exert pressure on State legislatures to allocate greater resources to the care of the mentally ill and retarded. Do you think this is the answer—greater constituent pressure on elected officials?

Mr. POSNER. I submit—and I am sure that Senator Scott would like to hear this—that it is not a question in the United States of more money. It is not a question in New York State of more money. There is in New York State a relatively fixed mental hygiene dollar, about $1 billion.

We accept the fact that this is a relatively fixed sum; that is what we have to live with. It is a question of the allocation of that money. It is a question of the orientation of the people who spend that money and who provide the services and administer the services.

It is not a question of more money at the State level. In fact, I would like to put into the record at this point a response to the constantly surfacing question of, "it will cost more money."

Yes, it will cost more money; but it need not cost more money forever. I do have a recommendation to make. I will really appreciate one of the Senators or Congressman, or both, introducing legislation along these lines—which would be an appropriation bill.

It would provide the turnaround dollar. You see, what is happening is, in the States you have a single dollar; it can only go one way. It can either provide decent levels of care for those remaining in institutions until they are phased down. Or it can provide for a comprehensive, in community system of alternatives for rehabilitation and residential purposes.

We cannot do both, especially in these days of the ever-inflating dollar.

Therefore, it is suggested that the Federal Government provide a time specified, turnaround dollar to the States for the purpose of developing the community alternatives, with those dollars diminishing as the State dollars previously used for institutions are shifted to local community purposes.

This would be a 10—perhaps 15—year process. The States could and should be mandated that, if they participate, they cannot shift their State dollars to other purposes such as highways but that they must shift the money for the mental hygiene programs in the community as State institutions are phasing down to an irreducible minimum.

It also should be—it could not be mandated, but certainly recommended that the States seek—and aggressively seek—to sell off their institutional land and properties to commercial enterprises so that those lands go back on tax rolls. That would be yet another source of income for the States to use to provide decent levels of care to the community and to those small institutions for that population which must, of necessity, remain.

I would also like to suggest with respect to this piece of legislation—and it has come to my attention, both in listening to Senator Scott and in other conversations that I have had, that perhaps civil rights issues concerning the penal institutions should be separated out from those affecting the other institutions listed in the bill. I would suggest that a separate piece of legislation be written. It could be a parellel bill, for the penal institutions.

This needs to be done so the two issues stand on their own merits. Whatever happens at that point happens. I submit that a lot of people—let's say the more conservative elements within the legislature—would be more comfortable dealing with this bill with the penal system separated out into another piece of legislation.

I would add to that that I think several other societal problems might begin to be resolved by such separation. I could go into more detail on that, but I do not have the time.

I, too, have heard and have been witness to all of the kinds of abuses that have been alluded to today. I want to present for the record the report of the State of New York Commission of Investigation called "Life and Death at the Bronx Psychiatric Center."[1]

This corroborates all of the inequities and deficiencies that the Federation have brought to the Governor's attention, to the Commission's attention, to the regional director's attention, to the Director's attention, and to the news media for the past 2 years. Finally, at our insistence, the State Investigating Commission did in fact investigate and did in fact write a report that documents all the things—I should say corroborates all that which we found to be wrong with Bronx Psychiatric.

Ms. MANELLA. Thank you. We would be happy to receive that.

Mr. POSNER. This, by the way, is part and parcel of the problems we have had in New York State. Somehow or other, the credibility

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[1] See Exhibit No. 21, p. 474.

of those of us who live with the problem—I myself have a daughter in a State institution for the mentally retarded. I have a son who has been in a private psychiatric hospital. He has been abused. I have been witness to his abuse. Yet, I was powerless, even in my present position, to effect a remedy, except for him personally, by getting him out.

When we bring these matters to the attention of the bureaucracy and the State legislature, it is a slow, slow process.

For example, at Bronx Psychiatric, now that the State Commission on Investigation has printed its report, now the Commissioner finally sees fit to establish an in-house investigation; but not 2 years ago when we first brought this to his attention. When we asked that instances of abuse be somehow charted, no, they couldn't do that because it was we who were asking it; we, who were too emotional, too irrational. Maybe we love our children and our parents too much.

Now, finally, after the State investigation—even with this report—all it is is an expose. What is the commissioner going to do? Will he fire the director? He might, What good will that do if, in fact, the underlying causes are not dealt with?

Again for the record, the New York Post, on May 16, 1977: "Mental Hospital Terror Bared"—rape, sodomy, and brutality that one would not even have believed of medieval days is reported in this newspaper accurately uncovered by one of our members and finally exposed in the news media.[2]

And what good is it? We cannot bring suit.

Malpractice of the most insidious nature—and we cannot bring suit.

What happens to those who are culpable for these acts? They get bigger and better jobs, higher paying jobs. They are never brought before the bar of justice. This is why it is important that the Attorney General be given the power to bring these people before the bar.

Again for the record, at my urging, the State Assembly Committee on Mental Hygiene formed a subcommittee on patient abuse chaired by Assemblyman Paul Harrenberg. Mr. Harrenberg has completed his investigations and has issued this book, "Wards of the State."[3] Again, it corroborates all of the things that we brought to his attention 2 years ago. It took that long for us to get even the legislature cranked up.

Senator James Donovan of the New York State senate has issued a report, "Violence Revisited," in which he investigated four separate institutions.

The reports are the same. I could have written it in my sleep.

We are powerless because we have, in New York State, an attorney general who I consider to be either ignorant or arrogant. He writes a letter to the editor of the New York Times, trying to justify his position vis-a-vis opposition to Senate Bill 1393. But thank God there is an Ira Glasser, director of the New York Civil Liberties Union, who wrote a response which pointed out all of the deficiencies in attorney general Leftkowitz' letter.

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[2] *See* Exhibit 20, p. 472.
[3] *See* Appendix 24, p. 998.

Perhaps I am not capable of being as kind and as diplomatic as those who preceded me here today with respect to the intent of those who are supposed to serve us and those who are sworn to uphold justice in their State.

In New York State the attorney general assigns lawyers to challenge the patient's rights to be discharged because he does represent the State's interest. And it is in the State's interest to keep that person retained in that institution. That offers jobs to the civil service employees and keeps them happy.

Never once, in all of my 2 full-time years as professional advocate in New York State, and none of the years prior to that, have I ever known an attorney general's lawyer to once challenge whether or not the individual being retained will be retained in the least restrictive alternative, or whether or not that person will be protected from harm, whether or not that person will receive appropriate services.

I have, instead, seen patients brought before a supreme court judge in New York State in their pajamas, with paper slippers on their feet, not shaven, hair disheveled, smelling from urine. This, of course, prejudices the judge before the case is even brought. Where is there justice, even in our courts?

The attorneys general claim that their rights somehow will be infringed upon. I call that arrogance and perhaps worse.

Attorney general Leftkowitz never stuck his nose into Willowbrook or Pilgrim State or Bronx State or Manhattan State or Mid-Hudson State or any of the institutions that we brought his attention where these crimes against humanity were being committed—never once. And it was not a question of conflict of interest. I consider it a question of indifference and insensitivity.

It is true that Senator Javits was a sensitive attorney general, but his successor is not.

I want to relate one specific incident at a small psychiatric center for children. This place is small.

What I am about to say points out that it does not require more money because in this particular institution the per capita annual budget is $26,000. It is environmentally beautiful. Many times I have gone there with parents who have youngsters in older institutions; they cried. They did not believe that an institution can be this colorful, as light and airy, with carpets and wood panels and carpeted floors and big windows with sun shining in.

Yet, at this institution, the commission of the State of New York Department of Mental Hygiene issued a press release supporting the director as being a woman who has contributed mightily in the field of child psychiatry. Yet, this women, who I can't even bring myself to call doctor, though she has that degree, was about to allow—as a matter of fact, she was condoning—an 11-year-old boy who had a history of biting—she was about to authorize, until we stopped it, having all of his teeth extracted.

Mind you, she thought this was more humane than what had been going on before. She was the one who signed the order to have a mask placed on this boy's head, a hockey mask, 24 hours a day. If it had not been for the caring, concerned, dedicated employees on that staff, on that ward, he would not have even had it off when he was

asleep; they saw to that. And they saw it was off when he was eating. Finally, they fished around and they found a fencing mask because the order was that he had to be masked.

This is the kind of cruelty. I believe it is the eighth amendment that says that we have the right not to be treated cruelly or inhumanely. That is not a new right; that right exists in the law today. I do not know what it was that some people were talking about earlier today about new rights.

We are not looking for new rights. We just want the present rights enforced.

This young boy's rights under the eighth amendment certainly were violated. Prior to that, by the way, he had been locked in a room, an isolated room. That was the way of treating him prior to putting the mask on.

I could go on and on. Just last night one of my dearest friends, who happens also to be an officer in our organization, called me up. This brave woman who had somehow managed to survive the Nazi holocaust and the concentration camps came to this country seeking a better way of life and had found it, only to find that her own son suffers the same kind of inhumane cruelty heaped upon her when she was a child in Hungary.

This young man, just 1 week ago, had been overdosed with Prolixin and whatever else. Then, as a result of being overdosed reacted violently. So they locked him into a locked ward, creating in him a sense of fear, which causes him to act even more violently: cause and effect and effect and cause.

When you call and ask that this be remedied, we are told, "He's a violent case and that's why he was locked up." But they do not say that it was the overdosing of the medication that caused him to become violent in the first place. Then, in order to confine him, they call his father in the evening. In a dimly lit corridor, they literally forced him into signing the papers without his father's knowledge of what those papers were. So, his own son became confined at his wish; which, of course, was not true.

We need the pressures. We absolutely, desperately need the pressures from the Justice Department on the States. Even without bringing the cases—as someone indicated earlier—it might start to see some relief. We need to be able to do, as I do right now constantly; that is threaten the States with lawsuits, threaten them with administration actions under the new Civil Rights Act and section 504.

I do not believe this next recommendation is an alternative that Senator Scott was looking for. I see this next recommendation, which I did include in my written testimony, as being absolutely vital to legitimatize the very act of S. 1393.

That is that the Civil Rights Act of 1964 must be amended to include that last minority, people with disabilities, people with perceived disabilities, people with disabilities regardless of the label, regardless of the severity, regardless of the nature.

If that is done, then we finally have the entire population covered.

Of course, the law would have to also very specifically include people who are institutionalized.

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5 OF 12

It would also have to include language—as does 1393—that waives the necessity for all administrative processes or all administrative remedies having been sought. I believe that is very vital. I would urge that this not in any way be weakened in the current act. I would urge that, when you get around to amending the Civil Rights Act of 1964, that language be likewise included.

Those two things together, I believe, would begin the process of remedying the wrongs committed against our people, our relatives, our loved ones.

I also want to put into the record, just so that it is clear to Senator Scott and the rest of the members of this body, that the reason that there are not more foster care families is because there is not sufficient moneys provided so that they can keep in their homes those whom they have accepted as part of their family.

I myself am in the process of establishing such a program throughout the State of New York. We have located sufficient sources of funds. In other States, those funds do not exist.

The fact is that in a city of 30,000 in Belgium 1 out of every 7 homes is a family care, foster care home for people with mental disabilities. This has been going on for 500 years.

In Pennsylvania they have a program that is successful; my only complaint is that that program is State operated rather than voluntary agency operated.

In Missouri there is a fine program. In the State of New York there is a good family care program except that family caretakers are leaving the program because the amount of SSI supplement is insufficient for them to be able to really honestly do a good job. Also, that program is State oriented rather than being community oriented.

There is one thing that I wanted to add. I have to say this so that I can look at myself in the morning and I can look at my constituents and say that we represent their interests honestly.

I would add that the passage of S. 1393 not become empty. The enabling legislation must be accompanied by necessary appropriations sufficient to effect full, efficient, and expeditious implementation of that act.

There must be fines exacted against individuals, agencies, and States found guilty of violating the constitutional rights. That money could be used to reimburse the Federal expenditures, just as traffic fines go to pay for courts.

That would serve as a further deterrent. It seems to me there is nothing as significant as being hit in your pocketbook. The States react to that much faster than anything else. If you throw them in jail, it doesn't mean anything somehow. Take away their dollars, and they will react to it.

I would further respectfully request that, when this bill is passed and is in the process of being implemented, that the National Committee on Patient Rights, of which I am privileged to be a member, a body consisting of former patients, parents, providers, and governmental officials, be designated to be a consultant to the Attorney General on this act, both as to its overall implementation and on a case-by-case review.

This, it seems to me, would set in motion one of the concerns raised earlier today about the Attorney General getting involved in every single case. I would agree that he could not and should not. But certainly somebody should assist in the process of determining which ones. We would like to be that somebody.

I would conclude by saying that I want to have expressed to Senator Bayh our very deep appreciation and gratitude for his sponsorship of the bill and to all the members of the Senate who sponsored the legislation.

We would urge its immediate passage. We would urge its immediate implementation.

Then perhaps we might start to see a light at the end of the tunnel.

Thank you.

Ms. MANELLA. Thank you, Mr. Posner.

Without objection, the material to which you referred will be inserted into the record.

I would like to ask you one final question.

I know that you are familiar with the *Willowbrook* case. From your testimony, you are obviously familiar also with the other avenues of redress which concerned and capable organizations such as your federation have attempted.

Is it your opinion that the *Willowbrook* case has, in fact, resulted in the improvement both of Willowbrook itself and of the lives of many of those former institution residents who are now in other placement settings?

Mr. POSNER. The answer is yes and no.

Yes; because it focused attention on a very singular problem.

Yes; because there is now in place a process of developing and initiating community residential alternatives for that population.

Yes; because the lives of some of the people have been saved. Bernard Carabello, who I believe testified here last week, is an example. A young man by the name of Washington had his life saved. I do not know all the names of all the people whose lives were saved. The other Bernard Carabello would be the best way I could express it.

No; because it only affects the Willowbrook class. The State has made it absolutely clear that this is the way they are going to implement the consent decree and have, in fact.

It is only because of the lack of money that we were not able to bring an action under the 14th amendment to claim that equal protection under the law was being violated. We are still trying to do that.

No; because an inordinate amount of money was poured into a bottomless pit. The per capita per resident of Willowbrook is up to close to $35,000 a year. Yet, I have very dear friends who work at Willowbrook who tell me that the situation regarding abuse and the lack of rehabilitation, et cetera, is still epidemic in that facility. Yes; the environment has been improved. Yes; there have been curtains put up and all of that. But it is still an institution. Institutions are, of and by themselves, debilitating and dehumanizing for staff as well as for patients.

No; for another reason; and this is most unfortunate. I mentioned earlier that we have a fixed mental hygiene dollar in the State of New York. What has happened is that—although the judge ordered that it be new money—it was in fact not new money.

They merely shifted money from one locus to another, shifted it from mental health to the mental retardation area. This is something that we are now desperately trying to do battle with in New York—unsuccessfully, I might add.

Just to give you an example of how this works. There is section 11:33 of Mental Hygiene law which authorizes the expenditure of up to 50 percent of operating expenses for community residential alternatives. In the mental retardation division, there is now $9.4 million—and appropriately so; I would not touch a penny of it.

But in the mental health budget—and this took a tremendous battle because up until this year it had been zero—we finally got $330,000.

So, there are inequities that have been caused unintentionally. But because of our inability to bring actions against the Psychiatric Centers that would have matched and counterbalanced the actions brought against Willowbrook and the other developmental centers, these inequities are taking place.

So, it has been good; and it has been not so good.

The education department in the city of New York is still very uncomfortable in implementing the consent decree. They feel that they do not have a financial obligation to continue to provide educational programs for those who are discharged. They say they do, but then they do not do it in actual fact.

Yet, we do not have the wherewithal to bring an action against the State education department, who are, in fact, violating the 14th amendment and who, in fact, will be in violation of Public Law 94-142.

So, it has gone both ways.

Ms. MANELLA. Thank you very much, Mr. Posner. We appreciate your being here.

I know Senator Bayh certainly is grateful for your appearance and testimony. I am only sorry that he had to take off early because of floor business. He would have liked to have been here.

We appreciate your being here, too, Mr. Rubin.

By the way, Mr. Posner, am I correct in assuming that, in addition to the documents you listed today, there is a New York Times article that you would also like inserted in the record.[4]

Mr. POSNER. Yes.

Ms. MANELLA. Without objection, that will be inserted into the record.

[The prepared statement of Morton Posner and the above referred to material follow:]

PREPARED STATEMENT OF MORTON POSNER

Mr. Chairman, honorable members of the subcommittee, I present this testimony in support of S. 1393, not only in my capacity as Executive Director of a State organization representing over 30,000 patients and residents in the New

[4] *See* Exhibit No. 17, p. 468.

York State Institutions and their families, but also as a volunteer advocate on behalf of all persons with disabilities for over 20 years, as a parent of three children with handicapping conditions, one of whom, unfortunately, resides in a State Institution because of the absence of viable in-community alternates. I serve by gubernatorial appointment on the New York State Council for Mental Hygiene Planning, and recently served by similar appointment as a delegate to the White House Conference on Handicapped Individuals. I number among my credentials the founding of the Illinois Association for Retarded Citizens, and currently am the initiator and developer of Family Residences and Essential Enterprises, a major community residential program to begin this Fall. I am particularly privileged as well to serve as a member of the National Committee on Patients' Rights.

In New York State, it is evident that the Willowbrook Consent Decree could not have been achieved without the very able assistance of the U.S. Department of Justice. It was this case, among others, which clearly established the Constitutional right to be protected from harm. The irony in New York State is that the Attorney General is mandated by law to defend the State's agencies which violate that right. Who, then, beside those of us, for reason of blood and humanity, are to be advocates for this put-upon population? Who then has the fiscal means and legal talent to bring the violators before the bar of justice, if not an arm of the Federal Government, which is authorized to investigate and enforce the laws of this land? Our Governor promises to provide advocacy, yet these promises have a hollow ring, since on the one hand, in New York at least, the State cannot sue itself, and on the other, the Governor names the various commissioners as advocates—another example of appointing the fox to guard the chicken coop.

We have had to witness abuse of our loved ones; psychological and sociological, as well as physical, perpetrated with impunity by those charged with their care and custody. The history of abuse by neglect is now legend. The incidents of over-utilized and inappropriate medication; restraints reminiscent of medieval days; incarceration without due process; and a host of other violations of basic human rights is made evident to us on a daily basis. Yet we have been powerless to seek redress for these grievances. There is intimidation and manipulation by those State agencies and their officers, who defend a corrupt and corrupting system for self-serving ends. This is compounded by a lack of fiscal resources by those stout hearts among us who seek to take legal actions. The actions taken to date are as a result of sacrifice by those least able to afford such financial hardship added to their other woes. Our less affluent, middle and low-income families are placed in double jeopardy; they can't afford the services needed, and cannot seek remediation, when their loved ones are underserved, inappropriately served, or unserved altogether.

We are told to accept as gospel the preachings of the psychiatric community and not make waves. Coercion obtains by subtle and overt means. Parents are thus silenced for fear of losing what little is being offered. The Civil Service Unions, in an outrageous attempt to maintain membership, spread malicious gossip and fear in the community to prevent even those individuals ready for discharge from being accepted back into the mainstream of society. All the while the State "dumps" ill-prepared patients and residents into substandard conditions and worse. These inhumane practices must be made to cease, or surely as the cancer that it is, it will consume us all.

During the past two years alone, actions should have been brought against the State and its agents because of the debilitating, dehumanizing conditions of degradation and despair that take place at such State Institutions as Manhatan Psychiatric Center, where a subtle form of genocide and brutalizations and maladministration are being investigated by a State Commission, powerless to do other than expose the facts (see attached news clippings); Sagamore Children's Psychiatric Center, where brutalizations of children were covered up by the Director, and where recommendations are on record to have all of a young boy's teeth pulled, because he had a history of biting. This was considered to be more humane than the despicable goalie's mask he was forced to wear 24 hours a day; Hoch Psychiatric Center; Pilgrim Psychiatric Center; Mid-Hudson Psychiatric Center; and others, where murder and mayhem, and the loss of personal property, and cruel and inhuman punishment in the name of "therapy" are the order of the day. These are but a few examples

of the unspeakable horrors parents, relatives and patients are expected to accept without question. State Auditor's Reports abound corroborating that the inequities and deficiencies do in fact exist.

We are denied access, and the Mental Health Information Service, an arm of the Appellate Division, refuses to bring legal action, although authorized by a weak State Statute to do so. We are accused of overreacting when we bring these matters to the proper authorities.

The District Attorneys want the "smoking gun" before they will take action. Without subpoena power; without statutory power, how can we conduct investigations to obtain evidence or pursue trails often covered up? The Volunteer Boards of Visitors, appointed by the Governor, and endowed with such powers, have no staff, no funds, and in any event with rare exception are generally co-opted by the Directors and staff, and act more as apologists for the institutions than as advocates for the patients/residents therein.

I cannot urge strongly enough prompt passage of S. 1393. Without such authority granted to the U.S. Department of Justice, we and more particularly our loved ones, are left as second-class citizens, and thus denied our Fifth, Eighth, and Fourteenth Amendment rights. I would ask only that the word "confined" be clearly defined to mean both voluntary and involuntary status for purposes of this Act.

I respectfully submit that there is yet another piece of legislation desperately needed to further legitimize the involvement of the U.S. Attorney General in State matters. You are right, Senator Bayh, when you say that this is the last great frontier in the Civil Rights Battle. I refer specifically to the need for an Amendment to the Civil Rights Act of 1964, which would include persons with disabilities (as defined in the regulations to Section 504 of the Vocational Rehabilitation Act of 1973). I can report that this recommendation surfaced as a high-priority, if not in fact a Number-One priority, in the reports to the White House Conference on Handicapped Individuals, presented thereto by the several states. It will be necessary to include in such Amendment, language that precludes the necessity to seek all administrative remedies before the courts will accept suits (such as that proposed in S. 1393), and to extend the authority of that Act to the popuations residing, voluntarily and involuntarily, in State Institutions.

S. 1393 and such an Amendment to the Civil Rights Act of 1964, will finally exend to this neglected population a recognition and protection of their civil and constitutional rights, not to mention their human rights as well. Their very enactment itself will give new hope to parents, relatives and concerned citizens, and a source of strength not heretofore statutorally available to them. It will serve notice on the perpetrators that they can no longer, without being held to account, abuse our loved ones, and thus hopefully will be significantly reduced the violations of their rights.

In conclusion, there is a Right which I believe transcends all others which such statutes will help to attain. The Right To Have Respected The Dignity of One's Humanity. I respectfully commend to you that "The Right To Have Respected The Dignity of One's Humanity" be included as a preamble to the proposed legislation to give the full essence of its intent to all who would doubt its purpose.

On behalf of tens of thousands of patients/residents and their families, I express a profound gratitude to you, Senator Bayh, who authored, and to all who sponsor S. 1393, and Godspeed in its adoption.

[EXHIBIT NO. 17]

[From the New York Times, June 10, 1977]

INQUIRY LINKS "INSTITUTIONAL INDIFFERENCE" TO DEATHS OF 7 AT BRONX MENTAL FACILITY

(By Ronald Sullivan)

Six patients at the Bronx Psychiatric Center died and a seventh was beaten in circumstances of "institutional indifference and ineptitude," the State Commission of Investigation charged yesterday.

Moreover, the commission said, the center's explanation was "inaccurate" and "omitted" facts surrounding several of the deaths.

While the commission's report did not use the word, its chairman, David W. Brown, said at a news conference at the State office building at 270 Broadway, that the center's handling "amounted to a bureaucratic cover-up."

The deaths occurred during a one-year period from July 1975 to July 1976, except for the sixth, which took place last March 24.

Three of the deaths were suicides by hanging, one was a homicide committed by one patient upon another, one was from "supposedly natural causes," and the sixth, the one in March, from exposure.

The death of a young patient suffering from seizure was attributed by the commission to an unauthorized lethal dose of a drug, Haloperidol.

The patient's death had been officially reported by the center as a result of "natural causes."

A suicide by a woman patient was described in the 60-page report as "occurring under very suspicious circumstances."

Testimony taken by the commission at the center during an eight-month investigation it conducted there has been turned over to the Bronx District Attorney, Mario Merola, to determine whether there was "evidence of possible criminal wrongdoing."

Mr. Brown also said that copies of the commission's report had been sent to Governor Carey, to the Legislature and to Dr. Lawrence C. Kolb, the State Commissioner of Mental Hygiene, who, through his office, declined to comment on it.

The deaths at the 700-patient institution simply "cannot be explained by inadequate funding or understaffing," the report said, adding:

"This commission does not accept any explanation that what has happened at B.P.C. is an acceptable standard of care or accountability for a mental-health facility in the State of New York."

The report, entitled "Life and Death at the Bronx Psychiatric Center," is the culmination of an investigation requested by the center's Board of Visitors. It urged that the Legislature approve a pending bill that would establish a State Commission on Quality Care for the Mentally Disabled.

The S.I.C. said the proposed commission "would initiate its own investigations of patient mistreatment or abuse" because the Boards of Visitors—laymen appointed by the Governor as overseers of state mental institutions—did not have the time or the capacity to conduct such inquiries.

All told, Mr. Brown said, there were 2,000 deaths reported in the 13 state mental institutions last year, which had a total of 27,600 patients. He said a major thrust of the commission's recommendations was to determine "how many of them could have been prevented."

"Otherwise," he said, "nothing will change."

The three suicides reported by the commission all involved hangings. The one that its investigators regard as "suspicious" involved the death of "nicely dressed, well-groomed" who had never shown any suicidal tendencies.

She was found dead in a utility room on Oct. 25, 1975, and an autopsy later listed the death markings of the hanging as "unusual in the case of suicide" and as resembling evidence of manual strangulation.

The unusual circumstances of the death of the 25-year-old man who was administered what the commission described as a fatal dose of Haloperidol would have gone uncovered, it said, if the city's Medical Examiner had not been alerted by S.I.C. investigators.

One employee of the center invoked her constitutional privilege against self-incrimination when asked to explain her entries in a report of the drugs given to the patient.

Finally, the commission was highly critical of the reassurance from the center that it had cleared up many of its institutional failings. And to underscore its criticism and in an effort to show that "nothing has apparently changed," the commission reported that a patient died there on March 24 of exposure after remaining outside overnight on the hospital grounds.

As for the State Department of Mental Hygiene, he said, "We don't think they know what's going on."

A spokesman for the American Psychiatric Association in Washington said that the six deaths were "unusual" but that such incidents "were not extraordinary" in large, government-operated mental facilities in the United States.

Dr. Hugh F. Butts, the director of the Bronx institution, said in response to the commission's investigation that "the majority of patients are not receiving what I regard as appropriate psychiatric treatment."

He added, "We can barely administer appropriate therapy to those patients that require it. We used medication rather extensively."

WOMAN SEVERELY BEATEN

In the case of the beating, the report said that a woman admitted two months earlier was severely beaten on July 14, 1975, and found at dawn near the center's ambulance entrance.

The report said that the institution had failed to explain how the woman got through two locked doors or the circumstances that had led to the attack on her.

The homicide involved the killing of one patient by another with a broomstick after the two patients had a fight. The report noted that it took 15 minutes of paperwork before the unconscious victim could be taken by ambulance to nearby Jacobi Hospital, where a physician later said that the delay could have cost the patient his life.

[Exhibit No. 18]

TABLE OF COURT ACTIONS AND AGREEMENTS IN "JACKSON V. HENDRICK," 457 PA. 405, 321 A. 2D 603, 607 (1974)

Case Concerning the Philadelphia Jails

1971

February—Class action complaint filed.

April 1—Defendants filed preliminary objections.

September 10—Court filed opinion dismissing preliminary objections and set schedule for hearings.

December 20–January 19—Testimonies heard.

1972

February 23—Argument by city heard.

April 7—Opinion filed by Court of Common Pleas.

June 7—Exceptions to Opinion and Decree *Nisi* dismissed—Court affirmed Opinion and Decree *Nisi* in Final Decree.

1973

August 31—Commonwealth Court filed its opinion on the city's appeal—*Hendrick v. Jackson*, 10 Commonwealth Court 392, 309 A. 2d 187 (1973).

1974

July 1—Supreme Court of Pennsylvania reinstated original Decree and affirmed appointment of a master to monitor implementation (appointment made in October).

1975

February 21—Common Pleas Court wrote defendant's counsel that compliance was expected.

May 1—Defendants submitted statement to Court on "significant improvements."

May 13—Common Pleas Court sought written response from plaintiffs.

July 14—Plaintiffs submitted response.

August 15—Parties met.

October 9—Stipulation of Voluntary Compliance (statement of agreements) filed in Court.

1976

January 22—Master filed Initial Report with the Common Pleas Court.

March 15—Court ordered to show cause why proposed Interim Decree should not be issued.

April 5—Full hearing held.

June 15—Court issued Interim Decree I—City appealed and parties entered negotiations.

1977

February 4—Stipulation and Agreement (including schedule of compliance) signed.

May 24—Contempt of Court Petition filed by plaintiffs.

June 27—Contempt of Court hearing before Court of Common Pleas.

[NOTE WELL.—The Master's Initial Report, Stipulations and Agreement, and current Contempt of Court hearings focus only on the most basic conditions of the prison. Other issues are still on appeal before the Commonwealth Court. The Master expects to submit further reports and thus there may be years of litigation still to come.]

[EXHIBIT NO. 19]

FOR ANNUAL REPORT (1977) PRISONERS' RIGHTS LITIGATION

During the past several years The American Foundation has been a party to an ever expanding list of court cases determining the rights of inmates sentenced or detained in prisons and jails across the country. The Executive Director has testified as an expert witness in cases challenging physical and operational conditions of institutions operated by all levels of government. We have accumulated quite a success rate and can reaffirm the validity and importance of prisoners' rights litigation as a strategy for institutional change.

Judgments about prison/jail conditions start from the application of constitutional principles—equal protection and treatment of people in like status; protection from cruel and unusual punishment; and for detainees, the right to the least restrictive means of holding someone to assure appearance at trial. Furthermore, a government's inability to pay does not excuse authorities from correcting violations of individuals' rights. The following description of cases we have been involved in is intended not as an index to all the issues of each case, but more as an assessment of the main points and significance of each case.

Although we were involved in the state prisons case in Alabama during 1975, it is worth mentioning here as the decision (*Pugh* v. *Locke* and *James* v. *Wallace*, 406 F. Suppl. 318 (M.D. Ala. 1976)) was the first to deal with an entire state system, to recognize that incarceration is unconstitutional because it further harms rather than rehabilitates prisoners, to contain an enforcement and compliance mechanism, to order the state to reclassify all prisoners and transfer them to the appropriate facilities, and to order the state to provide a "meaningful job" and transitional re-entry program to each prisoner. The decision is extremely detailed and expansive—from toothbrushes to staff quotas to the use of community alternatives. A more recent study done by the Foundation for the American Civil Liberties Union estimated a one year cost of implementation to be $28.5 million.

The case challenging conditions in the segregation unit in Clinton, New York (*Frazier and Reiners* v. *Ward*, 73-CV-306, Feb., 1977) is significant in that a conservative judge agreed to intercede and decide the constitutionality of routine, correctional practices. He decided that for segregated inmates, the denial of daily outdoor exercise and the routine of a rectal and testical search after vists are unconstitutional. The established disciplinary procedures and system of segregated prisoners requesting law books (instead of going to the library) were found to be constitutional.

Decisions are pending in New Hampshire and Rhode Island (*Palmiglano* v. *Garraby et al*, CA. 74-172 and *Ross et al* v. *Garraby et al*, C.A. No. 75-032 and *Hauman* v. *Helgemoe*, C.A. No. 75-258), both cases which challenge the totality of conditions in the one state institution. Idleness and uncleanliness are major issues of both, and the overuse of the disciplinary cells is under examination in the Rhode Island case.

A case developing in Utah (name and cite unknown) is being brought by the U.S. Division of Civil Rights to contest racial discrimnation in the state prisons. A similar claim has precipitated investigation of the Federal Institution at Lewisburg by this Division, and the Foundation has become involved in facilitating the resolution of this and other operational complaints uncovered during the investigation.

Cases challenging jail conditions differ from those challenging prisons since jails house pretrial people whose status should be equated to those out on bail except for restrictions required to insure appearance at trial and demonstrated by the government to be so essential to its interests (institutional security) as to override the individuals' interests. As a result, jails face much tougher constitutional tests.

The New York City jail, the Tombs, was closed in 1974 subsequent to a court order (*Rhem* v. *Malcolm*, 507 F. 2d 333 (2d Cir. 1974)) stipulating that the

city might use the building if plans were submitted and construction completed so that the jail achievel constitutional compliance. At issue were noise levels, outdoor recreation, lighting, heat, ventilation, views of the outdoors, program space, and most importantly, the unalleviated maximum security conditions. This past year the City submitted plan C94, and Judge Lasker, on April 11, 1977, rejected it as failing to meet constitutional tests. The city did not reliably establish the adequacy of the outdoor recreation facilities and did nothing to change maximum confinement conditions. The Judge rejected the City's claim that the manner of operation, rather than the physical structure, of cells determines their classification as maximum custody. The court instead agreed with Mr. Nagel's testimony that the cage-like cell structure amounts to maximum security when used for as many hours as they are at the Tombs.

Another example of a judge's persistent attention to the constitutionality of a jail's conditions in his district is drawn from Ohio. A new facility has been built subsequent to a decision closing the old Toledo jail (*Jones* v. *Wittenberg*, 330 F. Suppl. 707 (1971). During 1977, Mr. Nagel was called upon to testify as the judge considered the constitutionality of the new prison even before it is opened. The judge is most concerned that staff patterns will insure inmates protection. The decision is pending.

Inmate safety was also an issue in the case brought by the U.S. Civil Rights Division against the county of Dothan and the State of Alabama on the jail in that district. (*Adams et al* v. *Mathis et al*, Civ. Action No. 74-70-S (M.D. Ala.) filed March 31, 1975.) When the hearings began, the county capitulated to all the challenges—most notably, overcrowding, arbitrary discipline, lack of classification, and inadequate staff—but the state denied its responsibility. Results of this case are still uncertain.

Probably one of the most notable cases, if not the most notable case, on jail conditions concerns the Metropolitan Correctional Center (MCC) run by the federal government in New York City. (*Wolfish* v. *Levi*, 75 Cov. 6000 M.E.F.). This new facility was built as a model jail and yet still faces constitutional challenges. The MCC is being challenged on its unalleviated maximum confinement conditions, similar to the Tombs case but on the basis of operation rather than physical construction. Inmates are confined to their modular units twenty-four hours a day, except when they are escorted to the roof for exercise. Other key issues include the requirement that pretrial people wear uniforms and the inadequacy or lack of employment, recreation, and visiting facilities. A decision is expected sometime this summer.

The latest case the Foundation has been asked to be an expert in concerns the Baltimore City Jail (*Duvall* v. *Mandel*, et al, Civ. Action No. K-76-1255). This case challenges the legality of overcrowding the jail with sentenced prisoners who should be, but are not, transferred to state facilities. The claim of unequal treatment is brought on two grounds—for pretrial detainees being treated unequally to bailees because overcrowded conditions deny them facilities and services they deserve, and for sentenced prisoners being treated unequally to those held in state prisons because confinement in the jail denies them access to opportunities which are considered instrumental in obtaining parole. Testimony is expected to take place during July.

[EXHIBIT NO. 20]

[From the New York Post, May 16, 1977]

MENTAL HOSPITAL TERROR BARED

(By Michael Rosenbaum)

The 1500 mental patients at Manhattan State Hospital live under constant threat of murder, rape, assault and theft because of inadequate security, a Post investigation has found.

The lack of protection affects not only patients, but also visitors to the Wards Island facility, located under the Triborough Bridge.

The assailants include violent patients as well as muggers and rapists who can reach the huge hospital complex by bus or car or simply by walking across a footbridge from East 103d Street.

The investigation by The Post discovered:

Only nine security guards are on duty at any given time to monitor the 122-acre, 18-building complex, plus its four community clinics in Manhattan.
In April alone, according to hospital records, there were three rapes, 38 assaults, 42 patient fights, 24 injuries and 93 patient escapes.
In the past month two patients died under mysterious circumstances.
Drugs and liquor are regularly smuggled in to patients, according to the hospital staff.
Violent patients, who should be isolated, are housed among the non-violent.

$30,000 GUARDHOUSE

A symbol of Manhattan State's vulnerability to crime is a $30,000 guardhouse which was built last year at the hospital entrance but which never has been manned by security guards.
A city park occupies half the island. A wire fence between the park and the hospital was built last year for $40,000—but it is constantly being cut.
Access to all hospital facilities—except for wards, which are locked—is practically uncontrolled. A reporter recently passed unchallenged onto the grounds and then into several hospital buildings. Only one guard was seen in five hours.
"Patients and visitors are constantly under assault by outsiders," said Dr. Gabriel Koz, the hospital's new director. "And theft is massive—a lot worse than any other state hospital."
Security, he said, "is absolutely ridiculous," because the hospital is "too easily accessible."
While it's too easy for criminals to get into the hospital, it also is too easy for patients to get out.
Patients at the facility are generally chronic or acutely psychotic adults, according to Koz.
About half the inmates are committed involuntarily by doctors or courts—some in criminal cases. While 200 to 400 are long-term patients, the remainder are supposed to be there for two weeks to a year, he said.
Improper supervision of patient's movements apparently played a significant role in the recent deaths of two patients.
The body of Petra Cueas, an inmate in her late 20s, was found April 20 in an abandoned building on the hospital grounds. She had been dead about 10 days.
The hospital staff last saw her on March 25 when she went for treatment to the Rehabilitation Building.
According to Donald D'Avanzo, of the Manhattan State Citizens Group, several patients saw her being taken from the hospital grounds by two men.
D'Avanzo, whose group represents relatives of Manhattan State patients, said another patient saw her April 1 in Times Square.
"I'm convinced she was abducted, and either escaped or was returned by her abductors to the hospital," D'Avanzo said. "I'm sure she was murdered."
The medical examiner has not yet determined the cause of death.
The body of a second patient, a male whose name was not released, was found floating in the East River May 5. Koz confirmed that the man had been seen on the 103rd Street footbridge earlier that day, but said the cause of death—suicide, accident or murder—has not yet been determined.
Easy access causes other problems.
Al Sunmark, a therapist at the hospital who is active in the staff's union, describes a "large liquor and drug traffic" that flourishes in the absence of security.
"Drugs are available in the wards," according to D'Avanzo.
He said the most common drug is marijuana, which is sold for $1 per joint. A large tree near one of the main buildings, he said, is always littered with empty liquor bottles.

VIOLENT PATIENTS

Patients obtain the contraband, he said, either on unauthorized trips to the city or from what he termed "regular sellers" who come from Manhattan through the park.
But not all crime results from contact with the outside—the wards and in the hallways and elevators of the hige complex makes it difficult to protect non-violent patients from violent ones.
Two special units for violent patients were disbanded last year, largely due to staff shortages. The patients were redistributed among the hospital's general population, which include many elderly people.

[Exhibit No. 21]

STATE OF NEW YORK
COMMISSION OF INVESTIGATION

LIFE AND DEATH
AT THE
BRONX PSYCHIATRIC CENTER

JUNE 9, 1977

270 BROADWAY
NEW YORK, N. Y. 10007

THE TEMPORARY COMMISSION OF INVESTIGATION
OF THE STATE OF NEW YORK

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LIFE AND DEATH AT THE BRONX PSYCHIATRIC CENTER

	Page
INTRODUCTION	1
PATIENT #1 -- JULY 14, 1975	6
PATIENT #2 -- SEPTEMBER 26, 1975	11
PATIENT #3 -- OCTOBER 13, 1975	20
PATIENT #4 -- OCTOBER 25, 1975	26
PATIENT #5 -- JUNE 24, 1976	33
PATIENT #6 -- JULY 14, 1976	43
PATIENT #7 -- MARCH 24, 1977	51
CONCLUSION	54
RECOMMENDATIONS	56
APPENDIX I	58
APPENDIX II	66

INTRODUCTION

In the Fall of 1976, the Commission received a letter from Ms. Blanche Sanchez, the Acting President of the Board of Visitors* of the Bronx Psychiatric Center ("BPC"), calling for an investigation of six specific incidents that had taken place at the institution between July 1975, and July 1976.** Five of the six incidents resulted in the death of patients and the sixth led to a patient's prolonged hospitalization after a severe beating.

Pursuant to an order obtained from Justice Abraham Gelinoff of the Supreme Court of the State of New York,

* §7.19 of the New York State Mental Hygiene Law [L. 1972 c. 251; amended L. 1975, c. 574, §1] mandates that each hospital and school run by the Department of Mental Hygiene shall have a seven member board of visitors appointed by the Governor with the advice and consent of the Senate. The board is to meet regularly, inspect the facility, consult, advise and work with the director and is given the power to "investigate all cases of alleged patient abuse or mistreatment ..."

** BPC is located in the northeast corner of the Bronx on 113 acres and is equipped to provide inpatient services to 600 patients. It has a full-time staff of 1300 administrators, treatment and auxiliary personnel. BPC is mandated by law for the "care and treatment of the mentally disabled and for the research and teaching in the science and skills required for the care and treatment of such mentally disabled." MHL §7.15 (a). Its annual budget is $19,599,000.

the patients' records* were received and examined and each entry made during the individuals's last hospitalization was read and analyzed by Commission staff. For several months, Commission attorneys and investigators conducted field interviews and took sworn and unsworn statements. Autopsy reports, police reports and the files of the Bronx County District Attorney were also reviewed and compared with BPC records.

In each of the cases scrutinized, the Commission found that little had been done to prevent the incident and that after the incident, BPC failed to respond adequately and to take essential corrective measures in accord with the dictates of the Mental Hygiene Law, the Policy and Procedure Manual of the Department of Mental Hygiene ("DMH"), and BPC's own manual and other internal directives. Reports filed by BPC with the Regional Office and the Board of Visitors were in many cases inaccurate. Signatures of administrators and other designated officials were placed on reports by others with their consent, but without their review.

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* Mental Hygiene Law §15.13(c) 1. states in pertinent part: "(c) Such information about patients reported to the department, including the identification of patients, and clinical records at department facilities shall not be a public record and shall not be released by the department or its facilities to any person or agency outside of the department except as follows: 1. pursuant to an order of a court of record ..."

In several of the cases studied, the Commission has found that the BPC's explanation of the cause of the patients' death or injury was inaccurate. In other cases the facts surrounding the death were inaccurately or inadequately reported. Often facts indicating staff failings were omitted.

Quality control of patient care in these cases was often lacking. In April 1977, Dr. Hugh F. Butts, Director of BPC,* was asked in general about the kind of treatment provided at BPC:

> "Q ...can you state whether or not the majority of patients at Bronx Psychiatric Center are receiving what you and the medical community in which you practice would define as appropriate and sufficient psychiatric treatment?
>
> A I'd say no, the majority of patients are not receiving what I would regard as appropriate psychiatric treatment because we are not Sheppard, not Pratt, or one of those highly touted institutions that can administer intensive psychotherapy to patients on a five times a week basis, if it is needed.
>
> We can barely administer appropriate milieu therapy to those patients that require it. We use

* Dr. Butts became Director of BPC on January 31, 1974. He left temporarily to serve as First Deputy Commissioner of DMH from January 1975 until March 1976 when he resumed his duties as Director.

medication rather extensively, but there again, I don't think we are using medications as appropriately as we might. I think in many instances we either over medicate or under medicate patients.

We have, and I'm absolutely embarrassed to say this, introduced the course in the doing of mental status examinations for psychiatrists so they can more appropriately evaluate patients.

I, in conducting rounds, emphasize the appropriateness of accurate diagnosis of patients. For instance, in that many patients are misdiagnosed, and as a result, not treated appropriately.

So, by and large, I would say that there are many gaps in the kind of treatment that we administer to patients, and there are many areas in which that can be improved.

I think it will be improved. I think that for a significant number of patients the treatment is appropriate, but I think that for a significant number it is not appropriate."

This report focuses upon the manner in which BPC responded to the needs of certain patients placed in its custody and care* and the manner in which the hospital

* The various categories of admissions are discussed in Article 31 of the New York State Mental Hygiene Law -- Any person over the age of eighteen may voluntarily apply for admission to a state mental hospital. If the person is under sixteen the application must be made by the parent, legal guardian, or next of kin (Mental Hygiene Law §31.13). There are also several categories of involuntary admission; such as upon the certification of two physicians (Mental Hygiene Law §31.27.) If the person is between sixteen and eighteen the director has the discretion to either admit the person as a voluntary patient or admit the person on the application of parent or guardian.

responded after their death or serious injury. In each of the six cases, the Commission compares the story of the patient's death or injury as it was presented by the hospital with the facts as they have been established through this Commission's investigation.

Although the BPC administration has at times asserted that the failures uncovered during this investigation were unique to the one year during which the incidents occurred, these claims are contradicted by the facts surrounding the death of a male patient on March 24, 1977.

This report also includes two appendices which discuss the inadequacies of BPC's "incident reports" (Appendix I); and its failure to recover $600,000 in 1976 due to faulty third party billing (Appendix II).

PATIENT #1* -- JULY 14, 1975

On July 14, 1975, a little less than two months after her admission to BPC on a two-physician certificate,** and while still a patient at the hospital, Patient #1 was so severely beaten that after being found in a hospital corridor early in the morning, she required emergency admission to Jacobi Hospital's Intensive Care Unit. Her condition was described in a contemporaneous memorandum to Dr. Emanuel Lifshutz, BPC's Medical Administrator:

> "Patient presently is at the emergency room of Jacobi Hospital, and is receiving treatment for: 4 fractures of the right arm; fractures of 6 to 8 right ribs, in addition to one dislocated right rib; 40% Pneumothorax on the right side; Pneumomediostinum and contusions of the face and body."

* The Commission finds it necessary to identify the patients only by number, and not by name, due to the examination and discussion of information obtained from the patients' records.

** Mental Hygiene Law §31.27 provides for the admission and retention as a patient of "any person alleged to be mentally ill and in need of involuntary care and treatment upon certificates of two examining physicians, accompanied by an application for the admission of such person ..." The application may be executed by certain specified individuals and in this case the patient's sister [MHL §31.27(b)2] applied for her admission. This legal status is often known as a "2 P.C." commitment.

A review of this patient's BPC charts, as well as the results of interviews conducted by Commission staff members, when compared to incident reports and court records, indicates a confusing pattern of accusations and inconsistencies. How such a severe beating could be administered with no member of the staff being aware of it remains unanswered.

Questioning of ward personnel by the Commission staff has established that the hospital's records of patient bed checks for the night and ward in question are inconsistent. Medical records document that the hospital was on prior notice of this patient's overwhelming desire to leave. Five days before the incident in question, the patient had left the hospital without consent but was returned later in the day by her family. The nursing notes on that day clearly state, "Escape precaution necessary."

Although the bed check record for the ward indicates that on July 14, 1975, a staff member observed the patient in her bed each hour from midnight until 6:00 a.m., a therapy aide who made the hourly check stated to Commission investigators that at 4:00 a.m. the patient's bed was empty. The ward staff made no attempt to find out

where the patient was. At 6:10 a.m., two BPC safety officers found the badly beaten patient wandering in a corridor near the hospital's ambulance entrance. In order for her to reach that location, it was necessary for her to pass through several doors, at least one of which should have been locked, and walk down several flights of stairs, or go by elevator.

One month after the incident, a special report was submitted to Dr. Butts, Dr. Lifshutz, and Egbert Wilson, Associate Director of BPC, by Ms. Messier, Director of Nursing, and Elizabeth McGahan, a registered nurse on the Lincoln Unit. This report notes the staff's observation that the patient was missing at 4:00 a.m., but makes no comment concerning the obvious failure to make any attempt at finding her. The writers of the report raised four points which they could not reconcile:

> "1. None of the other patients in the room except [name deleted] seemed to be awake during the night. There were no reports of noise or screams.
>
> 2. Somehow she had to get through the locked door by the elevator. She states a man let her out. No one on the ward reports hearing or seeing any such person.
>
> 3. If she was beaten on the ward she had to open 1 locked door, 2 closed heavy doors which normally opened by right hand (which was apparently broken).

4. It would seem that a person so beaten would normally have run either to staff people on Ward 5 or Ward 7 straight across the hallway or have made some kind of noise."

In the aftermath of the assault, another patient who shared the victim's room made a statement to senior hospital staff members indicating that several people might have been involved in the beating; possibly out-patients on the ward or even hospital employees. This statement which was tape recorded in August of 1975 raised serious questions about the behavior and supervision of night shift staff.

On August 25, 1975, Sherelle Matthews, Associate Personnel Administrator at BPC, listened to the tape recording and then sent a memorandum to Marie Haskins, Acting Deputy Director, in which she stated:

> "I feel that the accusations made by this patient must be thoroughly investigated as many issues remain unclear. I suggest the following:
>
> 1. The Lincoln Unit under the direction of the Chief of Service conduct a complete investigation of the incidents reported by this patient.
>
>   a) Each employee be informed of accusations made by patient and directed by Chief of Service to submit statements of his or her knowledge of incidents.
>
>   b) Patients who were residing on unit during periods cited in statement be interviewed and questioned regarding their knowledge of reported incidents.

2. Patient be interviewed regarding her accusation of person who was responsible for her injuries.

3. Incidents regarding 'questionable night unit activities' be thoroughly investigated by unit administration.

   a) Are unassigned persons seen on unit, if so by whom, -- statements received.

   b) Question other patients regarding their knowledge of reported incidents. Witnesses should be present ..."

Ms. Matthews also stressed the importance of independent corroboration of any statements which might be used in future employee discipline proceedings. Copies of her memo went to Dr. Butts and Mr. Wilson.

On the following day, a memo from Dr. Butts to the Unit Chief, Dr. Conrad Mehler, directed that an immediate investigation be undertaken. "Findings" were to be reported to Mr. Wilson in a matter of days.

The investigation was never completed nor did Dr. Butts, Mr. Wilson, or Dr. Lifshutz follow up on it. Dr. Mehler submitted a brief memorandum of his interview with the two therapy aides on duty the night of the beating. The broader questions raised in Ms. Matthews' memorandum of August 25, 1975 remain unanswered.

PATIENT #2 -- SEPTEMBER 26, 1975

On September 26, 1975, shortly after breakfast at BPC, a fight over a record player ended in the death of one patient. According to the assailant who was also a patient at BPC,* Patient #2 entered his room and began to "touch" the record player. Patient #2's response to being asked to leave was to punch the patient in the face. The patient left the room, went to a nearby broom closet which should have been locked, and with the broomstick which he brought back hit Patient #2 over the head. Patient #2 fell to the floor, again striking his head. He was pronounced dead on arrival at Jacobi Hospital. The cause of death was found to be:

"Fractured Skull
Epidural Hematoma
Compression of Brain
Struck by Broom Handle
Homicidal"

The Victim's Two Days at BPC

The story of how a confused and disoriented patient became involved in an altercation leading to his death has been pieced together from an examination of hospital records, incident reports, Special Review

* The assailant pleaded guilty to criminally negligent homicide and was sentenced to five years probation.

94-420 O - 77 - 32

Committee reports and interviews with staff members and former patients.

During the evening of September 23, 1975, this individual was brought to the Emergency Room of Fordham Hospital. In the preceding two weeks, his behavior had been "progressively deteriorating." He had been, "breaking windows, threatening to jump from windows, verbally abusive, [and] threatening physical abuse." At the Fordham Hospital Emergency Room he was certified as in need of psychiatric treatment and immediate hospitalization and was transported by ambulance to BPC, arriving at 4:00 a.m. on September 24, 1975.

After arriving at BPC, the patient was examined by the resident on duty who wrote an admission note for the patient's record. The admission note is the professional staff's first evaluation of the patient's symptoms and is often used by the treating staff in determining what further treatment should be administered.

In this case, the admission note states:

> "31 year old ... male with a history of recent progressively deteriorating behavior over the past few weeks culminating in a fight yesterday which induced the police to bring him to the hospital for evaluation."

The admission note goes on to state:

> "There is a history of breaking windows, threatening to jump from a window and threatening behavior. There is a

> history of drug abuse, including heroin, pills, cocaine, marijuana, but he does not have a habit currently."

After two sentences of family history, the note continues:

> "There is a history of the patient talking to his radio and the radio talking back to him, as well as the patient believing that his radio is bugged by the police. He has not worked for the past five days because he has been drinking."

This narrative is followed by several one word observations evaluating the patient's speech, affect, intellect, judgment, hallucinations, etc. It is followed by a diagnosis which states "Probable Acute Schizophrenic Episode."

A comparison of the text of the admission note with the texts of the certifcations done at Fordham Hospital reveals that it is drawn from Fordham documents almost entirely.

Dr. Butts reviewed and discussed the admission note with Commission staff. Dr. Butts pointed out that although hallucinations were mentioned, there was no indication of what they included other than the talking radio. Dr. Butts continued:

> "I make the same critique in terms of delusions. It says present but does not define the delusions, does not define how long they had been present or the intensity of these delusions."

He also pointed out that the discussion or evaluation of the patient's intellect was grossly inadequate:

> "Intellect O.K. Sounds like the funny papers.
>
> ... it should state specifically the person has average intellect, above-average, minimally brain damage ..."

As to whether this patient was properly assigned to the ward, Dr. Butts stated:

> "... I do hesitate because I see evidence in the second paragraph of threatening to jump from a window .... I would have to have more information in order to make an assessment as to whether this patient didn't require care on the Intensive Care Unit."

Dr. Butts concluded that the admission note as drafted --

> "... would affect the nature of the program or the plan of treatment that was formulated for him.
>
> By not going into more details about the malignancy of his symptoms and the nature of hallucinations, it would leave the treating staff at a loss, just based on this precluding whatever further work they may have done, leave them at a loss as to how to deal with a patient for whom this evaluation was set forth."

Testimony of Dr. Phillip Shapiro, the physician executing the admission note, was taken by the Commission's legal staff. He informed the Commission that at the time he executed the note, he had been a resident in psychiatry

at BPC for one year, and that while a resident in psychiatry he had not received:

> "... any formal training on an admission note because that was done during an orientation the first week of July that I missed."

Investigation by the Commission found that this patient was seen briefly by the Ward Psychiatrist, Dr. Rudolph Procario, during the morning of September 24, 1975. At that time, medication and seclusion orders were written. Dr. Procario prescribed an anti-psychotic medication and ordered other tranquilizers and seclusion of the patient "as needed." He told the Commission staff that his actions were based on the contents of the admission note previously discussed and his assumption that any patient who had been admitted to the hospital was a danger to himself or others. Thus the inadequate admission note was the basis for a medical order which ultimately placed the discretion as to whether or not to medicate or seclude the patient in the hands of the nursing staff, most of whom were not even registered nurses.

Dr. Procario's seclusion order failed to comply with the Department's requirement that such an order set forth the reason for its use.*

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* The investigation also indicates that the information needed to provide the basis for the medical judgment that seclusion was appropriate was neither solicited by nor available to Dr. Procario.

On September 24th, the patient's first day at BPC, he was placed in seclusion from 1:00 p.m. until 6:00 p.m. BPC records indicate that this was done by the nursing staff based on the previously written "as needed" order.

The Ward Social Worker prepared a treatment plan and interviewed the patient's sister. The treatment plan, according to the Social Worker, was extremely brief and "not too good." Nursing staff notes and seclusion records indicate that the patient was at times drowsy and at other times agitated and "very confused." All other write-ups such as the psychological history were completed after the patient's death.

All incidents resulting in the death of a patient must be reported on a standard incident report form provided by the Department. Part 3 of the form in use in 1975 was to be completed by the Special Review Committee in their evaluation of the incident. In this case, the Special Review Committee report prepared following the death of Patient #2 summarizes the patient's psychiatric history and describes what happened from the time he was found with a large swelling on his head until his death.

The report fails to mention any of the facts surrounding the incident that might have allowed an evaluation of the institution's ability to provide proper custodial care. No examination or evaluation was

made as to how a violent incident occurred on the ward between two patients who were known to have had histories indicative of a propensity for violent episodes.

The report makes no mention of where ward staff members were at the time of the assault or of what their various responsibilities were. The Commission's investigation did not uncover any evidence that any of the staff were aware of Patient #2's whereabouts between the time he finished breakfast (before 7:00 a.m.) and the time he was found in the female dormitory (at approximately 8:25 a.m.), shortly after being assaulted. The report of the Special Review Committee is silent as to how a patient with known violent tendencies had access to a broom handle. Had the Special Review Committee made this inquiry, it would have learned, as this Commission learned when it asked the assailant, how he got the broom handle: he took it from the hospital's broom closet, which he knew was supposed to be locked.

Perhaps the most serious omission in BPC's evaluation of the incident was its failure to examine the reasons why the ambulance had to wait at least 15 minutes for necessary paper work to be completed before the already unconscious patient could be transferred to Jacobi Hospital. Thus, the Special Review Committee's report stated:

> "Immediate transfer to Jacobi Hospital was ordered and the patient was transferred by our ambulance."

By contrast, the patient's record contains an interview with the Therapy Aide who took Patient #2 to Jacobi:

> "He was very pale, and his eyes were rolled back. There was no movement. Mr. Guzman had to wait for the transfer papers to come from Clinic B and for Dr. Procario to fill them out. Dr. Jacobson was called. He went [Mr. Guzman] into the Nurse's Station to prepare for the trip to Jacobi. A lady called from downstairs to say the ambulance was there for 15 minutes. But he could not take the patient without the papers."

Far from pointing up possible staff or institutional failings, such a "review" of the incident in fact served to conceal such failings.

Commission investigators eventually discovered a report in BPC files which mentioned that a Dr. Jacobson from Jacobi Hospital had called BPC after this patient's death and wanted to "speak to someone medical." The memo makes no mention of any follow up. Dr. Sheldon Jacobson, Director of Emergency Services at Jacobi Hospital, was the physician mentioned in the memo. When he was interviewed by Commission staff members, he stated that if the ambulance had not been delayed, there was a possibility that the patient could have been saved. Dr. Jacobson also remembered being surprised that none of the staff from BPC who brought the patient to Jacobi attempted to resuscitate him.

Neither the Ward Psychiatrist who was on duty at the time of the patient's death, nor the Ward Social Worker were ever interviewed by the BPC administration. Indeed, when Dr. Procario was interviewed by the Commission and asked if he made any attempt to determine whether or not the incident in some way might have been caused by an omission in psychiatric care, he remarked that once a patient was dead, the responsibility for looking into the cause belonged to BPC administrators.

The Special Review Committee's report was submitted to the Director on September 29, 1975. It had the effect of deterring any further inquiry by presenting the incident as an isolated accident leading to a death for which the hospital bore no apparent responsibility and from which the hospital staff had nothing to learn.

PATIENT #3 -- OCTOBER 13, 1975

At approximately 11:45 a.m. on October 13, 1975, Patient #3:

> "Was found hanging in male bathroom 4/198 tied with his P.J. shirt -- a noose was made, patient was cut down, artifical respiration done -- Dr. on Call notified -- also Dr. Glickman, Administrator on Call. Patient was sent to Jacobi Hospital ER -- pronounced dead."*

For almost one month prior to the day of his death, Patient #3 had been exhibiting signs of agitation, destructiveness, depression and bizarre behavior. Several staff members recalled that this patient's condition required a "suicide alert" on the day of his death.**

According to the "Readmission Discussion," dated September 26, 1975, ten days after his transfer from Mid-Hudson Psychiatric Center, the patient was initially confined to the Intensive Care Unit ("ICU")*** but later transferred to a regular geographic ward. After briefly discussing the patient's prior history, the Readmission

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* Incident Report dated October 13, 1975, §1, Part 12.

** The BPC Policy Manual lists three levels of care for a suicidal patient and prescribes specific precautions to be taken by the nursing staff at each level.

*** All patients at BPC are assigned to the various wards based upon the particular "catchment" area in which they live. The ICU is reserved for the most assaultive or suicidal patients, and only for a limited stay until extreme behavior is under control.

Discussion states, "Nonetheless, in view of his history, it is necessary for him to be observed, both for assaultiveness and possible development of 'suicidal tendencies.'"

The Treatment Plan prepared by the receiving ward at the conclusion of the patient's confinement in the Intensive Care Unit also indicates a need to restrict the patient to the ward, to reinstate seclusion orders as a precaution in case of suicidal or assaultive behavior and to review medication.

On October 9, 1975, the patient was placed in seclusion because of violent behavior. On that date, suicide precautions were instituted; the patient was restricted to the ward in pajamas, and additional medication was administered. The geographic ward referred the patient back to the Intensive Care Unit for evaluation but he was returned to the geographic ward after consultation with ICU staff.

Apparently, for the next few days the patient alternated between levels of agitation, anxiety and stupor. Notations made on October 10, 1975, indicate that the patient was to remain restricted to the ward since there had not been sufficient improvement to allow ground privileges. On the day of his suicide, it is noted that he appeared depressed and withdrawn, was seen pacing the corridor, and finally at 11:45 a.m. was found hanging.

Suicide Precautions

The Procedure Manual prepared by BPC outlines steps to be taken in the care of suicidal patients. Suicide Alert Stage 1 -- the least intensive level of precaution -- calls for the following actions by the nursing staff:

1. The assignment of a staff member to spend time with the patient on a regular basis.

2. Helping the patient engage in activities that could increase his sense of self-esteem.

3. Being alert and responsive to the patient at points of increased stress.

4. Fostering attempts by the patient to strengthen ties to his support system, both in as well as outside the hospital.

5. The night shift should be alert to changes in his sleeping pattern and report them appropriately.

Neither the Commission's investigation nor the patient's clinical records indicates any of these precautions were taken. Those records reflecting staff observations and interactions with the patient indicate only that he continued to appear depressed and withdrawn while pacing the ward corridor. There is no indication either in the record, or from interviews, of any affirmative attempt to assist the patient through this period of agitation.

Although the day of the patient's suicide was a Monday, the hospital's on-call schedule for first year residents was in effect. On this holiday weekend, primary coverage for the entire hospital, both medical and psychiatric, was the responsibility of a young physician some five months out of medical school named Dr. Marjorie Smith.

While Dr. Smith was at lunch, she was paged and told of the hanging. The ward nurse informed her that she thought the patient was dead but that he had been cut down and mouth-to-mouth resuscitation had been begun.

The Physician arrived at the ward and found the patient unconscious.

> "At that point I didn't observe any pulse or respiration. However, the nurse was already there giving mouth-to-mouth resuscitation. I began to give external cardiac message and I guess at some point I asked for an Ambubag."*

* * *

> "... it was very quickly after I got up there that the security came up there and they had the oxygen and I had a stretcher.
>
> We took the patient out to Jacobi."

At Jacobi Hospital he was pronounced dead.

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* A portable resuscitation device.

When Dr. Smith returned from Jacobi, she found several high ranking members of the hospital administration on the ward. Statements were being taken from various staff members by Dr. Emanuel Lifshutz, Medical Administrator of BPC. At that time, Dr. Smith prepared the only statement she would be asked for concerning the death of this patient. Included in her handwritten statement was the following phrase:

> "I asked for an Ambubag which wasn't immediately available to us."

When Dr. Lifshutz saw this statement, he asked Dr. Smith to take the phrase out since one of the therapy aides said that he had brought the Ambubag. Dr. Smith persisted in her statement that the Ambubag was not made available to her.

The official Incident Report filed by BPC was examined by the Commission and the portion of the report entitled "Physician's Findings and Treatment Ordered" was shown to Dr. Smith. She stated that she had never seen BPC's version which omits the portion of Dr. Smith's handwritten notes that mention that she was not supplied an Ambubag. Her name was typed in on the line calling for a signature.

The common thread running through the Incident

Report, and Special Review Committee report,* as well as an undated Discharge Summary, is an absence of any serious analysis of the reasons for the patient's suicide, or examination of why, although suicide precautions had been initiated four days before his death, he succeeded in killing himself in the midst of daytime operations.

Interviews of staff members responsible for this patient indicate that no attempt was made, following his suicide, to analyze or identify any of the reasons for the suicide and thereby correct any inadequacies within the unit.

* As stated on the face of the printed form provided for Special Review Committee reports, the report should "include findings, autopsy review, recommendations, corrective action taken ..." None of this information is even mentioned in the report.

PATIENT #4 -- OCTOBER 25, 1975

Patient #4 was described as nicely dressed and well-groomed when she was found hanging by the neck from a small wall fan in a utility room on October 25, 1975. No one on the BPC staff ever saw her hanging. Two patients claim they untied the noose before anyone else arrived. Comments throughout her records indicate she was a highly improbable suicide candidate. The medical examiner says, from his perspective, it is a "very, very unclassical" case of suicide.

The Special Review Committee summarizing her prior records on the Incident Report, described her as:

> "an aggressive type person with no indication of hospital suicidal ideation or of severe depression while in the hospital. Staff reported she was manipulative and seductive and related well with staff and other patients. She was not withdrawn and was verbal about her needs."

In another report, generated by another committee, the patient's psychiatric history was again reviewed.* It too concludes:

> "There was no behavioral indication during this admission that the patient contemplated suicide. Despite multiple interactional

* A "Post-Mortem Study of Previous and Current Bronx Psychiatric Center Relevant Hospitalization Information."

> efforts with this patient and the establishment of strong, positive rapport, no communication on any level revealed suicidal ideation."

Although the official cause of death was deemed to be suicide by hanging, the New York City Deputy Chief Medical Examiner, Dr. Yong-Myun Rho, who conducted the post-mortem examination, described his findings as unusual in the case of suicide.*

His findings were considered so unusual that the very features that characterized the clinical picture in the case of Patient #4 were some of those he used in teaching medical students to recognize manual strangulations.**

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* He explained that BPC's description of the circumstances of death, and the repeated assurances of the police that there was "nothing suspicious" left him no other alternative.

** He indicated the horizontal markings found on the neck, often seen in cases of homicide, instead of the V-shaped lines, more typical of hanging. The fractured tongue (hyoid) bone which he found is "often caused by localized pressure like squeezing by the hand or squeezing by the ligature but not by mere suspension of the body."

Noting the presence of many fine hemorrhages on the whites and conjunctivae of the eyes, he stated: "When the constrictor is slow, it tends to occur, more [hemorrhages] to occur ... hanging is an acute [constriction], a fast one."

Although there were no open wounds or apparent sources of flowing blood on her own body, dried blood was found under her fingernails as well as on the surface of the body. Despite the possibility of blood from a possible assailant, no notation was made whether any foreign skin tissue was present in that blood and no tests were performed to detect its presence. Finally, Dr. Rho listed as a "very important point" the absence of hemorrhages (Tardieu spots) in the legs which are "very unusual to not see in the case of suspension from a height."

94-420 O - 77 - 33

The Incident Report indicates that Patient #4 was seen smoking a cigarette in the Day Room at 2:30 p.m. Several accounts confirm that time, as well as that she appeared in normal spirits and was nicely dressed. At 2:40 p.m., according to the Incident Report, a female patient approached Therapy Aide Ann Fouchee at the Nurse's Station and told her that a patient was trying to kill herself. The aide's later recollection though was that a male patient came to her saying he had just discovered Patient #4 hanging in the utility room. Ms. Fouchee's portion of the Report states that when she arrived there, she saw the patient on the floor, apparently not breathing, and that she immediately informed her supervisor who alerted the physician on call.

The male patient who allegedly found her described how he had walked into the darkened utility room, turned on the light, and had seen the hanging body of Patient #4. According to him, he went for help from the staff but was unable to find anyone. When he found another patient, the two of them returned to the utility room and took down Patient #4.

Dr. Thomas Sacken, the "on-call" physician, arrived in the utility room at 2:45 p.m. He described the prone body of Patient #4 as blueish, cool to the touch, without vital signs and with fixed dilated pupils. This clinical

picture, he said, led him to believe that the patient had been dead more than the five minutes claimed by the ward staff.

Dr. Sacken asked for an Ambubag, as had the physician who attended to Patient #3, but no one could find one.

The Special Review Committee merely noted on the Incident Report the locations of all the staff on the ward and summarized the statements of a few witnesses. It also made perfunctory mention of the patient's five prior admissions to BPC and cited the hospital records indicating behavioral traits which were atypical of suicides. Dr. Sacken, the examining physician at the time of death, was never questioned by the Special Review Committee.

The Incident Report, approved by Egbert Wilson, then Acting Director, obscures, rather than enhances the possibilities of further probing. In discussing these issues with Dr. Butts, the Commission asked:

> "Q Based upon the Incident Report and the report of the Review Committee contained therein, do you feel that that report in and of itself is sufficient as a summation of the incident which led to this patient's death?
>
> A No, I don't."

Dr. Butts admitted that the Report provides no constructive evaluation of either the quality of care given to Patient #4 or of the functioning of the staff or BPC administration involved in the incident.

The quality of other records of Patient #4 were examined with Dr. Butts and evoked similar disparagement. Her records, dating from 1972, contained four separate diagnoses reflecting a lack of attention on the part of the Unit Chief. Dr. Butts said that the file, taken as a whole, showed --

> "a paucity of information here, which raises a question as to how much was really known about her that could be used in a constructive way toward helping her."

In the attempt to find out what, if anything, actually had been done to help her, Dr. Butts was asked to inspect her treatment plan. Dr. Butts was unequivocal: "It's grossly inadequate."

With all of the clinical records at hand, he was asked what kind of treatment had actually been offered to Patient #4. And he answered:

> "I don't know ... I can't even infer from the progress notes that she was really receiving psychotherapy because these notes don't indicate what the nature of that therapy was and what went on in that therapy; they are kind of reports on how the patient is at a particular point in time."

In the attempt to establish how much was missing from the viewpoint of some acceptable standard, Dr. Butts was asked:

> "Q What should those notes indicate?
>
> A If she were involved in psychotherapy the note should state, today I sat down with patient [name deleted] and we discussed her feelings about her mother, and she talked about -- and get into the warfs and woofs of what the patient related, what the therapist stated, what kinds of insights, if any, the patient developed, and how she responded to the interaction between the two of them.
>
> Q Should that be part of the record?
>
> A If she was involved in psychotherapy, yes.
>
> Q Should she have been involved in psychotherapy?
>
> A I believe so.
>
> Q Does anyone state in that record that she was in any way involved in any kind of treatment directed towards her eventual release from the hospital and return to society?
>
> A (Perusing document) The only statement that comes anywhere near approximating that is the goal, long term goal stated of 'explore disposition alternatives whatever that means."

In view of Dr. Butts' own visible skepticism, the question was posed:

> "Q [D]o you believe that the Bronx Psychiatric Center offered her appropriate treatment?

A ... I don't see evidence from the record that she received treatment that I regard as appropriate."

From the staff which maintained poor medical records to the Unit Chiefs who failed to review them; from the therapists formulating treatment plans to the Acting Director responsible for implementation of treatment; everyone functioned in a most careless and indifferent manner. And no one was called to task, nor any inquiry or peer review initiated.

PATIENT # 5 -- JUNE 24, 1976

When he was 5 1/2 years old, this patient was committed to Willowbrook State School by Court Order. When he was four years of age, he was known to be suffering from seizure disorders, and during his childhood was subject to Grand Mal type seizures. During his last hospitalization at BPC, and for some time prior to that, he was given to seizures of a sort that some staff members felt were just an attention-getting device.

His last bout with his seizures began at about 2:30 p.m. on June 24, 1976. He was twenty-five years old. At about 6:15 p.m. on that date, Gloria Johnson, the nurse on duty, escorted his mother to his room for a visit and found him on the floor, apparently unconscious. He was pronounced dead about twenty minutes later. Eights months later the New York City Medical Examiner determined that his death was due to "Acute Haloperidol poisoning while being treated at Bronx State Hospital for seizure disorder with mental retardation, circumstances undertermined."

The autopsy results were initially inconclusive. It took several months for the various chemical and microscopic tests to be completed and more time for further inquiry to be made by the Medical Examiner's Office and this Commission.

On April 21, 1977, Dr. Michael M. Baden, Deputy Chief Medical Examiner of New York City, testified:

> "Upon reviewing the hospital records I was able to arrive at a conclusion that prior to death the decedent had received an unauthorized administration of Haloperidol, there not being any record in the chart, in the hospital chart, that Haloperidol was in any way prescribed for the decedent."

Dr. Baden was also able to corroborate this through a discussion with the treating physician:

> "Dr. Speken on February 18th did assure me by telephone conversation that [name deleted] had never been authorized to receive Haloperidol.
>
> Q Was that at least in the month or two months before the death that you are talking about?
>
> A Well, my impression from Dr. Speken is that he had never been prescribed Haloperidol. But particularly, the few months prior to death that Dr. Speken had immediate, full and complete knowledge of the medications."

Asked whether Haloperidol substances were contraindicated in cases of seizure, Dr. Baden answered:

> "It's my impression that it has to be given with great caution to people with seizure conditions because of the possibility that it makes persons with a history of seizure disorders more vulnerable to having seizures precipitated by the use of the drug."

He was questioned further about the causal relationship between the unauthorized administration of the drug and the patient's death at 6:15 p.m. following a seizure which began at about 2:30 p.m.

> "Q ... if some time between 2:30 p.m., when he entered into this seizure state and approximately 6:15 p.m., when he died, he was given a 100 miligram dose of Haloperidol without a physician's authorization, could that indeed have led to a more severe seizure state?
>
> A Yes.
>
> Q And could the increased severity of that seizure state have led to his death?
>
> A Yes."

Dr. Baden explained the final death certificate issued in February 1977, more fully when he said:

> "I think the interpretation of that would be that the unauthorized administration of Haloperidol contributed to the death of [name deleted], together with the seizure that the patient did have."

Baden concluded his explanation by saying:

> "... but for the administration of the Haloperidol [name deleted] would not have died when he did."*

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* Records of the Office of the Chief Medical Examiner, City of New York, indicated that on July 21, 1976, at 10:30 a.m., the patient's mother telephoned the Medical Examiner and alerted them to the possibility of the presence of unauthorized Haloperidol in her son's system. This was almost one month before the completion of the toxicology studies which identified the presence of Haloperidol.

Patient #5 had talked to his mother several times on the day of his death, starting with two calls in the morning. He was anxious because he was being taken for an outside consultation about the seizures. This consultation with a noted neurologist came about because BPC physician, Dr. Ralph Speken, had looked at the old electroencephalogram results and found:

> "[D]efinite temporal lobe disorganization consistent with seizure disorder ... Seems that this finding should have been followed up long ago."

This diagnosis was confirmed by a new EEG and Doctor Speken concluded:

> "EEG report back showing marked paroxysmal disorder. Apparently this was known since 1-75 according to the report. This represents negligent handling of the case in that he should have been sent for seizure control much before now. [quoting a June 10, 1976, entry on patient's chart]."

The specialist with whom Dr. Speken consulted recommended adding a new drug, Tegritol, to the Phenobarbital and Dilantin that Patient #5 was already receiving and asked to see him again in two weeks.

The patient called his mother again, at 1 o'clock, when he got back to the hospital, to tell her he was going to get a new pill. He called a fourth time at about 1:15 p.m. to say he had just received new medication. He spoke to his mother for the last time about one half hour later. Shortly thereafter, while in the Drop In Clinic, the seizures commenced that ended four hours later in his death.

According to entries in the hospital chart, the patient was brought back to BPC at about 1:00 p.m. Dr. Speken brought a bottle of the new medication from the Hospital pharmacy up to the ward and instructed a therapy aide to administer 100 mg. of Tegritol to the patient. According to the nursing notes, this was done. When questioned under oath by the Commission, concerning her entries in the chart, this employee invoked her privilege against self-incrimination.

When the seizure began, two attendants were sent from his ward with a wheelchair to bring him back. By 3 o'clock the patient had been given a 10 mg. intra-muscular injection of valium by a nurse in accordance with a doctor's existing "as needed" medication order for use in case of seizures.

According to Jacklyn Jackson, the nurse on the 8:00 a.m.-4:00 p.m. shift, she called a doctor before giving the valium injection, and either Dr. De Bell, a Ward Psychiatrist, or Dr. Speken responded and saw the patient. Neither doctor agrees with this statement, and the chart gives no indication that a physician attended the patient, although Nurse Jackson is sure that the doctor who was there made a chart entry. Although the chart does not show the presence of any doctor that afternoon, it does show that one hour after the valium injection at 4:00 p.m. he was still "not responding" to the valium.

In the hours following the 3:00 p.m. valium injection, four staff members claim to have regularly looked in on him. His condition was reported to the new shift that took over at 4:00 p.m.

One therapy aide says he found the patient on the floor of his room, blue and sweating, incoherent and biting a rag at about 4:30 p.m. A second therapy aide who helped the first lift the patient into bed, remembers him on the floor, but able to talk and without distress. The first aide says he reported the patient's condition to the charge nurse, but she denies receiving such a report and the records do not reflect it.

Gloria Johnson, the charge nurse on duty from 4:00 p.m.-12 midnight, says she looked in on the patient every 15 minutes or so between 4:00 p.m. and 5:50 p.m., once with Nurse Jackson from the earlier shift, and later with a therapy aide. She says she gave him juice, but no medication, that he talked with her, apparently recovered from the seizure, and that his vital signs were stable at 5:50 p.m. The records, however, say "4:00 p.m. not responding to medication" and nothing is seen in the records to indicate a later change.

At 6:15 p.m., his mother rang the bell to the ward and was admitted by Nurse Johnson. Together they walked down the hall to the patient's room. When they got there,

the patient was lying unconscious on the floor next to the bed. The mother stood at the door while Ms. Johnson ran to try to revive him. She shouted for help, and while she attempted mouth-to-mouth resuscitation, an aide performed external cardiac massage. Various doctors arrived but all efforts were ineffective. At 6:30 p.m. on June 24, 1976, he was pronounced dead. His body was sent for autopsy to the City Medical Examiner's Office.

Initially, the BPC medical staff believed that he had died from the unremitting seizure activity. Some thought of a possible idiosyncratic reaction to Tegritol, the new drug. There was a rumor that without prescription or authorization, this patient had been given Haloperidol.

The staff on the 8:00 a.m. to 4:00 p.m. shift denied administering any unauthorized medication. The 100 mg. of Tegritol had apparently been given at about 1:00 p.m., and once the seizure had begun, Nurse Jackson had administered 10 mg. of valium. All were adamant that no other drugs had been given, at least during that shift. One person reputedly claimed, but later denied the statement, that someone on the 4:00 p.m.-midnight shift had given the patient another medication. It was never substantiated. Nurse Gloria Johnson said the patient had received nothing but the juice she had given him

herself.

Despite the sudden and unexplained manner in which this patient died, BPC medical, psychiatric and administrative staff took little notice of his death. None of the then existing mechanisms for administrative or peer review of such an incident were properly executed. The professional staff wrote an Incident Report that the BPC Director himself later described as "inexcusable." The Report contains errors, omissions and irrelevant discussion. Nowhere does it mention the Tegritol given the patient for the first time that day. And it does not mention any attempt to summon a physician during the throes of the three and one-half hour seizure. It even incorrectly names as one of the attending physicians a doctor who was on vacation at the time. Inadequacies of the emergency kit and a delay in getting an intracardial needle are ignored altogether. The Special Review Committee section of the Report provides almost a full sheet of patient history followed by only nine lines at the end about the circumstances surrounding his death.

From the registered nurse to the attending physician to the so-called Special Review Committee* to the

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* What later emerged was that what was billed as a "committee" was the work of one physician, Dr. Gutierrez, who had "discussed" the case with Dr. Speken, the unit chief at the time, but not with any of the physicians present at the time of death, nor anyone else responsible for the patient's case and treatment.

Director and the Department's Regional and Central Offices, no one checked the accuracy of the Incident Report, questioned its omissions, or uttered a single objection. When asked why he gave approval to the obviously inadequate Incident Report, Director Butts stated: "I was remiss in the performance of my duty."

Dr. Baden, the Deputy Chief Medical Examiner, informed the Commission that all hospitals referring cases to the office of the New York City Medical Examiner --

> "must forward to us a clinical information on a form provided to the hospital by our office, which is the report to the Medical Examiner of the medical and circumstantial conditions surrounding the death of somebody who dies in a medical institution.
>
> * * *
>
> But, this ... report made out June 24, 1976 was ... made out in a very inadequate manner, being only a two line description, 'Patient found unconscious. No pulse, no blood pressure. Cyanotic. In shock at 6:15 p.m., on June 24, 1976.'
>
> This didn't provide us with any degree of necessary information that we needed to interpret the autopsy findings and because of that we required the entire medical records to be able to evaluate our findings in light of the treatment afforded to the patient at the time he died."*

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* In the seven months since the death, the Medical Examiner had not obtained the hospital medical records necessary to interpret the autopsy findings. In fact, he was frank to admit that without the review of the hospital records obtained by the Commission, a full year might have elapsed before he had an opportunity to see them.

Despite the disclosure to Dr. Butts of the Haloperidol poisoning, as well as to numerous BPC physicians and administrators, there has been no in-house investigation of where or how a patient in a seizure could have been administered a large dose of a drug which was known, even by many therapy aides, to be dangerous to seizure patients.

PATIENT #6 -- JULY 14, 1976

> "At 12 p.m., 14 July 1976, the following staff were on duty: Robert Ort, M.D., Agnes Carvalho, R.N., Loretta Chestring, T.A., Rose Durham, T.A., Mary Lewis, T.A., Miguel Rodriquez, ATA, Oliver Roane, Ward Aide, Vivian Rivera, Secretary. Shortly thereafter, patient was noted to be missing by Mr. Rodriguez, Ms. Carvalho and Ms. Durham. A search of the ward was immediately made with the exception of 4 regularly locked rooms which have not been accessible to patients. Rm. 5-215 was one of these 4 rooms. The Safety Office, the B.P.C. Telephone Switchboard Operator, and the 43rd Pct. were notified. Dr. Ort was not notified at this time but a continuous search and alert was maintained on the Ward and hospital grounds. At 12:30 p.m. all of the above noted personnel were on duty, in addition to the following 2 people: Rosa Cruz, T.A. and Gilbert Nelson, O.T. Aide. At 2:50 p.m., Miguel Rodriguez entered Rm. 5-215 and found patient hanging by the neck by a white cloth from a ceiling mounted microphone." (Excerpt from Part One of Incident Report dated July 14, 1976.)

The patient whose suicide is memorialized in the segment of the quoted Incident Report was only sixteen years old. The room in which he hung himself should have been locked; the search initiated three hours before his death was obviously incomplete.

The patient had been transferred to Ward 16 on June 28, but from that day until the time of his death, on July 14, 1976, his care had been minimal. He was not assigned to a physician until four days after his transfer. There are only four entries on the nursing notes between the day

94-420 O - 77 - 34

of his transfer and the day of his death. His prior stay on the Intensive Care Unit was marked by severe depression, discussion of suicidal thoughts, a leaving without consent and a homosexual relationship with a hospital employee. His legal status within the hospital had become totally confused, and although mandated to remain by an order of the Family Court, he had been told by hospital staff that his status was voluntary.

In discussing this patient's treatment while at BPC Dr. Butts said:

> "[he] was ... assigned to Dr. Astrigrieta, his primary therapist [on Ward 16], but no case plan was developed.
>
> In addition, no nursing care plan was developed, nor were nurses' notes written on twelve of the sixteen days he was on the ward ..."

Under further questioning, Dr. Butts acknowledged that the patient in question did not receive care which met the minimum standards of the medical community. He attributed this in part to the fact that the patient was so severely disturbed, though in other discussions, Dr. Butts pointed out to Commission staff that as a rule state mental hospitals are called on to treat the most acutely disturbed patients.

On September 22, 1975, while in a public park, he killed another youth by stabbing him repeatedly while attempting to steal his bicycle. After various court

proceedings, Judge Nanette Dembitz signed an order pursuant to Section 760 of the Family Court Act, committing this youngster to the Division For Youth for transfer to the custody of the Commissioner of Mental Hygiene.*

When the boy's records arrived at the DMH statistics unit in Albany after his admission to BPC on March 1, 1977, a data processing clerk informed his superiors that the computers were not programmed to accept information other than what the boxes on the admissions form provided. The handwritten notation referring to a §760 Family Court Act admission was thus ignored and the clerk was instructed to have the patient's records coded on an existing category of admission. As a result, the BPC Admissions Office accepted Albany's erroneous coding and offered the patient a voluntary

* F.C.A. Section 760 in pertinent part states: "Upon an adjudication of juvenile delinquency under this article, if the court also finds at a dispositional hearing pursuant to section 745 that the juvenile has a mental illness, as defined in section 1.05 of the mental hygiene law, which is likely to result in serious harm to himself or others, the court may issue an order placing or committing such juvenile with the division for youth. Any such order shall direct the temporary transfer for admission of the respondent to the custody of the commissioner of mental hygiene who shall arrange the admission of the respondent to the appropriate facility of the department of mental hygiene ..."

admission even though as a minor this was legally insupportable.

From early March until June 28, 1976, the boy was confined on the Intensive Care Unit ("ICU") at BPC. One document received from BPC describes his condition during his initial stay on ICU:

> "On March 1, 1976, [the patient] was admitted to Ward Eight and after a history was obtained, a diagnosis of Schizophrenia Paranoid was made. [He] reported severe headaches, frequently accompanied by auditory hallucinations, fire-setting, genital exposure, previous attempts to hang self and verbal and physical assaultive behavior. The patient insisted that medication be prescribed to control his voices. Serentil 50 mgs tid was prescribed."*

Throughout his stay on the ICU there are intermittent entries in the case record indicating that the patient was depressed, assaultive and continuing to hear voices.

During this time, he was sent for a number of transition visits to the geographic ward to which he would eventually be transferred. The purpose of such

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* Excerpted from a report of a clinical pathological conference on this patient conducted on July 20, 1976.

visits is to acquaint the patient with that ward and its staff and to allow the staff on the geographic ward to establish a therapeutic relationship with the patient prior to his or her arrival. It was learned, during the Commission inquiry, that the patient was not happy with these transition visits, since he felt no attention was being paid to him.

Dr. Amjet Hussain, the psychiatrist in charge of the ICU, was aware of the continuing nature of the difficulty in the transition process, but did not contact the geographic ward. He left such communication to nursing personnel. When asked why he did not personally contact the medical personnel on the receiving ward when he became aware of the patient's continued difficulty, he answered: "I seldom have time."

On at least one occasion the patient refused to go on the transition visit. The patient's condition became worse in the beginning of June. BPC records indicate that on June 1st --

> "the patient requested a private conference in his physician's office. Patient was described as withdrawn, depressed, and appeared apprehensive. [He] informed the physician of his act of Sodomy with an ICU employee and was worried about the consequences. On June 8th he told his physician that he was afraid to go to the open ward (16). On June 10th [he] was aggressive, crying, withdrawn, hearing voices and

> threatening to hang himself. The attending physician ordered seclusion [as needed], very close observation, commenting the patient is suicidal and hearing voices."

Some days later, the patient's condition had deteriorated to such an extent that Dr. H. Omar Gutierrez, the hospital's Associate Director (a board certified psychiatrist) was called in for a consultation.

> "So I came up to the ward the next day and examined and found that indeed, he was getting worse, and I wrote a note on the chart, and I made the first mistake in the handling of the case, which was not to be specific enough, and assertive enough in terms of what I wanted him [Dr. Hussain] to do with the case."

About one week prior to his transfer from the ICU to the geographic ward, he escaped from the hospital. Although he returned the same day, he came back with his head shaved. Gutierrez accepted Dr. Hussain's interpretation of this act as not one to raise substantial concern about the patient's well being. Dr. Butts, on the other hand, told the Commission that he interpreted these signs very differently.

> "I think that was a signal of some kind that he was in deep psychological trouble ..."

When the patient was transferred from the Intensive Care Unit to the geographic ward, Dr. Gutierrez was not informed of the transfer and only found out fortuitously

when he asked for him while attending a meeting on the ICU. Gutierrez has testified that:

> "I, at that point, I again in retrospect, even though I made a note in my own mind that I was going to see the patient and, in fact, had intended to go and see him on a Thursday or Friday morning when my schedule was lighter, because I had some doubts in my mind about his condition, and I decided that I would look into it and make my own determination.
>
> I didn't do it soon enough, nor did I decide -- I could have decided to, without seeing the patient, to reverse the transfer. I had that authority, I thought of it briefly, and then I decided against.
>
> Needless to say, [he] killed himself that same week, I think it was Wednesday or Thursday. So I never got to see him again."

Much controversy arose over the manner in which this patient was transferred from the ICU to the geographic ward. Dr. Amjet Hussain, who was the Unit Chief on ICU at that time was fired for his role in the transfer.*

Following the patient's death, the report of the Special Review Committee fails to identify any omissions or negligent acts. The report is signed by Judith Nigro,

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* Dr. Hussain initiated grievance proceedings and at the time of this writing the arbitrator has not yet rendered an opinion. Similar action was taken against the ward charge nurse on duty who did not order a search of the room in which the boy committed suicide. She has subsequently been disciplined but reinstated at the direction of an arbitrator.

one of BPC's associate directors, and dated July 15, 1976. When questioned by the Commission concerning this report, Ms. Nigro testified as follows:

> "Q That document purports to be a report of the Bronx Psychiatric Center's Special Review Committee and the document calls for certain criteria to be established in that report right on its face, and you have affixed your name as the person signing on behalf of that committee; is that correct?
>
> A Yes.
>
> Q Was there such a committee at that time that had reviewed ... the ... incident?
>
> A On the date of the 15th, no.
>
> Q So your signature for the Special Review Committee is, in fact, your signature for no committee; is that correct?
>
> A Yes, that's correct."*

Ms. Nigro further testified that what was called a Special Review Committee report did not meet the criteria set forth on the face of the printed form provided with the report.

BPC's response to the death of this patient was as superficial as the care and treatment accorded to him during his hospitalization.

* The Commission established that the Special Review Committee report was written by Dr. Lifshutz who was also the person who signed Dr. Butts' name on the Incident Report.

PATIENT #7 -- MARCH 24, 1977

The inadequacies and failures documented in this report did not end in 1976. On March 24, 1977, a 57 year old male patient with a diagnosis of "chronic organic brain syndrome" wandered off unobserved by two staff members who had escorted him and four other patients to a bingo game in BPC. The next morning, he was found dead on the hospital grounds. The autopsy report indicates the cause of death to be exposure.

Dr. Butts was questioned about this incident several weeks later.

> "I called a meeting with the nursing staff that afternoon to try and understand what had happened and, first of all, why the patient was allowed off the ward -- to understand, why he was a voluntary patient because, in my clinical view, he should have been on a two physician certificate.
>
> His 2 PC had expired several months ago and someone had him sign as a voluntary patient.
>
> I questioned that and felt that it was illegal so to do because I didn't think the man was really competent to sign as a voluntary patient.
>
> The staff, in questioning the staff, I asked them whether they knew about [the] policy about voluntary patients, when considered dangerous to themselves, should be reported to the police.
>
> They said they did.

I asked them whether they considered him a danger to himself.

They said no.

I began to go back to what constitutes a danger to one's self.

It was a kind of a charade in a way. They considered him competent to play bingo and considered him oriented in terms of being in a chapel.

So the man was very disoriented and not a candidiate to be off the ward.

Four or five days later, when Myrtle Scott, the administrator, was back, Dr. Lifshutz saw her with the staff and their conflicting stories meant somebody was lying.

One of the results of the whole episode, Dr. Mehler was given a counseling memo accusing him of being derelict in his duty for not having instituted a court remand on the patient.

Dr. Pemberton, the staff psychiatrist, was given a similar counseling memo.

All the nurses on the staff were also counseled, not in terms of taking the patient off the ward, but in terms of not notifying the police.

Dr. Lopez, resident on staff who came to the ward and who's only action was writing LWOC [leave without consent] on the incident form, was written a counseling letter to the effect that he could no longer do night work until he was sufficiently appraised of the regulations by Dr. Hornick.

Dr. Hornick was written a memorandum to the effect that he should conduct an orientation period with all of his residents especially Dr. Lopez into hospital policy.

> And subsequent to that I reissued the memorandum, the policy directive about the reporting of patients on leave without consent."

Dr. Mehler was the same unit chief who never completed an investigation ordered by Dr. Butts into allegations concerning the conduct of staff mentioned in the history of Patient #1. Dr. Lopez, the resident on duty, was interviewed by Commission staff about one month after the incident. He had not yet met with Dr. Hornick to be briefed on the appropriate regulations, and informed us that when he had begun the residency program there had been no discussion of basic regulations.

Patients continue to enter BPC -- the conditions seem mostly unchanged.

CONCLUSION

This Commission's investigation as discussed in this report indicates that the Bronx Psychiatric Center has been unresponsive to the needs of its patients. This report raises serious questions about the ability of BPC as presently operated to fulfill its statutory obligations to the patients entrusted to its care.

This investigation suggests that the consistent pattern of institutional indifference and ineptitude found at BPC may be attributed to at least three factors:

1) When incidents such as those already discussed occur, the hospital consistently responds in a manner that precludes its learning from past failings. It is often able to obscure improprieties from other review bodies merely by superficial compliance with reporting regulations, while remaining indifferent or oblivious to the underlying intent of such regulations.

2) The hospital does not clearly define and delegate responsibility for implementing regulations and DMH policies intended to ensure adequate patient care and protection. The result has been that personnel on all levels fail to recognize their obligations to patients in their custody and fail to assume the burden of making constructive changes.

3) Even to the extent that the responsibilities of staff members are clearly defined, enforcement mechanisms for ensuring that these responsibilities are carried out are rarely, if ever, employed.

What has happened at BPC cannot be explained as simply a reflection of life and death in a state mental hospital. What has happened at BPC cannot be explained by inadequate funding or under-staffing. This Commission does not accept any explanation that what has happened at BPC is an acceptable standard of care or accountability for a mental health facility in the State of New York.

RECOMMENDATIONS

The Commission is well aware that the Department of Mental Hygiene and the Bronx Psychiatric Center have many dedicated employees. We have found, however, that these employees often receive inadequate support and supervision from their superiors at BPC and some of the specialized support staff in the Regional and Central Offices.

In the hope of providing better care to patients in the Bronx Psychiatric Center, the Commission makes the following recommendations:

1) There is an urgent need for an oversight body outside of the Department of Mental Hygiene, in cooperation with Boards of Visitors, to initiate its own investigations of patient mistreatment or abuse. Therefore, this Commission recommends the enactment of pending legislation which would establish a State Commission on Quality of Care for the Mentally Disabled. This Commission wholeheartedly supports the concept of such legislation without endorsing all of its provisions. However, it is of paramount importance that any such new oversight commission be adequately funded and staffed.

2) Officials within the Department of Mental Hygiene should undertake an immediate and complete review of the operations and administration of the Bronx

Psychiatric Center. Dissemination and updating of current operating policy must be standardized and coordinated so that BPC personnel are able at all times to clearly recognize their existing duties. Such an effort should include a thorough review and revision of the "incident report" system at BPC. (See Appendix I.)

3) The Regional Director should take all necessary steps to assure that DMH policies and directives, emanating both from his Office and the Central Office, are conscientiously enforced at BPC. In addition, the billing procedures of BPC must be drastically improved to avoid further loss of revenue to the State. (See Appendix II.)

Respectfully submitted,

DAVID W. BROWN, Chairman
EARL W. BRYDGES, JR.
ROBERT K. RUSKIN

APPENDIX I

This appendix will examine the use of incident reporting at BPC. The goals and specific uses of incident reports are not clearly defined anywhere, nor is there any adequate description of the specific information to be included. A recent Legislative report observed that --

> "Most often [Incident Reports] serve as a self-protective device for employees and the director, enabling them to provide explanations of incidents to families, regional directors, and the Central Office."*

Incident reporting is explicitly required by DMH regulation (14 NYCRR §24.2). All alleged or apparent cases of patient abuse, all serious accidents and injuries, all suicides or attempts producing injury and all homicidal attacks are to be described on Form 147-DMH and sent by the facility to the Regional Office. In the cases of patient abuse, mistreatment or death, provisions are made for distribution of the report to the Board of Visitors and Mental Health Information Service ("MHIS").

147-DMH is the basic form for incident reporting.

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* New York State Senate Select Committee on Mental and Physical Handicap, Violence Revisited! A report on traditional indifference in State mental institutions toward assaultive activity, undated, at 19.

The instructions require the person in charge of the ward, or "Ward Charge" to complete Part 1 and give it to a physician. Included in Part 1 is a space for the statement of the Ward Charge and an instruction to attach separate statements from all parties and witnesses.

The physician is required to complete Part 2 and then submit it to the Special Review Committee which is responsible for Part 3. The last section, Part 4, is allotted to the Central Office for comments, if the report is submitted to the Central Office. There is no instruction as to the appropriate circumstances for such a submission, nor is there a time period within which it should be done.

The published procedures for the review and routing of incident reports contain a tangle of instructions, some in conflict with others. In some cases, the published procedures create duties without assigning responsibility to a particular individual or office. In other cases, the procedures assign responsibility to more than one office.

A Regional Special Review Committee, ordered in October 1976, to review the six incidents later investigated by this Commission, completed its review in one day, despite the absence of one of the incident reports. The Committee found everything in good order with respect to the investigations and reports of the incidents made by BPC staff.

94-420 O - 77 - 35

Joint responsibility for investigating all incidents, except those involving employee culpability, is shared among the Director,* the Special Review Committee** and the overlapping Incident Review Committee.***

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* The Directors' responsibility is set forth in Title 14 of the New York Code of Rules and Regulations (hereinafter 14 NYCRR), §24.1, promulgated by the Commissioner of Mental Hygiene as authorized by New York State §9901. See also: Department Policy Manual ("DPM"), §7650(E)(1), issued November 10, 1976.

** The authority for this Special Review Committee prior to November of 1976 is unclear, although a provision is made for an analogous committee in non-State facilities in 14 NYCRR, §82.5(b)(5). In November 1976, DPM §7650 (b)(3) was issued under the title "Special Review Committee," and required: "A standing committee appointed by the facility director to review incidents, and with the director, determine the nature of the incident and propose corrections when necessary. Appropriate members appointed shall include the Deputy Director, Administrative, Personnel Officer, and representatives from clinical and support services as needed."

*** This last committee was established by direction of Regional Director, Dr. Alvin Mesnikoff, in the Regional Memorandum addressed to all facility directors, dated October 14, 1976. It was established to review all incidents (not only serious incidents, as was the Special Review Committee), to investigate effectively, and to recommend policy practice and procedural changes. It has taken on the responsibility of completing the section of the Incident Report entitled "Special Review Committee." This committee at BPC consists of Drs. Butts, Lifshutz and Gutierrez, Mss. Nigro and Messier, along with other appropriate staff members.

In cases of deaths by suicide or homicide, and in all cases of serious accidents and injuries, State Regulations mandate that Incident Reports be sent to the Regional Office and the MHIS.* In cases where a crime may have been committed and in cases of "suicide, accidental death, homicide, or death under suspicious circumstances," the Medical Examiner and the police are to be notified. All deaths under "unusual circumstances," as well as "apparent abuse or maltreatment of a patient under 18 years of age" or "incidents of a sensitive nature which may involve a community concern" require an immediate telephoned report to the Regional Director.** All deaths under unusual circumstances must be promptly reported to the chairperson of the Mental Hygiene Medical Review Board.***

Reports to the Regional Office are to be made promptly by mail in cases involving attempted or actual suicide or homicide, and in specified cases of other injuries. They are to be reviewed promptly by the Assistant Regional Directors and the Program Analysts for the facility. Follow-up and corrective action are to be monitored by the Program Analyst.

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* 14 NYCRR, §24.2.

** Regional Memo, October 14, 1976, at 4.

*** Executive Order #35, May 19, 1976.

Every month, minutes of all Incident Review Committee proceedings, along with documentation concerning any actions taken, are to be sent to the appropriate Assistant Regional Director, accompanied by a Monthly Incident Summary and any supplementary reports. Copies of the incident reports are to be forwarded to the Central Office in Albany, in compliance with the Regional Memorandum.

The Regional Office, as monitor of all death cases, must also have a representative present at meetings of each hospital's Death Review Committees. This Committee (which must include an outside physician) is supposed to review the nature of the final illness, along with the treatment administered, the final cause of death and the autopsy results. BPC has no such Committee.*

Regulations require that the Director of a facility appoint a senior officer to be held responsible for investigating "immediately" any alleged or apparent client mistreatment, as well as all other incidents.**

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* The Death Review Committee is different from the State Mental Hygiene Review Board established by Executive Order of May 19, 1976 and which reports only on unusual deaths.

** DPM, §7650(E)(1). The time periods allotted for each step in the processing of the incident report are more limited in the cases of alleged mistreatment than is indicated by the instructions appearing on the face of the Report Form. See also: Regional Memo, October 14, 1976, at 6, requiring telephoned notice to the Board of Visitors and other various agencies. Cf 14 NYCRR §24.2.

The Director is charged with the duty of immediately notifying the next-of-kin or guardian of the alleged abuse and of informing the client and/or a surrogate that the MHIS may provide legal counsel in any legal proceedings relating to the incident.*

In the cases of abused clients under 18, the Regional Office is charged with insuring that investigations are made and that corrective action is taken, if necessary.**

An inquiry into violence and the incident reporting system at Bronx, Marcy and Buffalo Psychiatric Centers was undertaken by the New York State Senate Select Committee on Mental and Physical Handicap. Under the Chairmanship of Senator James H. Donovan, the Committee reviewed thousands of incident reports at the three hospitals and concluded:

> "... the Department of Mental Hygiene does not know what is happening in its institutions, a lack of knowledge that extends to institution directors themselves.

* DPM, §7650(E)(3) (f,g). <u>See also</u>: MHL §29.09(b)(5).

** DPM, §7650(D)(3). Regional Memo, October 14, 1976, at 4 contemplates a telephoned report from undesignated sources to the Regional Director reporting such cases of client abuse. By contrast, DPM, §7650(D)(3) requires the Facility Director's reporting to the Register of the Department of Social Services' notifying the Regional Office.

> They do not know what is going on because the basic incident reporting system is a flop ... the incident reporting system should reveal overall conditions at each state mental institution. It does not ... The basic incident reporting serves to protect the hospital and its employees by providing documentation for those who inquire about incidents or injuries."*

The Committee also concluded that the "report form [is] an obstacle to proper incident reporting, [but that] ... a reporting system could be devised that would enable the department to know what is going on in its institutions."** It notes the inadequacy and imprecision of the information requested. Most significantly, it indicates that the reports are not aggregated but are received "on an individual basis, with little relationship to incidents of the past."*** Without careful aggregation of the data, there can be no review of the wards or the shifts having the highest incidence of violence, nor can there be an analysis of the patient and institutional factors contributing to such incidents.

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* Senate Select Committee Report, at 1.

** _Id._ at 20.

*** Id. at 21.

The Committee made ten recommendations regarding the procedures which surround incident reporting and the format of the report itself. All recommendations were directed toward increased particularization and standardization, with a view to aggregating data for corrective change. It also gave reserved approval to a revision of the incident report form issued by the Department of Mental Hygiene scheduled for test use on or about May 1, 1977.*

Repeatedly, throughout the BPC incident reports reviewed by the Commission, even the minimal information requested by the printed form was disregarded and omitted. Rarely were separate statements of witnesses or participants included; and the space allotted to the Special Review Committee expressly for "autopsy review, recommendations, corrective action taken, names of people (or Committee) notified" was carelessly filled out. In those cases where investigative finds were made, no conclusions were reached, no recommendations were offered, and no indication existed of any corrective action taken. The Committee's sole acknowledgment of any autopsy is found in the standard notation: "awaiting results from the medical examiner."

* _Id._ at 22. Recent memoranda and other communications from the Regional Office indicate a new effort to make better use of the incident reporting system.

APPENDIX II

The Department of Mental Hygiene is mandated by law to charge fees for its services "provided, however, that no person shall be denied service because of inability or failure to pay a fee."*

Commission accountants have found evidence of a loss to the State in excess of over one-half million dollars for the year 1976 from BPC outpatient clinics alone. This loss is primarily attributable to the failure to bill third party obligors such as Medicaid, Medicare and insurance companies.

A preliminary check revealed that as early as August 1976, Dr. Ralph Speken, Chief of Service, had issued a memorandum in conjunction with the Office of Patient Resources which acknowledged that "in one outpatient area ... a major proportion of approximately 400 outpatients are not being billed for services provided by this hospital."

A review was made of BPC outpatient records for the year 1976, at the Office of Patient Resources, charged with the determination of billable services. It revealed that for a random sample of 269 outpatients, 144, or 53.5% of the sample, showed missing, blank or incomplete files.

* Mental Hygiene Law §43.01(a).

To determine the loss of revenue to the State, outpatient reports from the DMH for 1976 were used. Commission accountants determined the losses as follows:

Billable Outpatient Services		$ 77,685
Less: Medicaid Services Billed, NYC	25,956	
Medicaid Services Billed, NYS	2,700	
Private Billing	564	
Total Billed Outpatient Services		29,220
Billable Services -- Not Billed		48,465
Reported Services Dropped -- No Admission Data (MS-5)		7,940
Reported Services Dropped -- Unrecognizable		2,546
		58,951
58,951 Services at $25.72 (Average Medicaid Service Charge for 1976)		1,516,220
Medicaid Eligible Based on Sample		54.4%
Potential Loss of Medicaid Billing		824,824
Less: New York State share of Medicaid 25%		206,206
New York State Loss of Revenue		$ 618,618

A further loss of revenue to the State may be due to improper reporting at BPC of outpatient clinic services rendered. Psychiatric Centers in New York State, excluding BPC, reported 10.1% of their outpatient services were in the "No Fee" category. BPC reported 59.6% of its outpatient services were "No Fee." BPC provided no adequate explanation for such a disparity.

Mr. POSNER. The commissioner sent a telegram on the 15th of this month to the director of that facility ordering that he not make public statements, et cetera and so forth, because an investigation was now underway.

The very next day, the director of that institution held a press conference and rallied—quote, unquote—the public to his defense. This again gives you a sense of the kind of arrogance that we have to deal with in terms of getting these kinds of situations corrected.

Ms. MANELLA. Thank you very much, Mr. Posner.

Without objection, we will insert in the appendix of the record a statement of Representative Edward I. Koch regarding the proposed bill along with some other materials he has submitted.

Without objection, these hearings are recessed until Thursday, June 30, at 10 a.m., in room 2228 of the Dirksen Senate Office Building.

[Whereupon, at 2:45 p.m., the hearing was recessed.]

CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS

THURSDAY, JUNE 30, 1977

U.S. SENATE,
SUBCOMMITTEE ON THE CONSTITUTION
OF THE COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 2228, Dirksen Senate Office Building, Senator Birch Bayh (chairman of the subcommittee) presiding.

Present: Senator Hatch.

Also present: Senator Mathias from the State of Maryland.

Staff present: Nora Manella, counsel; Ted Humes, minority counsel; Mike Klipper, minority judiciary counsel; Nels Ackerson, chief counsel and executive director; Mary K. Jolly, staff director; and Linda Rogers-Kingsbury, chief clerk.

Senator BAYH. The committee will come to order.

I would like to ask our distinguished colleague, a fellow member of the Committee on the Judiciary, and the distinguished senior Senator from Maryland, to initiate our hearing this morning by introducing the distinguished attorney general of his State.

If he has no objection, we had planned to have Judge Walinski first and then to have a panel of attorneys general.

But I know the Senator is extremely busy. In order to make it possible for him to be two places at one time, Senator, if you have no objection, I would like you to make that introduction now.

Senator Mathias?

STATEMENT OF HON. CHARLES McC. MATHIAS, JR., A U.S. SENATOR FROM THE STATE OF MARYLAND

Senator MATHIAS. Mr. Chairman, you are kind, as always. I appreciate the opportunity to say a word.

The office of attorney general of Maryland is one of the longest established and one of the most historical offices in the United States. The records of that office go well back into the 17th century. It has been held continuously by able and distinguished Maryland lawyers who have rendered unusual service to the people of Maryland.

The present attorney general, Francis Burch, upholds that long, well-established tradition.

I was, myself, employed in the attorney general's office at one time, and I found it to be an effective educational institution, as well as an office rendering public service. I learned a lot of law there. I think Bill Burch is maintaining that tradition, as well, in keeping the office vital and alive.

I am sure, Mr. Chairman, that the testimony that he will give you today will be extremely useful to the Committee on the Judiciary.

I thank you for the opportunity to say these few words of welcome of introduction on his behalf.

Senator BAYH. Thank you, Senator. I appreciate your extra effort to be here.

We will proceed with the Honorable Nicholas J. Walinski, a U.S. District Judge for the northern district of Ohio.

The judge ajudicated the *Davis* v. *Watkins* case, which is a significant case in the legal area which the committee is studying; it was a class action suit brought to secure patients at the Lima State Hospital for the Mentally Ill the right to treatment.

The Justice Department entered the case as an amicus and extensive relief was ordered.

Judge, we appreciate very much your being here. We look forward to your expert testimony since you have been intimately involved with the whole problem area that we are addressing.

TESTIMONY OF NICHOLAS, J. WALINSKI, A U.S. DISTRICT JUDGE FOR THE NORTHERN DISTRICT OF OHIO; ACCOMPANIED BY JOHN CZARNECKI, ATTORNEY

Judge WALINSKI. Thank you, Mr. Chairman.

I have with me John Czarnecki, an attorney from Toledo, Ohio, who was formerly my law clerk when my litigation began. I have appointed him as my special master in the case to implement the orders that I have to issue from time to time.

The situation I have is similar to *Wyatt* and the horrors are similar. I will not repeat any of those, but the case is still ongoing and we have a constitutional problem to resolve before a three-judge court before it is finalized. That is the status of my litigation.

Senator BAYH. What is the constitutional question that the three-judge court addresses?

Judge WALINSKI. The constitutionality of the entire State of Ohio criminal commitment statutes. There is a parallel lawsuit with my cohort, Judge Young, on the civil commitment statutes that I believe is about to be resolved.

Senator BAYH. So the constitutional question—is this a three-judge panel of Federal judges?

Judge WALINSKI. Yes.

Senator BAYH. The constitutional question is directed at the constitutionality of State statutes and not the role that the Federal judiciary has played?

Judge WALINSKI. That is correct.

As I said, my case is still ongoing. It started in 1973. It began, as I said in my letter to you, and I will not repeat it except to give you a brief background, that we started getting a lot of habeas corpus petitions out of the State mental institution, which was the Lima State Hospital, but was formerly titled the Lima State Hospital for the Criminally Insane.

It has both kinds of committees there. After a number of the habeas corpus petitions came in, we looked around for one lawyer to

handle them. He finally threw up his hands and said he could not handle that because it was going to be a total institutional problem.

We talked with and obtained the services of one of our public service law firms. They got into it. It just became almost an unworkable situation. Then the Justice Department moved in and intervened and allowed them to. With their expertise and their access to experts, and their access to prior litigation experience, we moved the case along and are now in the final stages. That has been my experience. I do not know if I am an expert in these problems.

I would state my position basically that I think the Justice Department should have the right to intervene in any such litigation. I would hesitate at the broadness of the bill in letting them initiate, because I can foresee that you are going to get into areas where you are going to create a bureaucracy. It will be as large as HEW and medicare and medicaid in trying to enforce the constitutional rights. I think that should be handled by intervention rather than by total authority to bring the lawsuit.

I know that is contrary to the Justice Department's position, but the bill, as it stands in my mind, is a little bit broad.

Senator BAYH. Are there aspects of the bill that could be narrowed to meet the bureaucratic problems that you allude to? The problem we have, Judge—is it Lima State Hospital?

Judge WALINSKI. Yes, Lima State.

Senator BAYH. Those patients were heard and they reached to you. Unfortunately, there are a number of other institutions where that has not happened. You point that out in your letter to me very graphically. You mention the contribution that the attorney general made and that the Justice Department made in gaining access to materials, and in providing expertise. How can we make that available without getting involved in the bureaucratic situation?

Judge WALINSKI. In Toledo we are fortunate that we have a public-service-type law firm organization that is federally funded. That is ABLE, which is Advocates for Basic Legal Equality. There are similar public service law firms which are located in almost every major city. They can cover the area pretty well.

As I stated, Lima is 90 miles away from Toledo and they had a problem until we reached the point of intervention.

Senator BAYH. What was the Ohio State attorney general doing about Lima?

Judge WALINSKI. They were not doing anything. It was being run by the head of the institution. When we got into the problem, they immediately tried to cooperate. There were certain areas in which there was no disagreement on the facts that something had to be done. The attorney general was very cooperative. He had to go through a staff that had been doing things this way for 40 years and were not about to change without pressure.

We had no difficulty with the attorney general except the usual problem that some of the things that had to be done required a great deal of funding. The State does not have the money.

Senator BAYH. I did not intend to direct the question to him personally, but one of the problems we have here is that the State attorney general's major client is the people who run the hospital; is that not the case?

Judge WALINSKI. Yes.

Senator BAYH. So it is very difficult. I am anxious to hear the testimony of the official representatives of the State attorneys general who are here. These are people who have actually been in the field.

But it seems to me that there is a definite conflict of interest when you have to defend the State that houses the inmates that are bringing the suit.

Judge WALINSKI. It is not an easy problem. That is why it takes so long. The case was filed in 1973 and we are still going.

Senator BAYH. The role that the Justice Department played you feel was a positive one?

Judge WALINSKI. Very much so.

Senator BAYH. Could you be a little bit more definitive about that?

Judge WALINSKI. They were helpful in the investigative stage. We managed to get the FBI in there when we were having problems. That was resisted all the way along by the institution. They had access to experts who were well versed in the field of what should be done in a mental institution. They were able to produce those for us, which the State or the local attorneys could probably have not done at all.

With their prior experience in similar litigation, they knew precisely the course that the litigation was going to take and the kind of orders that we were going to have to be looking to. In general, they were very helpful.

Senator BAYH. You mentioned that there was a very confused and difficult situation prior to the Justice Department's intervention. Could you describe the kinds of problems that the private lawyers and the public service law firms experienced?

Judge WALINSKI. As I said, we became aware of the lack of treatment and the lack of rehabilitation and the problems through a number of habeas corpus petitions that were filed from that institution. There were two of us who sit in the western division. I think between them we had 17 habeas corpus cases. All were seeking counsel and all were seeking a hearing.

So we had to farm out and get a lawyer to handle that. Rather than appoint 17 different lawyers doing the same thing, we chose one, who threw up his hands because it was just a logistical problem for him.

He brought in ABLE and they had the same problem operating out of Toledo and trying to interview patients at Lima. They were denied access at Lima initially to the patients and we just had a difficult time getting the case rolling.

I am pressing all the time to get it over with and off the docket and so on. Then the Justice Department intervened and with a little steering of what had already been done, we had a little guideline and we were able to get a matter to an early hearing. We had a preliminary order out and we have an interim order now correcting some of the problems. Then we will clean it all up for the constitutional issue.

Senator BAYH. What would have happened if the Justice Department had not intervened?

Judge WALINSKI. We would still be trying to get to that initial hearing, I think.

Senator BAYH. Could you be more specific about the concerns you have about too much Justice Department involvement?

Judge WALINSKI. To go to an extreme, which is one way to point it out, suppose you have an elderly couple on social security who have no family and are living with some friends for the value of their social security check. Is that an institution that the Justice Department ought to be able to look into as to the standard of care the couple is getting?

Senator BAYH. You say living with "friends"?

Judge WALINSKI. Yes. Could the friends be State agents in there since the State is administering the medicare and medicaid program which these people will probably be using?

Senator BAYH. With all due respect, I think that is a rather extreme exaggeration. That certainly is not in any way perceived as the kind of problem we are addressing ourselves to.

Judge WALINSKI. In reading the bill, where it says that initially any State or agent, where you have the States administering the medicare and medicaid programs, that can be construed as State agents for the purpose of litigation, I think.

Senator BAYH. The legislation also has in it language talking about a pattern or practice of resistance to the law. I don't think a pattern or practice could be alleged in your example.

I think it is important that we understand that there are instances where the State might contract out. Instead of it being a State institution, it could be a privately-owned nursing home in which the State had contracted out for, let us say, 50 of their elderly recipients to be included therein, and certainly there could be abuse in an institution like that.

Judge WALINSKI. The nursing homes in Ohio are required to be licensed and a good lawyer can stretch that licensing into a State agency problem for the purpose of getting a case into court.

Senator BAYH. I think it is important for us to recognize the fact that there could be abuse in an institution like that.

Judge WALINSKI. I understand that.

Senator BAYH. It could be just as bad as the Lima abuse. After all, you suggest that there are abuses in the State institution and the State-licensed institution might also be abusing its residents; but the questions are: Does it have a significant public label on it? And how do you deal with the conditions that exist there?

Do you have other specific examples? That language of the bill can be drafted in such a way that we avoid the problem you raise. I appreciate your pointing it out, however.

Judge WALINSKI. I just finished litigation involving a nursing home and State welfare regulations that affect whether a totally disabled person can remain in the nursing home. The State has certain regulations. If a State throws them out of the nursing home, they are helpless.

The State is not involved in that lawsuit except for the fact that they administer the medical care program which they are attempting to terminate.

Senator BAYH. Do you know of any cases in Ohio, or in the country as far as that is concerned, where the Justice Department has intervened where there has been only one individual abuse? Has not the

Justice Department role in this type of institutional intervention, as well as the kinds of cases the Justice Department has gotten into in the whole civil rights area, involved large classes of people that were being discriminated against or abused?

Judge WALINSKI. I am thinking of a class action that they should be allowed to intervene, or possibly initiate, but in the individual cases, I do not think that requires the power or clout of the Justice Department.

Senator BAYH. I do not want to put words in your mouth, but it seems to me that, first of all, you recognize the significant contribution that the Federal involvement brought in the *Lima* case, and you are concerned that whatever the Federal Government does, that it should be directed at large numbers of people instead of individual relatively insignificant abuses. Is that an oversimplification?

Judge WALINSKI. I think the individual abuses, that is, people can get access to the courts. I am in favor of that. I think it can be done.

As I said, the public service type law firms are looking all over the place for that kind of situation. They manage individually to get the cases in court and resolved favorably. I do not think the Justice Department should need to intervene in a case like that, or initiate that kind of an action. They may have to in some areas where they have no ABLE's, and similar law firms close by. That might be, but that is discretionary with you as to whether you want to go that far with the power. I see no need for it in my district. Let me put it that way.

Senator BAYH. You point out that if it had not been for the Justice Department, you would still be in a mess. Is that right?

Judge WALINSKI. We would have probably reached the same conclusion but at a later, that is, many years later.

I agree totally with intervention. It is just the initiation in the small type with one-person abuse.

Senator BAYH. I see no problem with that at all.

I assume that we would be equally concerned about abuse that was going on in an institution where a case had not been initiated as to abuse, compared to abuse in an institution where there was someone who had initiated a case. Is that right?

Judge WALINSKI. One of the great burdens that the district court carries is a continuous series of repetitive habeas corpus from every institution, whether a penal institution or the Lima State Hospital.

This brings forth problems. When you see that is repeating and coming in and will engage or ask some attorney to take an appointment to look into it, then it may evolve into a class action. That is going on in practically every penal institution. Those kinds of problems can easily get into court and with those kinds of problems I think the Justice Department should intervene, simply because of the great expertise that they have.

The individual in a private institution cannot use habeas corpus to get into the court. He will have to find somebody to file his lawsuit for him. They are usually unable to afford counsel and it takes a public service type law firm to bring that problem before the court.

Senator BAYH. Thank you.

Senator Hatch?

Senator HATCH. Welcome to the committee.

As I reviewed your letter, it seems to me that you have made a good case why the Justice Department should have the right to institute these suits.

Judge WALINSKI. Yes.

Senator HATCH. Except the concern is that it should be in the flagrant area, rather than in every complaint area; is that right?

Judge WALINSKI. The class problem and the public institution problem and nursing home problem, yes.

Senator HATCH. We appreciate that testimony. We appreciate having you.

Senator BAYH. We thank both of you gentlemen.

Without objection, your letter will be inserted in the record at this point.

[The letter referred to was marked "Exhibit No. 22" and is as follows:]

[EXHIBIT NO. 22]

U.S. DISTRICT COURT,
NORTHERN DISTRICT OF OHIO,
Toledo, Ohio, June 15, 1977.

Senator BIRCH BAYH,
Chairman, Senate Subcommittee on the Constitution, Washington, D.C.

DEAR SENATOR BAYH: I have been asked to present a statement regarding my position on the intervention into (or institution of) civil rights actions by the United States Department of Justice to vindicate the civil rights of the institutionalized. I must caution that my view is highly subjective and somewhat parochial based on the single case with which I have had contact. The Ohio case which was the functional equivalent of *Wyatt* v. *Stickney* was filed in my court and tried by me.

In order to understand the role played by Justice in this case, it will be necessary for me to present some factual background. Lima State Hospital is an institution which had been reserved for those mental patients in the Ohio system of mental hospitals who were either most seriously troubled or overtly dangerous. As recently as 1971 the institution housed some 1,400 patients from all over the State. Upon the institution of this case (*Davis* v. *Watkins*, C 73-205 (filed May, 1973, N.D. Ohio W.D.)) 1,100 patients were incarcerated there. These patients ran the full gamut of psychiatric disorders as well as representing a wide range of commitment types. Patients were transferred to Lima who, although purely civil commitees, had become difficult to handle in a civil institution, for whatever reason. On the other end of the spectrum, hardened criminals with psychiatric disorders and psychopathic personalities were transferred to the facility from the Department of Corrections. Until the very early 1970's there were no effective internal checks on the management of the hospital and, due to its remote location (approximately equidistant between Toledo, Cleveland, and Columbus) very little external monitoring of conditions occurred.

In late 1972, an action in habeas corpus was filed in the Northern District of Ohio by a patient who sought investigation of the conditions of his confinement. Since the patient was almost illiterate, the petition was, to put it charitably, inartfully drawn. Since such complaints are to be given a broad reading by the reviewing court, it was necessary to do a certain amount of judicial discovery by way of Orders to Show to Cause why this patient's complaints were not well taken. That process uncovered many of the same conditions condemned in *Wyatt*. Recognizing, then, that the case would require the intervention of legal counsel, I sought to elicit the assistance of a local attorney in private practice who would be willing to represent either this individual or, if in his judgment it was necessary, to frame a class action for judicial determination. I might add that the appointment of counsel was made more difficult by the unavailability of funds with which to compensate counsel for litigants in Civil Rights Actions (unlike compensation allowed by the Criminal Justice Act of 1964). Although the attorney who was kind enough to assist the court, Mr. Gerald B.

Lackey, Esq., is as fine a trial attorney as any who practice in my court, in short order he was overwhelmed by the enormity of this action. The simple logistical problems of representing some 1,000 clients located 80 miles from your office would present problems enough, but the patients' inability to effectively communicate coupled with a certain degree of intransigeance on the part of the defendants made the task almost an impossibility for a single attorney. Discovery became almost a full-time job and, at Mr. Lackey's request, the court requested assistance from a local law reform group, Advocates for Basic Legal Equality. Three attorneys from that group were assigned to assist Mr. Lackey in his representation. Even with their help, however, the preliminary, investigative work made necessary by the unique character of such an action consumed most of their time and progress was very slow. Finally, the Department of Justice became interested in the action through its Civil Rights Section and leave was granted for that agency to intervene as *amicus curiae* with the rights of a party.

Two attorneys, Michael Lottman and Michelle White, both with experience in litigation concerning the mentally ill were assigned to the project. They brought with them the underlying technical expertise necessary to structure this action for trial. They were familiar with and had access to expert witnesses with experience in the treatment and care of mental patients institutionalized in large state facilities. They could draw upon a bank of information maintained by the Department through its involvement in a number of other cases around the country. They had access to in-house personnel necessary for the laborious job of culling through reams of material secured in the process of discovery. With their assistance the parties were able to enter into approximately 132 pages of stipulations which had the effect of cutting the trial to five (5) calendar days. (Without the assistance of such litigators experienced in a highly technical field, I could otherwise anticipate such an action stretching over months of testimony.) To give you some idea of the volume of material generated by an action of this kind, I have recently spoken with John Czarnecki, Esq., the Special Master who I appointed to maintain post-trial control over implementation of the Order, and Mr. Czarnecki informed me that the files alone now occupy approximately nine (9) lineal feet of file space.

Looking back over this action, with its somewhat inauspicious beginning, it is almost incredible that it was successfully prosecuted given the hurdles which existed throughout its progress.

I realize that my view is a highly subjective one and my approval of the Department of Justice involvement is based upon a single case; however, in retrospect, it would seem that my experience in a case of this kind is far from extraordinary. It would seem that no judge could achieve any degree of familiarity with more than one such action and, given the highly specialized nature of such public service litigation, few trial attorneys could develop the expertise necessary for its maintenance. An organization, then, such as the Department of Justice with a national overview of the problem would seem to be an indispensable aid in bringing such institutions into the national mainstream.

On the other hand, I would resist the development of a vast bureaucracy—perhaps at odds with the other executive departments who have been vested, by Congress, with the task of formulating national policy in the area of treatment and care of the mentally ill and mentally retarded. Since the enactment of the Developmental Disabilities Services and Facilities Construction Amendments to the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, it would seem that Congress has given the Department of Health, Education, and Welfare through the National Advisory Council on Services and Facilities for the Mentally Disabled, the power to formulate and enforce a national policy (through the withholding of federal grants). In light of that Congressional perspective, then, it would seem undesirable to enact legislation which, although intended to focus upon a particular narrow problem, might have the effect of creating a vast bureaucracy in conflict with HEW. Fortunately, to date, that has seemed not to have occurred and in fact, Justice and HEW seem to have complemented each other in that the latter has confined itself to a formulation of policy while the former has focused upon enforcement and has served, perhaps incidentally, as an information gathering agency. In fact, I note that many of HEW's standards have been promulgated as a result of findings made by Justice in the pursuit of actions such as *Davis* v. *Watkins*. See, e.g., 45 CFR 249.13.

In conclusion, I have reviewed the proposed legislation in detail and would offer my support with the following caveat:

(a) Although the section by section analysis contained in the Congressional Record of April 26, 1976 reflects the draftsmen's intent that the bill reach only cases involving widespread abuses of institutionalized persons' federally guaranteed rights, a reading of the section itself would seem to contain certain ambiguities. Consistent with my view that intervention should be limited to cases involving large, state-run institutions, I can see an overly broad reading of the act as permitting the institution of a bureaucratic "strike-force" approach which could reach, at its illogical extreme, into state licensed "institutions" such as three or four-person group homes or nursing homes under state regulation. As I suggested, the value of institutionalized litigation is its ability to deal with complex, large-scale, State-run operations. Extending its coverage to that of a national police force to deal with the institutionalized would be, in my view, an unwarranted overextension of the Federal Government's involvement.

(b) I would think that section 2 might well include a requirement that Justice, in addition to a notification of appropriate officials, attempt conciliation of the type seen in title VII of the Civil Rights Act of 1964. The federal courts are already inundated with actions and it would appear that Justice's involvement might well be enhanced if it were able to lend its technical expertise to plaintiffs and defendants in suits of this kind in effecting conciliation of complaints prior to litigation. In order to afford such time for conciliation, I would further suggest a brief interval (perhaps ninety (90) days) between the notification by Justice and the institution of an action. I would again borrow the ninety (90) days interim period from title VII.

(c) Although I am at a loss as to how this suggestion might be implemented, I would like to see local involvement in cases of this kind and would like such local involvement to precede intervention by Justice. As in Davis, while it is my feeling that Justice's intervention was an indispensible aid, I would not underestimate the assistance of Mr. Lackey and the attorneys of ABLE. Both whom extended, without hesitation or compensation, large amounts of time and legal talent on a cause which was largely thankless. Actions of this kind, perhaps as a function of their complexity, require regular local involvement in order to work out a myriad of problems that arise from day to day. Ignoring the importance of local intervention might well result in the very kind of protracted litigation which I view Justice's expertise as forestalling.

I hope the above has given you an insight into my experience as well as my perspective on the proposed litigation. Please feel free to contact me if I can provide any further information or if my testimony before the subcommittee will be helpful.

Sincerely,

NICHOLAS J. WALINSKI,
U.S. DISTRICT JUDGE.

Senator BAYH. We now have a panel of distinguished attorneys general, or representatives thereof. The attorney general from the State of Maryland has already been introduced by the distinguished Senator from Maryland.

I would like to ask our distinguished colleague and committee member, Senator Hatch, to introduce the attorney general from his State.

STATEMENT OF HON. ORRIN G. HATCH, U.S. SENATOR FROM THE STATE OF UTAH

Senator HATCH. Mr. Chairman, I have the pleasure to introduce to the committee the attorney general from the State of Utah, Mr. Robert B. Hansen.

Attorney general Hansen served as Utah's deputy attorney general for some 8 years prior to his election last November as the State's highest law enforcement official. During that time attorney general

Hansen achieved great success in obtaining a high degree of compliance with Utah's shoplifting laws, and I think, in enforcing other laws throughout the State.

He has been an active, intelligent, and alert law enforcement attorney.

Police departments and courts, as well as the general public, through educational programs and the schools and elsewhere have benefited from his leadership in Utah.

During last year's campaign, Mr. Hansen and I had the opportunity of appearing together on a number of occasions. I learned to appreciate his many fine qualities.

The first real problem that attorney general Hansen faced in his new position involved the Utah State prison system and the Gary Gilmore matter, which gained nationwide attention.

Mr. Hansen, of course, conducted himself very well there. He maintained his position and although it received nationwide attention, with some pro and some con, I think we can compliment Mr. Hansen for his approach in this matter.

Mr. Hansen has the highest concern for the well-being of those persons confined in our State's penal institutions and he is, indeed, concerned with the maintenance of an effective program which does protect the constitutional rights of all persons.

I commend him highly. He is a fine man and a good attorney and I think he should make a great attorney genral for the State of Utah.

Senator BAYH. Thank you very much, Senator Hatch.

I had the opportunity to say hello to attorney general Burch and attorney general Hansen.

I know Mr. Marvin, representing the national organization. Mr. Douglàs has sent assistant attorney general Mel Kammerlohr from the State of Nebraska. I appreciate your being here.

Attorney general Mendicino could not be here, but he sent his statement.

Without objection, we will insert his statement in the record at this point.

[The prepared statement of attorney general Mendicino was marked "Exhibit No. 23" and is as follows:]

[EXHIBIT NO. 23]

PREPARED STATEMENT OF V. FRANK MENDICINO, ATTORNEY GENERAL OF THE STATE OF WYOMING

Mr. Chairman, members of the committee, thank you for giving me this opportunity to express my opposition to S. 1393.

When I became attorney general of the State of Wyoming, I swore to uphold the constitution and laws of that State and the Constitution and laws of the United States. To me, that commitment is far more than a mere formality. For not only do I feel a strong legal duty to effectively defend lawsuits brought against the State, its officers, agencies, and institutions, I feel a compelling responsibility to ensure that the constitutional and statutory rights of Wyoming citizens are safeguarded against any possible governmental infringement.

I do not wait for others to initiate action against our State institutions; remedial measures are not the product of day-to-day reactions. Through my staff, I review institutional practices and procedures and advise the chief administrator of constitutional or statutory infirmities.

I am pleased to relate, for example, that in the past year the rules and regulations for the Wyoming State Penitentiary have been revamped to com-

port with constitutional guarantees—in many cases going far beyond the constitutional minimums prescribed by the courts. Because patients at the State mental hospital possess a statutory right to treament, progressive consent policies express the right to treatment, the right to refuse treatment, and the right to the least restrictive alternative in treating mental illness.

Responding to the strong recommendations of the Herschler administration, the Wyoming State Legislature has appropriated funds this year for construction of a new State penitentiary, reflecting sound and progerssive concepts of design. An impressive forensic psychiatry facility has recently opened at the Wyoming State Hospital, and further expansion is now underway.

A solid statutory framework for safeguarding the constitutional rights of juveniles was created in Wyoming in 1971 as was an act specifically governing the admission, treatment, training, and discharge of mentally retarded individuals at the Wyoming State Training School. Wyoming law requires appointment of counsel for convicted and imprisoned persons who assert a violation of their constitutional rights, and the Child Protective Services Act of 1977 provides remedies for institutional child abuse and neglect.

These types of actions illustrate the capacities of the States to enhance the quality of their institutions and to provide remedies for institutionalized persons without the pressure of litigation. And I can assure you that States such as Wyoming and attorneys general such as myself are committed to and are capable of doing the job that needs to be done. S. 1393 is an affront to that commitment and capability.

I have reviewed Senator Bayh's speech in support of S. 1393, and I share his deep concern for the rights and needs of institutionalized persons. Neither I nor my fellow attorneys general speak against those rights and needs; we support them. But we also support the fundamental principles of Federalism that guide this constitutional system of government, and we vehemently oppose the intervention of the Justice Department in the administration of State and local institutions.

My concern is the same concern expressed by the U.S. District Court for the District of Maryland in *United States* v. *Solomon*, 419 F. Supp. 358 (1976), successfully defended by Attorney General Burch. It is extremely important that this committee underestand the basis of the court's decision, and I quote from that decision:

"The proper habilitation of mentally retarded citizens is a matter of acute concern to this court, as indeed it should be to all decent and civilized persons. This court has no doubt that the instant lawsuit stems from a benevolent desire on the part of officials of the Department of Justice to improve the lot of the menally retarded. Important and compelling as a charitable aspiration for helping the mentally retarded achieve a meaningful existence may be, however, it must not be allowed to impel a procedural result which by implication, if not by direct effect, would threaten the delicate balance of power which the Constitution conceives among the various branches of the Federal Government and between the Federal and State Governments * * * This, then, is not in any sense a decision about the rights and needs of the mentally retarded. It is a decision about the proper limitation of the power of the executive branch of the U.S. Government."

In authorizing the U.S. Attorney General to initiate and to intervene in lawsuits against State and local institutions, S. 1393 presumes that current Federal and State judicial remedies inadequately protect the rights of institutionalized persons. That simply is not the case.

The past decade has brought with it into the Federal courts a vast increase in the number of cases filed by State inmates and patients pursuant to 42 U.S.C. 1983. The number of cases has continued to climb each year to the point that dockets are clogged by civil rights cases. I refer you to Chief Justice Burger's report on the Federal Judicial Branch—1973, 59 A.B.A.J. 1125. Many of these cases aldress trivial administrative issues, but some of them—including the cases cited in Senator Bayh's speech—have provided extensive relief for plaintiff classes, clearly indicating that institutionalized persons are not without adequate resources for the protection of their civil rights. State judicial remedies and administrative remedies are also available.

To justify the broad discretion in matters of State and local concern that S. 1393 would vest in the U.S. Attorney General, and to justify the damage the bill would do to contsitutional concepts of federalism, proponents of S. 1393 must satisfy you that there is an extreme need for this legislation. In view of

the effective remedies already available to institutionalized persons, no such need exists.

In passing, I would like to advise you of several other specific objections I have to S. 1393:

1. Not only does the bill not require plaintiffs to attempt resolution of their grievances through administrative channels before filing suit, it does not give institution officials an opportunity to correct alleged violations before the U.S. Attorney General may sue the institution. The notice provided for in section 2 of the bill is meaningless if the institution is given no compliance time. The overall effect is that S. 1393 encourages litigation and discourages informal solutions of problems.

2. The bill embraces a disparate group of potential plaintiffs whose respective rights and interests are not comparable, and it does not distinguish voluntary patients from involuntary patients.

3. No investigative obligation is imposed on the U.S. Attorney General which must precede the filing of a lawsuit. S. 1393 would encourage arbitrary actions by the Justice Department in matters of great social concern.

To sum up, I make two fundamental points to the committee. First, S. 1393 poses a dangerous threat to the constitutional relationship between the Federal Government and the States. Second, S. 1393 is unnecessary because adequate administrative and judicial avenues are open for protection of the constitutional rights of institutionalized persons. I respectfully urge the members of this committee to oppose passage of S. 1393.

Senator BAYH. I do not know how you want to handle this. I will let you proceed under your own initiative here.

Mr. BURCH. Mr. Chairman, in view of the fact that I have to be back in Baltimore for a luncheon address that I have to give at 12:15, I would ask my brothers to let me proceed first if it is agreeable with them.

Senator BAYH. That will be fine. We will have an informal shop here.

TESTIMONY OF FRANCIS B. BURCH, ATTORNEY GENERAL, STATE OF MARYLAND; ACCOMPANIED BY GEORGE NILSON, DEPUTY ATTORNEY GENERAL, STATE OF MARYLAND

Mr. BURCH. I would like to thank you for the opportunity to address you on S. 1393. As you already know, the Justice Department was prompted to request this legislation by the opinions in *United States* v. *Solomon*, and *United States* v. *Mattson*, the latter decided on the basis of the *Solomon* case.

The *Solomon* case was brought by the Justice Department to enjoin various alleged violations of the civil rights under the 8th, 13th, and 14th amendments, of the residents at the Rosewood State Hospital, a Maryland hospital for the mentally retarded.

No resident or relative of a resident, or even an organization representing residents ever took part in this proceeding. We moved to dismiss this action on the grounds that the Justice Department lacked both authority and standing to initiate this type of action.

The district court, in a scholarly opinion, which I believe your staff has, agreed with our position and dismissed the action. The case has been appealed and is now being held sub curia by the fourth circuit.

We have taken a strong position that the Justice Department does not have the present authority to bring this type of action without some statutory authorization. Our argument has been that the 14th amendment has given the exclusive power to enforce its provisions to Congress. Congress has chosen to exercise that power by giving the

Attorney General the authority to initiate suits to protect 14th amendment rights in the areas of voting, housing, employment, education and public accommodations.

Congress has repeatedly rejected giving the Attorney General the broad powers to bring suit which the Justice Department claimed in the *Solomon* case.

Senator BAYH. If I may interrupt just a moment, are you pointing out that Congress has not given this authority?

Mr. BURCH. That is right.

Senator BAYH. Do you contest the constitutional grounds that Congress has this authority?

Mr. BURCH. I am not.

Senator BAYH. That is what this is all about.

Mr. BURCH. I want to point out the historical background.

Senator BAYH. Certainly. Please excuse my interruption.

Mr. BURCH. I am submitting today a copy of our brief to the fourth circuit which states in great detail our legal position as to the right of the Attorney General to initiate suits to protect 14th amendment rights.

I am also of the opinion that the Attorney General should not, as a matter of sound public policy and constitutional government, have the plenary powers which it claimed for itself in the *Solomon* case.

Former Attorney General Robert Kennedy's remarks to the House Judiciary Committee in opposition to proposed title III of the civil rights bill of 1964 are appropos:

> Title III would extend to claimed violations of constitutional rights in State criminal proceedings or in book or movie censorship; disputes involving church-state relations; economic questions such as allegedly confiscatory ratemaking or the constitutional requirement of just compensation in land acquisition cases; the propriety of incarceration in a mental hospital; searches and seizures, and controversies involving freedom of worship, or speech, or of the press.
>
> Obviously, the proposal injects Federal executive authority into some areas which are not its legitimate concern and vests the Attorney General with broad discretion in matters of great political and social concern.

Such a power would blur all distinctions between the State and Federal governments and could lead to a profound distortion in our political system.

My opposition to untramelled authority to initiate these suits in the hands of the Attorney General should not be understood, and I wish to make this clear, should not be understood as blind opposition to any attempts to give the Attorney General a constructive role in the protection of the rights of the institutionalized.

We are all aware of the good work done by the Justice Department in the protection of the civil rights of racial and ethnic minorities under the authority of the various civil rights laws. If a well-drafted, thoughtful statute would result in the improvement of the condition and protection of the rights of the institutionalized, no civilized person in good conscience could oppose it.

S. 1393, in its present form, is not the type of statute which could command such universal respect. In the light of our experience in *United States* v. *Solomon*, there are significant deficiencies in this legislation.

The most fundamental defect is that not enough attention is given to the delicate problem of inter- and intra-governmental relations.

Let me illustrate. First, in 1975, Congress passed the "Bill of Rights for the Mentally Retarded", 42 U.S.C., section 6010, et seq. Section 6012 of that act mandated the establishment of a State advocacy system which would have the power to seek "legal, administrative and other appropriate remedies" for the protection of the rights of the mentally retarded.

I might mention that the State of Maryland has taken active steps to establish just such an advocacy system, and it is our hope that the system will be of assistance in the State's efforts to provide for the mentally retarded.

Yet, even though the Federal Government is paying for this State advocacy system, S. 1393 is silent as to the effects of such a system on the Justice Department. Should a suit by Justice or by the advocate preclude the other from acting? If the advocate is pursuing administrative remedies, may the Justice Department still file suit? What happens if Justice and the advocate request incompatible remedies? Which agency should control the terms of a settlement, et cetera?

Second, similarly, no mention is made in this statute of the role of HEW in the enforcement of rights. Judge Northrop, in *United States* v. *Solomon*, concluded that HEW had exclusive enforcement powers in the area of mental retardation by means of the cutoff of funds. What can it mean when, as in *Solomon*, HEW finds no cause to cut off Federal funds, but Justice files suit claiming that conditions are so poor as to constitute a denial of constitutional rights?

As to the State advocate and HEW, and the Attorney General, this legislation must spell out areas of responsibility and priorities lest State institutions be emeshed in a procedural nightmare.

Third, section 2 of S. 1393 provides that prior to the institution of a suit, the Attorney General must certify that he has informed the relevant State officials of the existence of violations of rights protected by the Constitution. This section contains the germ, but only the germ, of a good idea.

S. 1393 could be satisfied if the Attorney General sent a registered letter or even made a phone call to State officials a few moments before filing suit. A requirement so easily satisfied cannot serve the salutary function of protecting harmonious Federal-State relations. It is surprisng to me that even though much of S. 1393 is conceptually borrowed from the various civil rights acts, one of the key devices of those acts is not used here.

42 U.S.C., Section 2000e–5(b) requires the Equal Employment Opportunity Commission to attempt to resolve disputes by conferences, conciliation, and persuasion before resorting to enforcement mechanisms. The EEOC is also required to defer to State and local antidiscrimination procedures when they are available. Surely, a State of the United States is entitled to at least as much deference as an employer accused of racial discrimination. Before a suit is brought, the State should be entitled to a grace period of perhaps 6 months or a year to eliminate or begin eliminating whatever problems exist.

In essence, the Attorney General should be explicitly required to engage in reasonable good faith conciliation efforts prior to instituting suit. It should be remembered that most of the problems against which this legislation is aimed do not result from malice, but from

the lack of funds and staff, from a failure in the institution's philosophy of treatment, or from simple inertia.

The *Solomon* case provides a good example of the problems which can result from changes in treatment philosophy. When Rosewood was designed, the ideal treatment facility was thought to be a large hospital in a rural setting with an opportunity for residents to perform useful farmwork. Rosewood was based on just that model. Present treatment philosophies are oriented toward small community-based facilities.

One of the Justice Department's aims has been to reduce Rosewood to a community-based facility of relatively small size. We are not convinced that this treatment philosophy is constitutionally mandated. It further remains to be seen whether this new concept will prove to be any more successful than the old.

Overnight cures of the problem are not possible. However, the threat of suit could serve as the catalyst to resolve problems of long standing, but sufficient time is necessary to permit the State to act responsibly. While the threat of a possible suit may serve as a constructive catalyst for change, the actual filing of a suit may cause positions to crystalize and harden because of the pendency of an adversary proceeding which undercuts the partnership approach.

Fourth, a further difficulty in this legislation is the prospect of an award of money damages in a suit. Section 1 of the statute authorizes the Attorney General to seek such relief as he deems necessary. Presumably this statute will not serve to abolish the 11th amendment so that damages will not be awarded against the State.

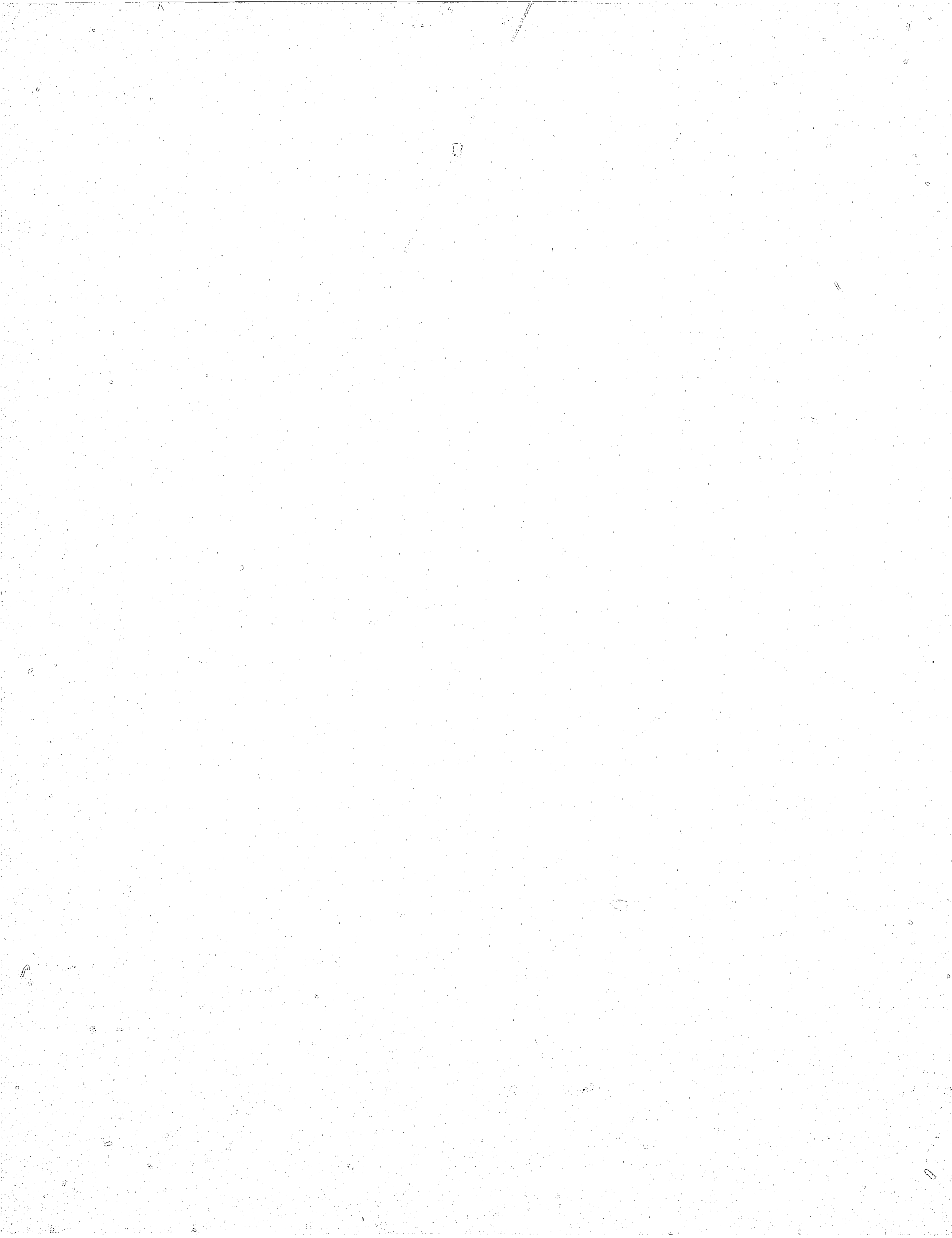
However, the prospect of the Attorney General of the United States seeking money damages against a hospital attendant, a prison guard, a juvenile counselor, or a nurses' aide is both disturbing and unnecessary. The United States is a formidable litigant for a State, much less for a private party.

An incident which occurred before the filing of the *Solomon* case will show you the difficulties of litigating with the Justice Department. Our first contact with the Justice Department occurred one fine day when a team of FBI agents showed up at Rosewood, out of the blue, and began questioning the staff about conditions. The FBI's visit, which I might add was properly conducted and under the orders of the Justice Department, threw the hospital into an uproar. Yet, the visit was completely unnecessary. Had Justice asked for the information they sought, we would have given it to them.

Fifth, and that brings up my final point. The Justice Department at that point told a member of my staff that conditions were no worse at Rosewood than at a number of other institutions, and that nothing was likely to come of the investigation. Six months later, again with no warning, suit was filed. The same member of my staff later asked why we were being singled out, and he was told that Rosewood was chosen because the Baltimore Federal Court was only an hour's drive from Washington.

So, my final point is that the circumstances justifying a particular suit by the Justice Department must be delineated more clearly.

As an example, I do not believe the Justice Department should bring suit if any private litigants are available to present the case.



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6 OF 12

In such situations, the Justice Department would only be wasting its resources and preempting a proper litigant.

When the Justice Department has brought a suit, it is essential that the persons in whose behalf the relief is sought be brought into the case. The patients or inmates will have to live with any settlement or court decree in a case brought by the Justice Department. Either directly or through localized and legitimate advocate groups they ought to have some say in such decisions.

One of the frustrations of the *Solomon* suit was the difficulty we had in settlement discussions. We always had the feeling that what interested the Justice Department in the suit was the opportunity to establish its authority to bring such an action. Justice had no incentive to settle the case until our motion had been decided.

As an example, we presented the Justice Department with a proposed settlement agreement. Justice rejected the offer out-of-hand with no explanation other than a general statement that Rosewood, as it now exists, should be abolished and replaced by a 300- to 500-bed facility. We decided to go forward with this settlement proposal unilaterally after the case was dismissed. Among other changes in the hospital are a reduction from 2,400 to 1,600 patients and improvements in staffing and sanitation.

In closing, I would like to leave with you one final thought. Any scheme of selected litigation in a sensitive area will necessarily suffer from the fundamental, and perhaps unsolvable weakness. The Justice Department simply does not have, and will never have, the full range of information necessary to intelligently determine whose institutional conditions are the worst and what each State's order of fiscal priorities should be.

Every suit resulting in substantial relief as to one institution may result in a diminished availability of funds for another institution where the need may be greater. The States are in a far better position to establish these priorities.

I will be glad to answer any questions.

Senator BAYH. Thank you, attorney general Burch.

Since attorney general Burch has a luncheon engagement, I would like to give him a chance to leave, if the other members of the panel have no objection.

We will direct questions to attorney general Burch now, if you do not mind.

You say the first time that anybody in the State of Maryland knew anything about the FBI agents coming to Rosewood was when they arrived, and that there had been no consultation with the mental health people in the State of Maryland whatsoever?

Mr. BURCH. They descended upon us en masse.

Senator BAYH. Have you ever been to Rosewood?

Mr. BURCH. Yes.

Senator BAYH. You have been out there personally?

Mr. BURCH. Yes.

Senator BAYH. I notice in the Justice Department complaint that they list a number of conditions: failure to provide Rosewood residents with living or sleeping space sufficient to insure protection against physical harm at the hands of others; failure to provide safe

and sanitary living and sleeping areas; failure to maintain sanitary and minimally adequate kitchen facilities, et cetera.

Is that a valid complaint?

Mr. BURCH. Let me say this. First of all, I cannot tell you as of the time of their visit what the conditions were because obviously I was not there. There have been some complaints that we have looked into which are justifiable, whether raised by Justice or by others.

Where those have come to our attention, we have consulted with the Department of Health and Mental Hygiene and we have indicated that those conditions should and must properly be corrected.

I might say that we have had a rather good experience, given the proper amount of time, to negotiate and conciliate with HEW and the Justice Department to correct a lot of conditions that exist simply because they have been brought to our attention.

We have had the opportunity to advise the particular department involved that they will be in violation of the constitutional mandates that have been laid down. We have been able to resolve many of these problems.

I can give you an example of two instances. One dealt with the Civil Rights Division at the Department of Justice, proposing the institution of a suit against the State of Maryland because of the number of blacks in the State police service, and the number of women in the State police service, and some of the criteria that were established with respect to recruiting both blacks and women in the State service.

We sat down. I personally sat in on these conferences as did my deputy. We sat down with the head of the State police and we said that there were areas that required some correction. We did not agree to a quota, but what we did is that we agreed to goals and we finally got to the point where we entered into a consent decree where we were able to resolve our problems at the conference table rather than in the court room.

The second instance dealt with the mental institutions and the hospitals in the State of Maryland where there was a charge by HEW that there was insufficient staffing of nurses. They were ready to cut off the funds which they had the right to do under the HEW statute.

I met once with my deputy and with the members of the Department of Mental Hygiene and the members of the Civil Rights Division of the Department of Justice. At that one meeting with a bunch of people we were able to work out a proposal and a procedure to try to increase the number of nurses and to generate a recruitment program within the institutions to give more nurses to those institutions.

That has been going on now for the past 8 months. It is working quite well.

What I am saying to you, Senator, is this. The States have an interest in this. There ought to be a good working relationship between the State and the Federal Government. We have been litigating in the courts against HEW in the State of Maryland. We filed a suit here the other day in the District of Columbia against HEW because they tried to cut off $2.5 million worth of nursing home funds simply because of some technical violations and failure to get reports in on time. They threatened to cut off $330 million in funds and some 20 or 21 other States are involved.

The answer is not to go into court and litigate these things day in and day out. The courts then will be running institutions. The courts do not want it. The HEW does not want it. Justice really does not want it, in many instances. Certainly the States do not want it.

We have problems. All we are saying is that if there is going to be a statute that addresses itself to this problem, then let us have a meaningful one. Let us have one where the Justice Department must come in and sit down and say that "This is what the problem is and that this is what we see is wrong, and we will give you 6 months or a year to correct those conditions, and if you do not, we will go in and take action in the courts."

This is an open-ended bill.

Senator BAYH. I think the thrust of this is to try to get the kind of cooperation that often makes sense. The Attorney General said in Indianapolis in addressing your national convention, that he would not utilize the power given under this bill until all efforts to achieve voluntary compliance by the States had failed.

I see no reason not to put that kind of test in the bill to require this effort be made.

But let me ask you this, Mr. attorney general.

Suppose somebody in the *Solomon* case had brought suit against the State of Maryland or had gone into the Federal district court and sued the State of Maryland. Who would you have been representing in that case? The patient, the inmate, or the State of Maryland?

Mr. BURCH. The State of Maryland.

Senator BAYH. You would have been fulfilling your constitutional obligation?

Mr. BURCH. That is right.

Senator BAYH. You and other attorneys general are in a decided conflict of interest.

Mr. BURCH. I have been attorney general for 11 years now. I have worked with attorneys general throughout the United States for 11 years. I will tell you that we are in a much more enlighted age in the area of administration of State government over the past 4, 5, or 6 years than we have been in all the other prior times in the history of this country.

I can tell you the difference between the attorney general today in the States and the attorneys general of yesteryear. It is an entirely different breed.

They are determined to go out and do that which is necessary to protect the constitutional rights of all of the people, whether they be mentally retarded or whether they be in hospitals or whether they be prisoners, or whoever they be. I can tell you that.

Senator BAYH. I am not about to urge you to do this, because you are wise enough to do it. We have had horror stories brought to us that exist today that did not exist 10 or 20 years ago. I would hate to see you, or any other conscientious public official, which you are, get yourself in a position that really there is no need for.

The fact of the matter is that we had a Federal judge just now who told us that if it had not been for the intervention of the Federal Government, they would not be providing relief for the patients of the Lima Hospital in Ohio.

Mr. Burch. Let me read to you from Judge Northrup's opinion. It gets to the heart of what you are saying. First of all, it refers to 42 U.S.C., section 60008, which are regulations giving the Secretary of HEW the right to promulgate regulations. It goes on to say, "A State's funds may be discontinued after notice and opportunity for hearing, if the Secretary finds that the standards prescribed by the regulations are no longer being met."

Those are the qualitative standards as to whether there is proper care given in the mental institutions.

Senator Bayh. You just pointed out to this committee that you are suing HEW now because you do not agree with their position.

Mr. Burch. Only because of the arbitrary action.

Senator Bayh. That is your judgment, but you have a conflict there where you make that judgment.

Mr. Burch. I cannot believe, Senator, that you would believe that the Justice Department should have the right to move in and deprive the States of their rights, simply because of capricious or arbitrary action they may want to take. That would be an abominable theory of government.

Senator Bayh. I do not think we are really that far apart in our theories of government, but I also do not believe that when you, as an attorney general, are in a position of defending a State in a suit brought by institutionalized persons who feel they are being abused by the State that you can adequately represent their side of this.

The HEW question is a good one. You refer to what the Judge says, that the real way to do this is to let HEW make the decision. Yet, in another unrelated instance where HEW made the decision, you are suing HEW because you think their judgment was capricious.

Senator Hatch. That was not the point, as I understood it. The one I understood was that you feel there are conflicting agencies here.

Mr. Burch. That is the point I was trying to make.

Senator Hatch. The point is this. I know areas in government and business where you have as many as 30 agencies vying to try to tell you what to do. What you want to do is prevent that.

In other words, if we are going to have this bill, then we have to get HEW out of it and let the Attorney General handle it.

Senator Bayh. No. The Attorney General is relying on the judges saying, "The way to handle this is to have HEW cut off funds." That is not the way to handle it.

Mr. Burch. Senator, you did not let me finish the quote. Senator Hatch is correct, because the balance of the quote gives it. I was giving you the preparatory remarks.

The balance of the quote is, "The court simply cannot believe that Congress intended or expected that while an elaborate plan to improve the lot of the mentally retarded was being implemented by the one Federal agency," the Department of Health, Education, and Welfare, "with expertise in the field of mental retardation, another government agency," the Department of Justice "with no expertise in the solution of the very difficult problems posed by mental retardation would simultaneously be making wholesale attacks on a State's mental retardation programs under the guise of protecting 13th and 14th amendment rights."

I do not believe you want it. I do not believe the people want it. I know the States do not want it. They do not want HEW coming in with their expertise and saying one thing and the Department of Justice, with no expertise whatsoever, coming in and saying something else.

Whether you like it or not, if this bill passes, and if the Department of Justice files suit, we are going to be in court and we will waste a lot of the taxpayers' money and a lot of the people's time and a lot of our time and a lot of the Department of Justice's time.

Senator BAYH. Was HEW involved in the *Solomon* case?

Mr. BURCH. I do not believe they were. I do not believe they have given us any indication that we have not met the criteria established under the regulations.

Senator BAYH. Let us get the facts straight. You are familiar with them. I am not.

At the time that the Justice Department got involved, was HEW involved in what was going on in Rosewood?

Mr. BURCH. They were not involved with Justice and the actions that the Justice Department took, but they were familiar with Rosewood, if that is what you mean.

Senator BAYH. Were they trying to get the State mental health people to upgrade their standards? Had there been any effort to try to cut off funds there?

Mr. BURCH. Mr. Nilson tells me they were not trying to cut off funds, but they were working with us in saying that "in these areas you ought to have this and that improvement", but they never threatened to cut off funds.

But they were satisfied we were making progress in trying to correct the situation. They saw them as they existed. But we do not need another proliferation of governmental agencies telling us what to do. It will end up by hurting the people that it is intended to help. This is our point.

If the Congress of the United States wants to pass a bill such as this, and if it wants to do it in a responsible manner and give the States a reasonable opportunity to correct matters without an open-ended bill which says that a man can call you on the telephone and do what they did to us when they came in the *Solomon* case and simply notify you they are going to file suit tomorrow.

Senator BAYH. I certainly think there should be every effort expended to try to get the States to move. Theoretically the States ought to be aware of this problem and ought to be resolving it before the Federal Government ever gets involved.

So, I think that point is well taken.

But, I think it would not be totally accurate to paint a picture in which all States are rushing out there to solve these problems, because all States are not. It is not that they do not want to. They have a conflict with spending moneys. We all know that. But sooner or later there has to be somebody who says, "All right, there are some significant constitutional rights that are being violated here and you have to shape up."

Mr. BURCH. The HEW does that. In today's age, you might as well forget it if you do not think that the Federal Government and HEW

does not have a lot to say as to how these institutions are run. So much of the funds that are being used to support those institutions are Federal funds. One of the conditions under which those Federal funds are received is that we comply with the standards that they lay down. They are really running the institutions indirectly as it now exists.

If the matter reaches a point where they are going to cut off those funds, then they will go in and we will end up in court. So we will end up in court either way.

But we do not need somebody coming in and telling us to do something when they do not know what they are doing. The Justice Department is not an expert in the care of the mentally ill.

Senator BAYH. We had a Federal judge here half an hour ago who said the Department of Justice made a significant contribution and had great expertise and was able to get at records that had not been made available to any of the complainants.

Senator HATCH. In all honesty, Senator Bayh, what he meant was that they had greater legal expertise in getting the legal problems resolved and in getting the case moving. That does not mean what the Attorney General says, that is, that they are not health experts.

Senator BAYH. The judge said they got experts and made them available to the court and this had not been made available prior to that time.

Senator HATCH. I believe he said that. That is true.

Mr. BURCH. They also came in in a vigilante fashion in Maryland.

Senator BAYH. I would be very incensed, if I were you, and you are incensed, if the first notice I got of this was a call saying that I was supposed to be in court at 11 o'clock this morning.

I want to find out about this. We will dig into the *Solomon* case. Apparently this was not the first time the State of Maryland was aware you had problems out there. HEW had made those problems apparent to the mental health people.

The question I would like to find out from HEW is this. It seems to me that a legitimate question to ask those people is: Had you reached an impasse with the Maryland mental health people and had you then said to the Department of Justice, "It is important for you to intervene?"

Otherwise, the right and left hand do not speak to each other.

Mr. BURCH. The Executive Committee of the National Association of Attorneys General met in March with the Chief General Counsel of HEW, Peter Libassi. What we tried to tell him was this. You are dealing so many times with the middle layer people that you do not get in touch with the Attorney General so the Attorney General has an opportunity truly to advise the department head what he is required to do and not required to do under Federal statutes and the Federal Constitution.

We think we have arrived at a resolution of that problem for greater communication.

I will tell you, sir, that at no point in time, did HEW ever say to the Department of Mental Health and Hygiene, insofar as our knowledge is concerned, that you have to do this, that or the other thing and an impasse was reached.

Their attorneys were involved and as a matter of ethics, they should have sat in then with us as the Attorney General. If the Federal Government is going to run the Government this way and refuse to communicate with the State officials, who are their counterparts at the State level, then we have no hope for solving these very, very difficult and intricate problems that we have in the country today.

All I say is that it did not happen. As far as our office was concerned, it did not happen. Had an impasse been reached, I personally have a policy that whenever we have a matter of this import, I will sit in and do the negotiating, if necessary, to try to resolve the problems in order to see that things are done.

I have one final thing I would like to say.

You mentioned that the statute would not be abused. My simple answer to that is the same thing that I get when every member of the legislature says, "I do not want to give this power to the Attorney General, not that I have anything to worry about with him, because I know he is an honest man and I know that he acts responsibly, but I do not know who is going to come after him."

The truth of the matter is that the Attorney General, in the Federal orbit, does not have control over all of the actions that take place within his departments. It is too vast and too intricate. You know it and I know it. I remember Attorney General Levi told me that he could tell his subordinates what to do but if they do not do it, there is nothing he could do about it.

That is the way the Department of Justice has been run in the past. I am not saying it will be run that way in the future because I have the greatest respect for Judge Bell. He has done a tremendous job. I am sure he will continue to do so, but I do not know who is going to come after him and I do not know what the middle layer people in the Department of Justice will be doing, because the Attorney General himself is not going to be able to make each of these decisions.

Senator BAYH. You mentioned the Maryland advocacy program. Has that been implemented yet?

Mr. BURCH. It is on the threshold.

Senator BAYH. What authority is given this advocacy agency?

Mr. NILSON. Senator, the final terms of the advocacy program are just now being completed. I am not sure exactly how that is going to come out, but my understanding is that they will be given full ability to litigate both in administrative proceedings and in court proceedings and to represent patients and inmates.

Admittedly, this advocacy does not reach all of the kinds of institutions identified in your bill.

Senator BAYH. Do we know how much money is going to be budgeted for them to function?

Mr. BURCH. That probably has not been budgeted as of yet. It probably will be budgeted either by an emergency appropriation through the Board of Public Works or at the next session of the legislature in January.

Senator BAYH. I appreciate your giving us your thoughts on this. I think it is important for us to structure whatever we do here in a way that can use the power, the prestige, or indeed the threat of Justice Department involvement in a way that will get the States to

use maximum haste in resolving these problems themselves. I am glad to have any thoughts from you as to how we can word this. You had an opportunity to see things go awry.

The real concern I have is this: those of you who are upholding your constitutional authority are really in a conflict of interest situation. When you come to an impasse, and we have some examples of that, it is much easier to move in the area of constitutional rights for the mentally ill than it is in the area of prisoners. Society just sets different standards and understandably so.

But, where you have an impasse between the Federal court, let us say, or the plan that has been laid down even by HEW sometimes, and where the State just refuses to follow out the order, then there has to be some mechanism to bring in an outside force to deal with the conflict that a State attorney general has. His primary client, his sole client, really, is the State.

Senator Hatch?

Senator HATCH. As I understand it, Mr. Attorney General, you have listed four or five points. One is States rights. You feel like the States are more enlightened today and that they can take care of a lot of these problems, especially in consideration with your second point, which is that if they are given advance notice, and 6 months to 1 year lead time, they will correct bad conditions which are there because most conditions arise either out of a lack of funding or oversight or some other problems.

We have heard some significant abuses here. These are isolated situations. I think you will certainly not find that in every State, but in many, many cases. There are many States involved here because of what you are talking about.

Sometimes these isolated cases of severe abuse really need to be curtailed. All abuse needs to be curtailed, but they really are flagrant. We have heard some of those.

Your third point, it seems to me, was this. Outside of the protection of State's rights and the need for a grace period of 6 months to 1 year, so that the States can do something about it without the necessity of going to court, and having all the congestion that comes from that and the expense from that, and the bitterness and acrimony that comes from court litigation.

But then you indicated that you are concerned about the prospect for the award of money damages, citing the 11th amendment which, of course, would prevent money damages against the State. But if the Federal Government is going to seek money damages against the individual guard or attendant or nurse, or whatever it is, then that could be an overwhelming problem to whomever is involved.

Last, but not least, you want to have a more clear-cut delineation concerning the circumstances justifying a particular suit. You want to have more notice of what is going on here.

I commend you for going through this carefully enough to point out those inadequacies because those are inadequate aspects of the bill. I think the States will clean up abuses. If they do not, maybe we need the Attorney General to come in to see that they do.

The points that you made, I think are well taken. I am concerned also about allowing the Federal Government another right to come

in and harrass the people in the various States. There are going to be complaints, millions of complaints immediately from people in mental institutions, for instance, and I think we will see many, many complaints in penal institutions as well.

Those are not going to be ideal places, no matter what we do. So, we have to hit a happy medium here. If we just go all the way in a broad-based bill to where we are bringing a suit everytime somebody makes a complaint—that is not what Senator Bayh or I want—but you are afraid it is going to happen.

Mr. BURCH. I am afraid the bill does it.

Senator HATCH. I think you are right. I think the bill is broadly drafted.

Mr. BURCH. It is open-ended and we will have nothing but a rash of suits depending on who wants to go after somebody.

Senator BAYH. The purpose of these hearings is to perfect the bill.

Senator HATCH. I think he has pointed out five pretty good ways that we could perfect the bill.

You are not particularly against the Justice Department having a right, after certain cautionary, and you might say, justification is proven, to come in and clean up a mess that a State is unwilling to clean up; are you?

Mr. BURCH. That is correct.

Senator HATCH. What you are saying is that we should not jump into this thing without some reasonable grace period and some reasonable approach to get the States to take care of it.

Yesterday we passed an amendment to the HEW labor bill on the floor of the Senate that requires OSHA, instead of coming in and issuing fines when nobody knows what the rules and regulations are, OSHA now, according to this amendment, if it is formally approved through the legislative process, has to give notice and a reasonable time to correct.

You are suggesting that maybe that is not the worst approach here and that we at least ought to have some reasonable approach that does not get us embroiled in a quagmire of litigation which ties up the courts and the Attorney General's time from other things that may be equally, if not more, important than problems which should be resolved by local governments.

Of course, this would prevent the excessive expenses that comes from that type of litigation.

I think your comments are good. I think both Senator Bayh and I, and other members of the committee, will give great weight to them. You have been through this pain. I agree. I have had to defend a few cases where the Federal Government has jumped in and really, because of some over-zealous advocate or some over-zealous prosecutor, has prosecuted some very innocent people.

After those people are dead financially and can never come back and they are broken emotionally, it is nice to say, "Well, they were vindicated by a jury." Sometimes they are not even vindicated by a jury.

I think you have brought some very important things here. I think you are a heck of an advocate. We will take into consideration everything that you have brought out here today.

Thank you.

Mr. BURCH. Senator, may I be excused? I have to get on the road?

Senator BAYH. Of course.

Senator HATCH. I hope you do not get this excited on all matters that come before you. I hope it is just the Federal Government and the State relationship that gets you this excited.

Mr. BURCH. I always get excited about everything I do. [Laughter.]

Senator HATCH. I want to keep you around for a few years. You sound like a good man. [Laughter.]

Mr. BURCH. Thank you.

[The prepared statement of the Prisoner Assistance Project of the Baltimore Legal Aid Bureau subsequently submitted was marked "Exhibit No. 24" and is as follows:]

[EXHIBIT No. 24]

PREPARED STATEMENT OF THE PRISONER ASSISTANCE PROJECT OF THE BALTIMORE LEGAL AID BUREAU, INC.

The Prisoner Assistance Project of the Baltimore Legal Aid Bureau, Inc., provides free legal assistance in civil cases to Maryland prisoners who are unable to retain legal counsel. The Project has been and is involved in many important cases concerning the rights of prisoners.

The Prisoner Assistance Project supports S. 1393 for two reasons. First, the limited resources of the Project prevent representation in many meritorious. cases. Involvement in civil rights cases by the United States Attorney General could provide this necessary representation. Secondly, the absence of an "exhaustion" requirement in civil rights cases is essential. The experience in Maryland with an "administrative remedy" has been one of abject futility.

Prisoner assistance project resources.—In excess of 8,000 convicted prisoners are currently incarcerated in the Maryland penal institutions. Aside from the few court-appointed attorneys throughout the State, the staff of the Prisoner Assistance Project is the only law office available to represent the interests of prisoners in civil rights cases. However, the staff of the Project has only three attorneys to challenge all violations of the 8,000 prisoners' constitutional rights.

The Project's only source of funding is the Baltimore Legal Aid Bureau, Inc. Baltimore Legal Aid money must be divided among the several specialty units, including housing, domestic, welfare, mental health, etc. As the overall Legal Aid budget is reduced, so too is that of the Prisoner Assistance Project.

The Project currently operates with a maximum caseload. In addition to the cases pending in State and Federal courts, we have received up to 200 requests in a month from prisoners for assistance. However, the Project is able to accept only the cases of an emergency or serious nature. For example, during the month of May, 1977, the Project received 161 requests for assistance from prisoners. Of those only 13 requests were assigned to an attorney or paralegal for aid.

There are numerous violations in the Maryland prisons which reach unconstitutional proportions. However, the Prisoner Assistance Project is forced to choose only the most outrageous or reprehensible violations for purposes of litigation.

An example of such a violation would be the inadequate medical care in the Maryland prisons. Approximately 25 percent of the prisoners' requests for assistance are medically-related. Prisoners encounter a wide range of obstacles in obtaining medical care. Many prison guards, without any medical training whatsoever, often arbitrarily screen out medical complaints, and refuse to issue the necessary "pass" for sick-call. Frequently, prisoners complain that many of the nurses treat them rudely, assume they are malingerers, and regularly prevent them from seeing the doctors. Some nurses have even been known to countermand or ignore a doctor's order, prescription or treatment.

Some prisoners have had to wait up to 2 years for surgery if it is diagnosed as being of a "non-emergency" nature, e.g. hernias, orthopedic problems. The long delay is partially due to the fact that the University of Maryland hospital, where surgery is performed, has only an 8–10 bed security ward. In addition, there are not proper facilities in the Maryland prisons to isolate prisoners with

contagious diseases, or to treat mentally retarded, geriatrics or psychologically disturbed prisoners.

There is no such thing as a "yearly" physical in the Maryland prison system. In fact, many prisoners complain that the doctors do not work full-time even though they draw a full-time salary. Indeed, the doctors are actually present at the institutions only a few hours a week.

Recently, a prison doctor was hired to work at the Maryland Penitentiary who diagnosed and treated many prisoners. He was later exposed to be operating under an assumed name, and in fact was not a doctor at all. As a result, many prisoners treated by this "doctor" are suffering from very serious illnesses and side effects.

The obvious solution is a statewide civil rights suit challenging the pattern and practice of the medical system in Maryland as inadequate and unconstitutional. Unfortunately, that necessary medical suit could take up to 5 years to litigate, and would involve such complicated discovery and fact gathering as to deplete the financial and staff recources of the Project. As a result, the Project has decided not to file the medical suit and is now forced to resolve these problems on a case-by-case basis.

The medical situation is but one example of unconstitutional patterns and practices in Maryland which must go unredressed. It is essential that the United States Attorney General become involved in civil actions to redress such unconstitutional deprivations. The United States Attorney General has a larger legal staff, a broader discovery and investigative staff, more financial resources and unlimited access to agency expertise. With the assistance of the Attorney General, many more system-wide violations of constitutional rights could be challenged.

Absence of an "exhaustion" requirement.—The State of Maryland has had an "administrative remedy" in the form of the Inmate Grievance Commission since 1971. In fact, it was the first grievance mechanism in the nation established to provide a forum for prisoners to file grievances against officials or employees of the Maryland prison system. However, the Maryland prisoners have found the Commission to be virtually useless and ineffective in resolving grievances.

Ideally, a grievance mechanism should be independent from the prison system which is the source of the prisoners' complaints. This is not the case with the Maryland Inmate Grievance Commission. The Secretary of the Department of Public Safety and Correctional Services, who ultimately reviews the Commission's decisions, is also responsible for the operation of the Maryland prison system. In fact, the Secretary frequently consults with the Wardens of the prisons on an *ex parte* basis prior to affirming or reversing the Commission's decisions. The prison system and the Commission are far from independent.

In terms of relief, this Commission is far too limited. The Commission is not able to award money damages. Although the Commission can order injunctive relief, it has no enforcement powers and the prison officials often do not obey Commission orders voluntarily.

The hearings before the Commission often last only a few minutes. Clarity of procedures is sacrificed for the sake of informality and the result is a chaotic and confusing hearing with all talking at once.

An analysis of past decisions of the Inmate Grievance Commission provides compelling evidence of its inadequacy as a remedy for Maryland prisoners and shows that an exhaustion requirement would not result in any benefit to the federal district courts. Only a small number of the total complaints received by the Commission are granted hearings. The Commission's statistics indicate that 63.6 percent of the complaints are dismissed without a hearing:

	Complaints received	Administrative dismissals without hearings
October 1975	90	47
November 1975	107	46
December 1975	104	59
January 1976	87	54
February 1976	85	90
March 1976	134	90
Total	607	386

In addition, during the period from January, 1976 through April 13, 1976, the Commission issued decisions in 145 cases in which the prisoners were granted hearings. The dispositions were as follows:

Meritorious	17
Meritorious in part	4
Not meritorious	119
Dismissed as moot	5
Total	145

In reviewing those dispositions where the Commission found the complaint to be wholly or partially meritorious, the Secretary made the following decisions:

Affirmed	4
Modified	4
Reversed	12
Moot	1
Total	21

In short, of the 145 cases heard by the Commission, relief was finally granted to only 4 prisoners. (2.8 percent).

To summarize, the Commission dismisses without a hearing about 64 percent of all complaints received. Relief is granted in about 3 percent of the remaining 36 percent. For every 100 complaints made to the Commission, relief is granted to one prisoner.

The Inmate Grievance Commission is also inadequate as an administrative remedy for purposes of an exhaustion requirement because of the excessive amount of time a prisoner must spend in having a complaint decided by the Commission. During the period from January 1, 1976 through April 13, 1976, the median time a prisoner waited for a final decision on his or her grievance was 17 weeks.

Week of final decision:[1]	*Number of decisions issued*	*Week of final decision:*[1]	*Number of decisions issued*
1–7	0	19	13
8	1	20	10
9	2	21	3
10	1	22	2
11	2	23	2
12	3	24	3
13	9	25	1
14	10	26	2
15	5	27–29	0
16	15	30	1
17	14	31–34	0
18	11	35	1

[1] The Week of Final Decision is the week in which the final decision was made after a complaint was initially received by the Commission. For example, the case of the prisoner Duryea Johnson, I.G.C. No. 3946, the Commission received a letter of complaint on November 24, 1975, and issued a decision on March 26, 1976, granting partial relief to Mr. Johnson. On April 5, 1976, the Secretary reversed the Commission's decision. The final decision in Mr. Johnson's case, therefore, came in the 19th week of after the Commission received his complaint.

Over a three year period, from July 1, 1971 to June 30, 1974, the Maryland Inmate Grievance Commission received a total of 1,680 complaints. The final result was that only 191 of the complaints were found meritorious. Most recently, from April, 1976 to May, 1977, the Commission received a total of 1,105 complaints and found only 121 of those to be meritorious.

Therefore, a prisoner filing his or her constitutional claim with the Inmate Grievance Commission has only a remote possibility of being granted relief, and it is likely that he or she will have to wait 4 months for the Commission's decision. An exhaustion requirement would needlessly delay, for an excessive period of time, the prisoner's right to proceed in federal court.

The unconsitutional conditions in the Maryland prisons are fast reaching a crisis situation. The need for prompt and thorough resolution is immediate. Therefore, we strongly urge this Committee to accept S. 1393 in its present form.

Senator BAYH. It is important to point out here that this bill is really not designed to reach a standard of really good treatment in these institutions. Unfortunately, we are not able to do that.

The thrust here is to try to make sure that our institutions at least maintain minimum standards, realizing the competition that exists for resources.

We are hopeful that we can word this in such a way that when the attorney general does get involved, he can expedite the process and not exacerbate it. I want to look more carefully into this Rosewood situation. It sounds like we have a case of the right hand not knowing what the left hand is doing, which is not unique.

Senator HATCH. This is what irritates everybody in State government because once the Federal Government gets in and we pass laws and there are some inconsistencies in some of the agencies who interpret their powers differently. All of a sudden we are embroiled in a situation that nobody likes. We have overzealous people in the Federal Government who are basically oppressive. I think the points are well taken. I know you and I are certainly together on this.

Senator BAYH. I think we are a lot closer to agreement than the dialog her might lead one to believe. In fact, there is a case now involving a plaintiff by the name of Battle, out in Oklahoma, where the Federal judge has cited five specific instances where the State has been in contempt of a court order and has absolutely refused to do what it was required to do.

A State attorney general will earn his money battling for the State. That is the responsibility he has.

Well, let us move on.

Mr. Hansen, we welcome you.

Mr. HANSEN. I will defer to my colleague from Nebraska and Mr. Marvin from the National Association of Attorney Generals before I make my statement.

Senator BAYH. That will be fine.

Mr. Kammerlohr, I appreciate your being here. I am sorry that the attorney general could not be here. I do not know how much notice he got. The statement looks like he did not get any notice.

I would like to suggest that I think it was on June 6 that we asked the National Association of Attorney Generals to be represented and how you were chosen. We understand that your boss wanted to be here. We sort of left it up to the national association to determine who could be here. If it was inconvenient, we are sorry.

TESTIMONY OF MEL KAMMERLOHR, ASSISTANT ATTORNEY GENERAL, STATE OF NEBRASKA

Mr. KAMMERLOHR. I am sorry, too. He did not actually get notice that he was invited to appear until June 22. However, be that as it may, we did get a statement and I hope you have copies of Attorney General Douglas' statement.

Senator BAYH. Yes. I hope you will mention to him that the first effort that this committe made was on June 6, not June 22. That would have been awfully short notice. Eight days is not very long.

Mr. KAMMERLOHR. As we said, we would have probably been able to document a statement a little more. However, I think you have the

main points in there that we wanted to bring out. I will not read the entire statement. I am just here to try to represent Attorney General Douglas. If I can answer any questions or anything I would be glad to.

I would like to point out a few of the highlights of his statement.

Senator BAYH. Without objection, Attorney General Douglas' statement will appear in the record.

Mr. KAMMERLOHR. I think all responsible people would agree on the horribles that have been presented here that are always pointed out in the various State institutions. If there is some way of solving them, I think we all want to solve those kinds of conditions. But this really does not get down to the problem of what our experience has been with the U.S. Justice Department. They may come in, alleging these horrible conditions, but the Justice Department does not want to stop there.

This bill would not set any guidelines. It merely refers to constitutional and legal rights. No one really knows right now how far that goes. Does that mean the worst type of conditions? Or, does this refer to the highest and most ultimate type of conditions that could be afforded to, let us say, mentally ill or mentally retarded people.

Senator BAYH. We all know as lawyers that constitutional rights are often described by those nine men in robes across the street here. We do not know exactly what those rights are going to be. They could be different tomorrow from what they were yesterday. That is the process.

As of right now, I think it is fair to say that they themselves have said that they do not know exactly what the Constitution gives residents of mental institutions, but at least it entitles the patients to some kind of treatment which is more than nothing. Unfortunately in most of these instances, the patients would be better off if they were left out in the field someplace. We get the horror stories and that is the kind of abuse we are trying to avoid.

Mr. KAMMERLOHR. We agree with you. I think everyone would agree that these horror stories should be eliminated, but this has not been the experience of most of the States that have been involvd with the U.S. Justice Department.

For example, the case they intervened in in Nebraska, one of the primary thrusts is not what is going on in the institution, but to get people out into the community programs—which we do have a very advanced program on.

I have a chart here [indicating] entitled "Table VI" from a booklet entitled, "Trends in State Services to the Mentally Retarded: A Survey Report" by Robert N. Gettings, National Association of Coordinators of State Programs for the Mentally Retarded.

This shows the move from institutions for the mentally retarded into the community programs from the period of July 1970 to January 1975, which is a little over 5 years.

This chart has Nebraska No. 1 in the United States with a movement of 43.1 percent from the resident population in the retarded institution into community programs.

Yet, the Federal Government intervened in 1975, after the period covered above, in the State of Nebraska, with this as one of their primary thrusts, which was to move more people.

Whereas, some States increased during that period, including the State of Georgia, by 91.4 percent. They increased. I am talking about the State retarded institutions.

No action is pending in the State of Georgia. I believe they did try to bring one, that is, someone tried to bring one there. I do not know if it was the Justice Department, but there were a lot of other States where the Justice Department had not brought them, with much worse records on decreasing institution population.

This brings up the question. What are the rights that they are trying to protect? How do we delineate them? Also, how are we going to pick which State to sue? Are they going to pick the worst or best one or try to set an example or what are they doing? We do not know.

Senator BAYH. I appreciate the chance to have this kind of dialog because what I would like to see—and maybe I am too idealistic and I do not think this is necessarily what will happen when we pass this legislation—is that the States—by their own initiative—would assume these responsibilities. I have been in the State legislature. I know the competition for resources. Ultimately it depends on where you want to spend the money. Too often you shut these people off in institutions and forget about them. I know how that happens.

But what we are trying to do is to create a working relationship where Justice, by its intervention, can help deal with the most critical problems that the States cannot take care of themselves.

The situation that the attorney general is in right now is that he is at the mercy of individual plaintiffs out there. It is impossible for the Justice Department, under the *Solomon* rule, to select those institutions where the worst abuses may exist.

As it is, the department is forced to rely on intervention in pending suits. This is not to say the conditions in those cases are not bad. In fact, to my knowledge, the Justice Department has always won these cases. When they have gotten involved, the situation has been so bad that the court has ruled that the problem needs to be resolved.

But one of the things that I think this bill, if we go at it properly, can do is to permit the Attorney General to pick and choose, not an hour's ride from the courthouse, but where you have the most critical problems. That way their intervention can help the most people with the least litigation and have the greatest impact.

Now the Justice Department cannot do that. They can only respond to a plaintiff who initiates suit.

Excuse me; I interrupted you.

Mr. KAMMERLOHR. That is true. Even with negotiations you have this problem however, of how ideal must the conditions be that the State must provide—the bill only refers to rights which have never been legally defined. In the prior discussion, someone said that maybe the Justice Department should come in and give the State a year's warning or 6 month's warning to remedy something.

All right, everybody can agree that certain horribles could be remedied if they gave us notice. But what about the other things? The Justice Department says what constitutional rights are under this bill. Does it mean the highest form of training, let us say, for the retarded? Does it mean they are entitled to the best vocational

training, no matter what their level of retardation? Does it mean, let us say, reasonable medical care? What does it mean. We do not know.

You will never be able to resolve those by negotiation without guidelines or restrictions on the standard of care involved.

The Justice Department—the experience has been this: the Justice Department wants the States to provide the highest form of care once they come in? You were in the State legislature. You know again that the States cannot possibly finance the highest form for which everybody happens to be complaining. We would like to.

Even Congress does not know what the public is entitled to in the way of national health or housing programs. These things are being argued here daily.

Senator BAYH. May I ask you this, sir?

In the study that you pointed out showing the movement toward deinstitutionalization, was any effort made to study the effect—if any —that Federal court involvement had on the State's decision to move in this direction?

Mr. KAMMERLOHR. That was not the case as far as movement of patients.

Senator BAYH. If we look at *Willowbrooke*, there was nothing being done before the suit was brought, and after the court got involved there was a negotiated settlement where a lot of people were moved out of the institution into better placements.

Mr. KAMMERLOHR. It was not true in this case. In Nebraska we moved almost 50 percent of the population before the Federal Government intervened in the lawsuit. A large number of people had been moved. This is my point.

The U.S. Justice Department has not been merely concerned with the types of things that you are talking about as the horrible situations.

If they get in a particular case, they keep fighting for the ultimate in that particular area to the exclusion of others, let us say, if they are in mental retardation, they are not concerned about crippled children, dependent children, blind persons, or any of these things. All they are concerned with is that one area in which they might be involved.

They complained about the distribution of title XX funds. They spent weeks investigating and taking testimony on the distribution of these funds in Nebraska. They complained because we did not give more title XX money for the retarded. I asked if the people in the Justice Department are concerned about the blind and other categories who are also entitled to title XX funds. They would not answer me. All they would say, "This suit is about the retarded."

These are the kinds of things we are concerned about.

Your intention may be good, but there is no limitation in this bill to restrict the Justice Department from this activity. These are past experiences.

I have one more point. I hate to keep harping on it.

Senator BAYH. Harp on it.

Mr. KAMMERLOHR. There is no real remedy as a practical matter. When you get into Federal court and you try to do everything you

can and the Federal judge makes an order, then you have this. You might have an agreement. Our Governor wanted to try to do the same things the Federal Government is talking about. There is no way that you can require the State legislature to come up with the funds. They may either not be able to come up with the funds, or they may not do it. But either way the only ultimate sanction that I know of is for the Federal courts to close down the institution involved if it does not comply with what the Federal judges want.

That would not do anybody any good. So this brings up another question. Maybe each State eventually will have to get out of the institution business altogether.

I cite you a case in my report from the U.S. Court of Appeals in the Eighth Circuit where they sent back a Minnesota case, *Welsch* v. *Likins*. In that particular case the court of appeals agreed with all the things the Federal district court had ordered; but the legislature in Minnesota was in session, which was just this last session, and the court said they would send it back and see what the legislature is going to do. Maybe they would get out of the business of retarded institutions altogether and maybe reduce the number of hospitals so that staffing ratios would be better in some.

But the court said ultimately that Minnesota or the court may close them. The court said, "We will give them a chance to see what they are going to do." I do not know what the Minnesota legislature has done, but this is the type of problem we have as far as the ultimate sanction is concerned.

I also agree with attorney general Burch that the States do have problems with coordination as far as HEW and the Justice Department is concerned.

HEW may be telling us to do certain things in our State institutions if we expect to get Federal funds, which we are very dependent upon.

Whereas, at the same time, the Justice Department is taking an entirely different approach and saying, "If you spend any more money at that institution rather than move those people out into the community, then you are violating the court order."

So, they give you Hell if you do and Hell if you do not, if you will pardon the expression.

Senator BAYH. Is it not conceivable that there are institutionalized structures where the very nature of the institutionalized defies a reasonable approach to treatment, not only at the optimal level, but even at the minimal level? And, also, that the court, in taking into consideration expertise that neither the Congress nor the Justice Department has, hears experts in the area who can generally say, "OK, this is a minimal standard; we are not going to reach the ultimate standard, but only minimal standards"; but that even these standards cannot be reached as long as you have this institutionalized structure? Thus, you have to deal with the institutionalized structure if you are ever going to reach minimal treatment. Is that not fair to say?

It seems to me that *Wyatt* and *Willowbrooke* are probably two pretty good examples of that because when the court did get involved there, they did change the institutional structure. The State legislatures did appropriate more money.

Mr. KAMMERLOHR. As far as we are concerned, we would be more than happy to see better than the minimal enforced. But I still think that it is a problem with the Justice Department because it wants to bring in its outside experts and get all it can, or whereas the Justice Department is going to have to work with HEW to reach a workable solution and then with the States to work these standards out.

As I said, the ultimate enforcement is of litigation closing the State institutions which does not help anyone.

I had better close for now. I am taking Mr. Hansen's time. I did not really mean to take as much of the committee's time.

I thank you very much.

Senator BAYH. I appreciate your being here. We appreciate attorney general Douglas' interest in this.

I was going to mention this to attorney general Burch, but let me say this: You get into a situation where you have various interests competing for State funds. The remedy of HEW saying, "We are going to cut off our funds," is an alternative that only makes matters worse.

[The prepared statement of attorney general Paul L. Douglas was marked "Exhibit No. 25" and is as follows:]

[EXHIBIT No. 25]

PREPARED STATEMENT OF PAUL L. DOUGLAS, ATTORNEY GENERAL OF THE STATE OF NEBRASKA

JUNE 27, 1977.

Re S. 1393.

Mr. Chairman, members of the committee, before giving my comments on Senate Bill 1393, I wish to emphasize that I did not receive Senator Bayh's letter, inviting me to appear here and to submit comments, until June 22, 1977. Because of the shortness of time allowed me, I have not been able to express or document my remarks as fully as I would like. Neither will I be able to attend the hearing to be held on June 30 because of prior commitments which are too late to change. However, I submit the following remarks for the subcommittee members and will send Mr. Mel Kammerlohr, Assistant Attorney General of Nebraska, to be present at your subcommittee meeting to answer questions of the members. Mr. Kammerlohr has had considerable experience in both advising our administrators of state institutions and in federal litigation involving state institutions.

COMMENTS ON S. 1393

The real issues, pro and con, on the above bill do not involve the protection of the constitutional rights of persons in state institutions. I consider myself, and persons with whom I have come in contact in administration of the state institutions of the State of Nebraska, as much concerned with the protection of the constitutional and other legal rights of persons in our institutions as anyone, including the staff of the United States Department of Justice. The real issues involved, as I see them, are how may these constitutional and legal rights best be identified and protected commensurate wtih the constitutional rights of the public generally.

On these questions, I would first point out that except for prison cases by inmates, no United States Supreme Court decision concerning or delineating any constitutional right to treatment has yet been decided. The only case thus far, touching only tangentially, is that of *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975), which held that a nondangerous mentally ill person not receiving treatment must be released from custody if he has a satisfactory place to go.

If the levels, techniques, gradations, goals, etc. of treatment have not even been determined, the question arises, how is the United States Justice Department to determine that constitutional rights of institutionalized persons are

being violated. Of course, there are certain conditions, such as those cited by Senator Bayh in the Congressional Record when introducing this bill, upon which all reasonable men would agree are violative of a person's constitutional or legal rights. However, experience demonstrates that the United States Justice Department has not and will not be restricted to such flagrant abuses as there depicted.

Once the United States Justice Department gets involved, on the grounds that minimal constitutional rights must be protected, their demands quickly turn to an all-out effort to secure a maximal, ideal program of services, minutely prescribed by their experts, costing millions in tax dollars to implement and resulting in lowered services to other citizen groups. (Witness New York State which has spent an additional 60 million dollars on mentally retarded programs over the past two years to implement the Willowbrook consent decree.)

Another problem with the approach to S. 1393, besides the United States Justice Department selecting standards it feels are constitutionally required, is the selection of the states against which it wishes to litigate. Does it pick what it considers the worst first, or does it pick the best first, or somewhere in between? The State of Nebraska, which is one of the leading states in the United States in providing community programs for mentally retarded and is first in the nation in percentage of persons transferred from its one state mental retarded institution into community programs, was selected by the United States Justice Department as a target for intervention in an exising case, and in which it has led litigation ever since, the primary objective of the case being the transfer of more persons to community programs. There are no guidelines as to which states have to suffer the high costs of manpower and money in defending these onslaughts. So, presumably, it is to be done at the sole discretion of the United States Justice Department (apparently in Nebraska to set precedent to show other states they had better fall into line).

In *United States v. Solomon*, 419 F.Supp. 358 (1976), one of the cases which held the Justice Department had no authority to bring such suits, and triggered, in part, this proposed legislation, the federal district court pointed out that the United States Congress has already taken a number of steps through the Department of HEW to improve state institutions, not only by providing funds, but also by delegation to a department with experts in the field. In this regard the court stated:

"This Court simply cannot believe that Congress intended or expected that while an elaborate plan to improve the lot of the mentally retarded was being implemented by the one federal agency (the Department of Health, Education & Welfare) with expertise in the field of mental retardation, another government agency (the Department of Justice) with no expertise in the solution of the very difficult problems posed by mental retardation would simultaneously be making wholesale attacks on a state's mental retardation programs under the guise of protecting thirteenth and fourteenth amendment rights. Surely, if Congress had wanted two agencies to be inovlved in ameliorating the states' efforts to help the mentally retarded, it would have at least provided some legislative guidance as to procedures for preventing the conflict and contradictory goals that can and do occur when two federal agencies independently act on the same matter."

In this vein, pending litigation with the Justice Department, of which I have personal knowledge, involves many conflicting and contradictory goals as between HEW and the U.S. Justice Department to the point that the states' compliance with standards of HEW in order to receive more federal funds is denounced by the Justice Department as a violation of what it deems to be the constitutional rights of the retarded. (One example: If the state expends matching funds to improve the living facilities at its one institution to meet the standards of HEW to qualify for large grants, the Justice Department claims these funds should be spent to better improve community facilities.)

Of course, when the approach of litigation is to be used, the federal judge must become the expert in whatever type of institution may be involved. He must be guided by the experts selected to testify for the Justice Department (who in the past have frequently been the same people) as opposed to the experts the state may present, often very limited by lack of funds. The Justice Department comes sweeping in with a battery of experienced attorneys, investigators, and all types of discovery methods gleaned from specialization in this one type of case, frequently to be opposed by attorneys for the state who have

never litigated these issues before. The result may be a heavily weighted presentation in favor of the U.S. Justice Department.

A federal district judge, in attempting to determine what are constitutional and legal rights of residents, has no legal guidelines to go by. The same is true as to finding solutions. Assuming the case before him is one involving mental health, in drafting orders he does not have to be concerned with the state's problems of funding programs for the mentally retarded, convicted criminals, persons with disabilities of all kinds, education problems, dependent children, etc.

An example of the tunnel vision which may result from litigation into one specific type of institution arose in litigation with the U.S. Justice Department involving the retarded in Nebraska. The Justice Department objected vigorously, even claiming that court orders had been violated, because of the allocation request of the Governor in the distribution of Title XX funds among the various categories of needy and disabled persons eligible for said funds. This, despite the fact that the retarded received, and had received for years, a much larger percentage of said funds than the ratio of retarded persons to the other eligible categories.

In this same regard, there are not only policy decisions which must be made as to the distribution of funds among persons entitled to categorical assistance, but very grave decisions must be made, as this Congress well knows, as to the entitlement to the national resources of all persons. For example, what is the level of housing or national health to which all citizens are entitled? Is everyone entitled to the ultimate in housing or medical care as a matter of constitutional right? Obviously, any one extreme in any one field such as mental health, mental retardation, etc., when carried to the highest standard, could exhaust all available state funds to the detriment of other goals and need groups.

Litigation will not solve these questions even as to the one particular field involved in the case. Should the U.S. Justice Department obtain an order from the federal court which requires the state to provide treatment of the highest standard, which is what it will seek, how is it enforced? Suppose the Legislature of the state cannot or will not comply because of too many other demands upon the limited funds of the state.

In the recent case of *Welsch v. Likins*, No. 76-1473 and No. 76-1797 (Mar. 1977), which involved the level of treatment to be provided in a state institution for the retarded in Minnesota (a case instituted by private individuals under the Civil Rights Act, 42 U.S.C. §1983, and injunctive relief under 28 U.S.C. §1343(3)), the United States Court of Appeals for the Eighth Circuit, while upholding the orders of the United States District Court requiring extensive changes in the staffing and other levels of treatment, recognized that the Minnesota Legislature was still the ultimate determiner of what was to be done. In this regard, the Court of Appeals stated:

"In this case we are dealing with the right of a sovereign state to manage and control its own financial affairs. No right of a state is entitled to greater respect by the federal courts than the state's right to determine how revenues should be raised and how and for what purposes public funds should be expended."

The court further recognized that if the State of Minnesota was going to operate institutions like the one involved, it must do so in a constitutional manner. The court then went on to recognize, however, that alternatives to such operation do exist, as follows:

"An extreme alternative would, of course, be the closing of the hospitals and the abandonment by the State of any program of institutional care and treatment for mental retardees. A lesser alternative might be the reduction in the number of hospitals. Or the Legislature and the Governor might decide to reduce by one means or another the populations of the respective institutions to a point where the hospitals would be staffed adequately and adequate treatment could be given to individual residents."

The case was then remanded to the district court to see what action the Governor and current (1977) Legislature, then in session, were going to take.

From the foregoing, it is obvious that the problem is not one which can be or should be attempted to be solved by litigation. The problem is primarily a financial one. Under litigation, the ultimate sanction of the courts, as pointed out above, presuming nothing else works, is closing the institutions. This re-

lieves the state legislatures from providing any facilities at all and is no solution for the patients or inmates involved.

A much more meaningful and desirable solution can and should be worked out between the states and the federal government. The level of standards which can practically and uniformly be reached in all states commensurate with availability of trained staff, money, and the needs of other citizens should be worked out after a thorough study of the problem. Considering the mobility of the population, the availability of trained personnel, and the diversity of the states, perhaps each state should not have an institution of each and every type.

In spite of achieving "landmark" decisions in their favor, the United States Justice Department has really achieved no significant benefits for the classes it represents. In *Willowbrook*, for example, costs have increased to $35,000.00 per client per year. Yet, all parties agree, no significant benefits have resulted for the client. Some clients are not responsive to current medical technologies and no amount of funds will help. The involvement of the United States Justice Department has focused on making a case for the inability of state government to insure rights and provide services. To do this, the U.S. Department of Justice frequently distorts reality (i.e., gathering only negative pictures of the institution and only positive pictures of community services and depicting this as objective comparisons).

In Nebraska, the totality of human needs far outstrips the availability of funds to meet these legitimate human needs. In fact, if the total income of all working Nebraskans were taken via taxation and applied to the identified needs of Nebraska citizens, there would still be insufficient funds to meet all needs for housing, education, medical care, food, roads, etc. S. 1393 represents a mechanism for developing responsiveness to a special interest or need group, at the expense of other citizens. Since there is not enough money to adequately meet the needs of all people, court action to insure that the needs of specific groups of people are met, simply reduces the level of services to other need groups.

Lastly, but of utmost importance, the area which has probably suffered more than any other because of the past litigation by the United States Justice Department is that of State-Federal relations. Further litigation can do nothing but broaden this gap. Except for the Civil War, State-Federal relations are undoubtedly at one of the lowest levels since the Constitutional Convention. Had the framers of the Constitution remotely envisioned the breaches in the principles of federalism which have occurred, the arguments over the adoption of the Constitution would probably still be going on. Congress has repeatedly rejected this type of legislation in the past, except when based upon racial discrimination. Not only does the present bill go farther than ever before, it permits it to be done without even giving the States an opportunity to remedy an alleged situation after notice. The United States Justice Department says, "We'll give them a chance to remedy the situation first"—the bill doesn't require it and it frequently has not given time to the States in the past. Be that as it may, the last thing this nation needs is the Federal Government suing the States if it is to continue to survive. The United States Justice Department frequently treats us as the enemy already, without legislation.

I respectfully pray that this subcommittee will seriously look at all the ramifications of this bill.

[Statement subsequently submitted by the National Center for Law and the Handicapped, in response to the statement submitted by Paul L. Douglas was marked "Exhibit No. 26" and is as follows:]

[Exhibit No. 26]

THE NATIONAL CENTER FOR LAW AND THE HANDICAPPED: A RESPONSE TO THE STATEMENT SUBMITTED BY PAUL L. DOUGLAS, ATTORNEY GENERAL OF NEBRASKA

While the Center does not wish to dispute Mr. Douglas' stated concern with the protection of the legal and constitutional rights of its institutional population, one must look at the results and not the intenions, however good. As has been illusrated through the lengthy proceedings in the case of *Horacek* v. *Exon*, the Beatrice State Home for the Retarded has in fact existed and functioned while repeatedly violating legal and constitutional rights. The intention of

litigation is not to fix blame nor to question good intentions, but rather to uncover legal deficiencies in a system which harms its residents, and then to search for an appropriate solution.

This problem can in no way be viewed as an isolated situation. In State after State, right to treatment suits have been brought, alleging a variety of "horrors" and unconstitutional deprivations and conditions. Attesting to a recognition of the inadequacies of these institutions is the frequent settlement via consent decrees; this serves to illustrate the awareness that problems exist and must be corrected. Such its what occurred in Nebraska as its State officials, recognizing the deficiencies of its system, voluntarily signed a decree which intended to upgrade the system to a constitutionally minimal basis. The Center questions the complaints which arise now concerning the decree; one would hope the complaint is not that short of the involvement of the Justice Department, the State could have avoided correcting the conditions.

The fact that the United States Supreme Court has not decided the right to treatment question does not mean persuasive legal guidelines are non-existent. Numerous rulings by Federal Circuit Courts of Appeal as well as Federal District Courts set guidelines as to constitutional requirements. The standards arising from *Wyatt*, upheld by the Fifth Circuit, as well as the right to treatment principles upheld by the Eighth Circuit in *Welsch* v. *Likins*, lend clear precedential value by which lower courts may be guided.

The State's reading of the Eighth Circuit's opinion in *Welsch* v. *Likins* is somewhat misleading. While recognizing the right of a sovereign state to manage and control its own financial affairs, the court went on to state:

"In any event, we desire to make it clear to the present Governor and the current Legislature that the requirements of the 1974 Order and the requirements of the April 15, 1976 Order that we uphold today are positive, constitutional requirements, and cannot be ignored. We will not presume that they will be ignored. On the contrary, we think that experience has shown that when governors and state legislators see clearly what their constitutional duty is with respect to state institutions and realize that the duty must be discharged, they are willing to take necessary steps including the appropriation of necessary funds."

Clearly the Eighth Circuit was informing the State that it must act to meet constitutional standards. In deference to the State, the Court asserted that it believed the State would conform, once it realized the existence of deficiencies and the importance of the rights involved. On is left with the definite impression that the Court viewed this as a scenario whereby the State's awareness arose through litigation, which raised the questions, followed by the State reacting and trying to rectify conditions. Finally, describing the court's role:

"And it is the function of the federal court to determine whether the plans and steps taken or proposed by the state satisfy constitutional requirements."

A further reading of *Welsch* also is instructive in its recognition that less drastic alternatives exist than the closing of all institutions. Workable solutions include the closing of some institutions or the reduction of population in some institutions. This is, in fact, exactly what the litigation in *Horacek* established when the State agreed to reduce the Beatrice population. The alternative is not an absence of care but a shifting of care to a community setting.

The Center believes the State of Nebraska is underestimating the problems which exist regarding institutional populations and raising an inappropriate scare tactic concerning the costs of providing ideal services to all its citizens. The problem which the United States faces vis-a-vis its institutional populations is a massive one. Very rarely, if ever, has such a blameless group, such as the mentally retarded, been singled out in society, locked up, and treated so inhumanely. It is unquestioned that savage physical and psychological harm has been done in the name of "treatment" of retarded persons.

States often choose groups that need services, care and aid for their conditions. The physically ill, the poor, the homeless or the abused are provided needed services in the community. However, the mentally retarded, instead of being treated similarly, were chosen to be locked away from society. The key element is deprivation of liberty which has led not to promised treatment but to cruel and inhumane conditions. Once this deprivation of liberty has occurred, the Constitutional protections are activated full force. Thus ensuring full rights in an institution or correcting past injustices by affirmative attempts at community placement and services, does not mean that identical expenditures will necessarily be made on every citizen, only those with whom the

State has been so intrusively involved. As Senator Bayh aptly observes during Mr. Kammerlohr's testimony (transcript p. 55), the State must make decisions on limited resources yet it is impermissible to forget those who have been shuttled off to institutions.

The Center is disturbed by the repeated references to the States' intentions to improve conditions on their own. Experience has taught us that this does not happen, not even when court decrees exist nor when consent decrees have been signed. One of the major problems which exists in this area is the proper implementation and enforcement of right to treatment decisions. Thus, it is not as if all States were just awaiting the signal or proper guidelines so they could correct the deficiencies in their institutions. Many have fought, delayed, or refused to act.

These problems have certainly arisen in Nebraska. An essential element of the consent decree was the establishment of a Mental Retardation Panel, to create and monitor a plan of implementation. This Panel has never come into existence as the State has refused to fund it. The consent decree calls for a reduction in the Beatrice population to 250 over a period of time; however the State has consistently resisted this, and its plans and funding have repeatedly been based upon future projections of 700 residents, long after the target goal of 250 residents should have been achieved. On the one hand, the State attacks a consent decree, a document agreed to voluntarily by the State; on the other hand, it asks us to believe that the Justice Department involvement is unnecessary since the "Governor wanted to do the same things the Federal Government is talking about" (p. 59), which, in fact, is embodied in the Consent Decree which the State is attacking.

Furthermore, scrutinizing the State's response to the entire suit, dispels any notion of attempted cooperation. Funding allocations initially decreased for community programs, throwing them into a state of chaos. As funding has been restored, priority is still upon the institution. Communications with Dave Powell, Executive Director of Nebraska ARC, which has been consistently advocating for a community priority, indicate that the Governor's budget recommends a 36 percent increase in per client costs at Beatrice for next year while only a cost of living increase for community programs.

Finally, I would like to respond to the comments about experts. Despite what individual experts might say, it is clear that as a whole, the expert feeling is that communities are much superior to institutions. In some instances, granted, there may be abuses in community settings or an exceptional institution may exist; however, to reach a desired goal of normalization, community services must be pursued. This whole discussion returns us once again to the fact, which cannot be ignored, that the situation involves a deprivation of liberty, necessitating efforts upon the part of the State to provide habilitative and treatment services in the least restrictive setting.

I am enclosing in summary a copy of a letter from a college student who worked at Beatrice. This, I believe, awakens us to reality much more than theories, facts, budgets or plans; it indicates firsthand the tragedy of the situation.

BOUNTIFUL, UTAH.

CARL V. SULLIVAN, *Chairperson, Human and Legal Rights in Res. Ser. Comm.*

DEAR MR. SULLIVAN: I received your letter from Dave Evans about 2½ months ago. Working at the Beatrice State Development Center was an eye-opening experience for me. When I finshed working there I wanted to forget most of my experiences there. I kept putting your letter in the back of the drawer, but I was always remembering it was there; so now I am finally taking some time to answer the questions you presented in your letter.

First I would like to explain a little about my background in getting a job at the BSDC. My name is Karma Sparks. I was employed at the BSDC from August 22, 1976 through Dec. 20, 1976. I am a senior at Utah State University majoring in Special Education for the Mentally Retarded. This past summer I came to Nebraska to work for the Easter Seals Society at Camp Kiwanis in Milford, Neb. Many of the campers came from the BSDC, so one afternoon, two other counselers and myself went to visit some of the campers, and get an idea of how things were run. I have always been really negative towards institutions because I figure we in society use them to put

handicapped people out of our way instead of taking the time to teach them and learn from them.

I was really impressed with the BSDC when I first saw it. "These people really looked like they had a home. They were with other people with similar handicaps and cared for by a staff who wanted to do the most for them." (I thought). I was really excited and wanted an opportunity to work there and get some ideas to take back with me to Utah. I planned to finish school at Utah State University and informed my employer that I would only be working at the center until December. I also requested to work with children because my main interest is at the elementary level. My employers were very positive about granting my request and I looked forward to starting work. I wanted to teach the mentally retarded children.

The BSDC has a hard time keeping employees, and this could be one of the reasons—My employer failed to inform me that I would be moved all around the campus and work a different unit almost every day wherever they were shortest (every place was short) of staff. Employees were expected to work programs with a resident they were unfamiliar with and had no idea if the resident had been engaged in the program the previous' day. Usually when I was pulled to a unit, the Charge gave me an armload of program books to mark and initial. (The residents were already in bed.) That's how most of the programs are run at the BSDC. At first I thought this was really awful, but after about a month, the attitude of the rest of the home began to rub off on me and I became blind to the things I would normally disapprove of. It is really sad and as I talked with a few other employees, they commented that they too had been excited when they first started working at the home, but after a time they became apathetic.

I don't know answers to the situation but from my observations, I can see that working at the BSDC is just a job to many of the employees. They dread going to work and look forward to getting off. They have to work to support their families and the BSDC is a job that does not require a lot of education or a lot of thought (or a lot of labor if you can get away with it). They don't regard a mentally retarded person as a whole human being, but more as someone who will always be at the BSDC and will never make anything of his life. Well, that is a self-fulfilling prophecy—you get what you expect.

You can't make people want to work or give them the desire to help those who are less fortunate than they, so I don't know how to solve the problem, because even though the employees are not doing their best, the BSDC needs them to keep the living units functioning. Someone has to feed, change, bathe, and care for those who cannot do it for themselves. I talked with the personnel department and asked why they did not hire more employees, because I figured that if more employees were on the living unit, more time would be spent with the residents, which is something they badly need. I don't know if this would help or not, but it doesn't seem to matter because the lady I talked to said, "I realize we are short of staff, but all I can do is sympathize with you." Well, I sure did not get anywhere on that one.

It seems that it is hard to get employees to work at the BSDC and the turnover is tremendous. I can understood why. I will now answer the questions you wrote to the best of my remembrance:

Are "the kids" provided an opportunity to participate in decisions affecting their lives?

I think in this regard, many of the residents who are capable have the opportunity to participate in activities and go places they choose. But the same group of people are always the ones that get the opportunities. I often wondered if some of the residents who were extremely physically handicapped (bedridden, physically deformed) did not have more brain power than they were given credit for. For example, a girl on west wing II (I don't know her name) cannot walk, and is not given very many choices that I know of. Twice in the time I was employed at the BSDC she was reported to have been found outside and brought back to her living unit by the campus police. She had somehow crawled down the hall, on to the elevator, got it down to the 1st floor, got out of the elevator and then out the door. I think she is a lot smarter than she is given credit for being.

Are "the kids" treated on an individual basis according to their abilities disabilities, skills, potential, etc., as individuals?

Like I mentioned in No. 1, the residents who can speak up for themselves are given a lot of opportunities to participate in activities such as dances,

movies, various camps, shopping, etc. But they are always from buildings like B, D, L, or cottage 416, Rehab., etc. The residents on living units like Cottage 414, 413, 412, etc. don't seem to get a lot of outside environment that they need. The kids are categorized into living units and hence are treated as a unit in a lot of things, not as individuals. The BSDC does try to place all the residents on program geared to their abilities but the employees do not take the time to work the programs correctly.

Are "the kids" treated with the same respect that you demand for yourself?

No. In my opinion, most of the residents were treated like freaks who had no potential to progress. "They would always be at the BSDC and so it would be a waste of time to teach them anything. They would soon forget it anyway." was the attitude of most of the employees. It really made me mad when I first started working there, and I said to myself, "Every one of these kids has the potential to accomplish something," but I soon lost the desire to try to teach anyone anything, because I never had the opportunity to work with the same residents 2 days in a row. You can't teach a handicapped person something in one session. The residents don't have a chance.

Are the kids the subjects of instances of negligence?

Yes, things I thought were abuse, my mom informed me were more in the category of neglect. Example: Cottage 412. I worked one evening with a man. His attitude was "do as little as possible with the residents: Make it as easy on yourself as you can to keep the cottages clean." When it came time to put the men in bed, I thought we had them all, when the man I was working with said, "Now for the guys in the bathrooms," I said, "huh?" He took me to two of the bathrooms where he had lined up two wheelchairs in each and had wrapped sheets from the neck down around each of the residents. They had sat there like that from the end of supper (about 5 p.m.) until bedtime (about 8:30). The purpose was, "because sometimes they throw up and it would save cleaning it up off the carpets". I was really shocked. (But I don't know if he did this every night, because I only worked with him one night and it was back in Sept. 76.

Another example is in the infirmaries. When I was placed there I found the only time the employee interacted with the resident was at feeding, changing, and bathing. Several times while feeding I was told I had given the resident "enough." He would "survive." (So what if half the meal was still on the tray.). The changing of diapers was once or twice a shift. Bathing was done if the employees felt up to it, and then it was awful. It was a very hurried job. The resident was stripped, roughly put on the cold tub, soaped, rinsed, put back on the bed, dressed and diapered. The younger ones and some of the older ones cried through the whole thing.

Are "the kids" disciplined in a manner which you, personally, find acceptable?

No, but I don't know how you would discipline some of the kids. I am referring mainly to C building girls. They are awful. Usually there is only 1 or 2 employees to control 20 or more girls. The girls are not given any activities to occupy them during 2nd shift time, (many go to school during 1st shift time). They resort to turning over furniture, tearing down-curtains, tearing beds apart, biting themselves or others, throwing things, stealing food at dinner; they have been in such a state for so long, that I don't know if they would become interested in activities. I took my guitar once to play and sing songs, but only a couple of the residents showed any interest, and that interest was directed at grabbing the guitar and throwing it.

The way these girls are controlled is by slipping, pushing down, beating or threatening with a stick, newspaper, or whatever else, and being tied in chairs, on toilets, in beds. Every time I worked C3 in particular, one girl was tied on the toilet from after supper until bedtime. Sometimes she got off the toilet and urinated on the floor, then the unit charge found her on the floor and would hit her until she got back up on the toilet. The purpose of keeping her tied on the toilet was so she would not go to the back room and tear the beds apart. Pain does not seem to affect these residents; they have so much of it, it just doesn't hurt any more.

Are the kids treated as human beings?

Animals are not treated like some of these residents were.

Are meaningful activities provided for "the kids" which help them grow in specific areas?

Refer to No. 2. I want to give an example of the kind of activity provided for one cottage I worked in. 414 has children living on it. None of them speak. They have a t.v. they can watch all day, but not many of them seem interested in it. For their Christmas party, the BSDC sent a movie that lasted about ½ hour. It was shown right in the middle of supper. Then a treat was left to be given whenever we felt was best because the kids probably weren't hungry at that time. That was probably the easiest part they ever gave. If it had been an experiment to see how a movie with this group would go over, that would have been fine, but the BSDC provided the same type of party for Halloween.

Does training provide "the kids" assist them in achieving greater independence?

When the training provided is done correctly, yes; however, there were very few living units that I worked on, where I saw the training being done correctly. Usually programs were marked after the residents were in bed.

Would you find the conditions at BSDC acceptable for a member of your family who could suffer brain damage from an accident and be placed at BSDC?

No, I would never place anyone I know in the BSDC.

How are employees mistreating the residents?

Refer to answers No. 3, 4, 5.

Are there programs established to help the residents learn more appropriate behaviors?

As I stated before, the employees rarely continued to work on a program long enough to give the resident a change to learn.

Are the majority of BSDC staff truly concerned about the residents?

In my opinion, there were a few employees who really cared; most of them were just spending time at the BSDC, so they could receive a pay check every 2 weeks. You could see this by looking at the programs for the residents (which was one of the duties the employees were supposed to perform). Nobody would stay on Step 1 of a program for 900 times if the person who was in charge of the program was taking the time to work it correctly.

Are you a part of the problem or a part of the solution?

I am part of the problem. When I first started working at the BSDC, I was shocked at what I saw, but I did not do anything about it. Then I began to accept what I saw. I couldn't wait until I quit and "got out of there."

Do you feel obligated to act as a spokesman for the residents?

I want to see things better for everyone, and if speaking will help, I will, but I can't remember specific names and dates, so I cannot give factual statements, only memory statements.

Who needs the most help, the employees or the residents? Why?

Both. The residents need the most help, but they cannot get it unless the employees are helped. A lot is expected of the employees. Most of them go to work not knowing which unit they will be assigned to for their shift. They never get closely associated with one group of kids. Each unit is understaffed. Employees are expected to work on a 1 to 1 basis with each resident, while at the same time watching 10 or more others. You can't work a program that way. If the employees were better satisfied, maybe they would do their job better. I don't know. It was a vicious circle. Those who cared, didn't have much of a chance to help the residents because of the instability of their living unit assignments. The depression of some of the units develops an apathetic attitude after a while.

What are you, as an individual, actually doing to improve things at BSDC?

Nothing, I quit as planned and went home.

What are the "undesirable activities" you mentioned?

Refer to No. 4 and 5.

What is "heavy discipline" at BSDC?

Refer to No. 4 and 5.

I hope this letter is clear in the things I am trying to explain. There are a lot of neat people at the BSDC, both residents and employees.

I hope you can find some useful information in this letter.

Thank you for being patient with my reply.

Sincerely,

KARMA SPARKS.

[The Nebraska State Bar Association Jail Survey was marked "Exhibit No. 27" and is as follows:]

[EXHIBIT No. 27]

NEBRASKA STATE BAR ASSOCIATION JAIL SURVEY

INDEX

Introduction
Data Format
I. Administration
1.1 General Records
1.2 Medical Records
1.3 Prisoner's Property
1.4 Rules and Policies
1.5 Disciplinary Sanctions
1.6 Disciplinary Infractions
1.7 Prisoner Supervision
1.8 Trusties
1.9 Safety Plan
II. Facilities
2.1 Jail Capacity
2.2 Cell Capacity
2.3 Cell Space per Individual
2.4 Drunk Tanks
2.5 Separation of Prisoners
III. Health and Sanitation
3.1 Medical Services
3.2 Medical Personnel
3.3 Admitting Examination
3.4 Sick Calls
3.5 Treatment of prisoners
3.6 Maintenance
3.7 Laundry Services
3.8 Bedding Items
3.9 Bathing Facilities
3.10 Inmate Meals
3.11 Preparation of Food
IV. Program Services
4.1 Education
4.2 Vocational Training
4.3 Work Release and Furloughs
4.4 Counseling
4.5 Recreation
4.6 Communications
4.7 Visitation
4.8 Visitors
4.9 Commissary
V. Staff
5.1 Number of Employees
5.2 Assignment Procedure
5.3 Education Levels
5.4 Salaries
5.5 Security
5.6 Female Staff
VI. Prisoner Population
6.1 Average Daily Population
6.2 Pre-trial Length of Stay
6.3 Post-trial Length of Stay

INTRODUCTION

Local detention and correctional facilities are an integral and important phase of the criminal justice system. For many years, these institutions have operated largely in isolation, without public concern, interest, or knowledge about conditions within them. Local jails have long been housed in inappropriately designed

facilities, staffed by underqualified, underpaid workers, and denied the funds necessary to finance adequate services and resocialization programs. Consequently, in most jails, prisoners sit in idleness and despair, isolated from the community to which they must eventually return.

The Nebraska State Bar Association, in coordination with the National Clearinghouse for Criminal Justice and Architecture, conducted a controlled survey of Nebraska's local correctional facilities (July, 1976) with the goal of developing and establishing Jail Standards for the State of Nebraska. The need for this type of survey was recognized by the State officials in order to identify and delineate possible probelm areas and deficiencies in the existing corrections system. Conducting the survey was complicated by the absence of sophisticated systems for collecting and compiling data in most jurisdictions in Nebraska. Ready access to a great deal of information is crucial for the successful accomplishment of a project as this.

To remedy the situation, the National Clearinghouse, ably assisted by Nebraska officials, designed a detailed survey instrument to collect the basic information in 6 primary areas pertaining to Jail Standards: Administration, Facilities, Health and Sanitation, Program Services, Staff, and Prisoner Populations. Almost a hundred questionnaires were distributed, of which ninety were returned. Approximately 16 percent of the returned questionnaires were from city jails; 78 percent were from county facilities, and the remaining 6 percent originated from other local facilities, such as youth and juvenile homes, etc.

The following document is a brief outline of the detailed computer analyses performed on the returned surveys. It is presented in the form of a commentary highlighting important elements in each of the six primary areas, and has been cross-referenced with the Jail Regulations presented in the previous section. The commentary was prepared in order to provide a concise and comprehensive overview of the information obtained in the survey and should be regarded only as an appendix to the computer print-outs. The latter, though cumbersome and difficult to handle, contains much more detailed and descriptive analyses of the data. It should be treated as the major source of information.

In order to facilitate further analyses, the data have been classified in terms of city and county facilities, respectively. It should be emphasized, however, that many of the analyses performed on the data may prove to be irrelevant and/or inconsistent because of the limited size of the survey sample, errors in recording and coding of data, and possible misinterpretation of the questions by person filling out the questionnaires. Some of the spurious relationships are delineated in the course of the commentary but a strong word of caution must be offered in regard to the interpretation of any of the correlations observed between analyzed variables/factors. The obvious inferences often cannot be drawn from significant statistical relationships due to internal inconsistencies in the data. Similarly, the data itself may sometimes appear illogical, prohibiting decisive conclusions. Nonetheless, the information does serve its major purpose adequately: it provides a background for the development of standards that will dictate and enforce improved conditions in Nebraska jails. It is cautioned only that Nebraska officials recognize the limitations of the survey data and treat it accordingly. The data can be considered as a valid and useful tool which helps identify problem areas. On the other hand, it is not sufficient to make administrative or planning decisions.

DATA FORMAT

The tables in the Commentary are presented as three columns (i.e., City Jails, County Jails, and Total) and several rows of data. In order to facilitate reading and analysis of this data a sample table is explained in the following paragraphs:

[In percent]

Example	City jail	County jail	Tota
Facilities which hold adult females	(i)100	(ii)93	(iii)94
Facilities which hold juvenile females	(iv)50	(v)39	(vi)45

City jails: This column indicates the number (or percentage) of city facilities in the total sample which satisfy a specific row criteria.

County jails: This column indicates the number (or percentage) of county facilities in the total sample which satisfy a specific row criteria.

Total: This column indicates the number (or percentage) of facilities in the entire sample (i.e., it includes city, county, juvenile, etc. facilities) which satisfy a specific row criteria.

(i): This figure indicates the number (or percentage) of city jails which satisfy the specified row criteria. In the given example, (i) indicates that 100 percent (or all) of the city jails hold adult females.

(ii): This figure indicates the number (or percentage) of county jails which satisfy the specified row criteria. In the given example, (ii) indicates that 93 percent of the county facilities hold adult females.

(iii): The figure indicates the number (or percentage) of all the surveyed jails, including juvenile and other facilities, which satisfy the specified row criteria. In the given example, (iii) indicates that 94 percent of all the jails hold adult females.

(iv): Using the same analogy, (iv) indicates the number (or percentage) of city jails which satisfy the 2d row criteria i.e., (iv) indicates that 50 percent of the city jails hold juvenile females.

(v): Similarly, (v) indicates that 39 percent of the county facilities hold juvenile females.

(vi): (vi) indicates that 45 percent of all the surveyed jails hold juvenile females.

I. ADMINISTRATION

1.1 GENERAL RECORDS (NOS. 6.1–6.3; 6.12; 11.7)

[In percent]

	City jail	County jail	Total
Facilities that make a list of cash and valuables and maintain property envelopes	100	100	100
Facilities that keep property envelopes under lock and key	71	79	78
Facilities that maintain a record of expenditures and receipts	86	89	86
Facilities that maintain a record of:			
(i) Visitors	17	11	13
(ii) Each visit	40	34	17
(iii) Attorney's visits	33	18	19
(iv) Inmate phone calls	67	21	31
Facilities that maintain records of:			
(i) Rule violations	33	29	33
(ii) Disciplinary actions	40	34	38
(iii) Unusual occurrences	60	77	75

Commentary

Nebraska jails appear to maintain extensive and thorough records of inmate cash and valuables. Eighty-five percent of the jails maintain records of all expenditures and receipts as well. All fcilities maintain property envelopes signed usually by both the prisoner and the officer-in-charge. Most city and county facilities appear to safeguard prisoner valuables in an adequate manner i.e., under lock and key.

Visitor and visitation related records do not appear to be maintained in as thorough a manner as (offender) property records. Records of (inmate) disciplinary actions also appear to be neglected to a certain extent with only 42 percent of the facilities reporting any kind of recording being done in this area. However, detailed records are kept of all unusual occurrences (i.e., fires, accidents, etc.) in most of the state's facilities (68 percent).

1.2 MEDICAL RECORDS (NOS. 6.5; 12.9)

[In percent]

	City jail	County jail	Total
Facilities that maintain medical records	54	51	51
Do the medical records include:			
(i) Physical condition on admission	46	36	38
(ii) Physical condition during confinement	31	34	34
(iii) Physical condition at discharge	15	20	19
(iv) Record and date of services provided	54	64	62

Commentary

Medical records appear to be less thoroughly maintained in the Nebraska local corrections system. Only about one-half of the facilities maintain any kind of medical record system and only about a third keep records of the physical condition at the time of admission (38 percent), during confinement (34 percent), or at the time of discharge (19 percent). On the other hand, about two-thirds of the facilities keep a record of all medical services provided during incarceration.

1.3 PRISONER'S PROPERTY (NOS. 6.3; 6.4)

[In percent]

	City jail	County jail	Total
Facilities that keep property envelopes under lock and key	69	80	78
Facilities that give prisoners a receipt for his cash and property	77	42	48
Facilities that have received complaints regarding the handling of inmate's cash and property	8	10	10

Commentary

In Nebraska, 78 percent of the surveyed jails keep prisoner valuables under lock and key and 48 percent of these facilities give prisoners receipts for their cash and property. Most of the facilities (77 percent) keep inmates' cash with other valuables; about 15 percent maintain individual prisoner accounts. Only 2 percent of the facilities allow the inmate to keep his cash with him. Other inmate property is usually stored (89 percent) or kept by the prisoner himself (3 percent).

About 10 percent of Nebraska's jails receive complaints regarding the handling and storage of inmates' properties. None of the city jails profess to have any problems in this area; however, theft (13 percent) and loss (13 percent) are two fairly big problems in county facilities. Damage and other related occurrences account for 25 percent of the inmates' property-handling complaints.

It should be noted that certain discrepancies in the recorded data were noted in this area. For example, although 92 percent of the surveyed county facilities claimed that they had not received any complaints in the handling of cash and property, only 50 percent answered likewise in the following question regarding the types of complaints. Such inconsistent answers prompt one to believe that the persons recording information on the survey questionnaire very often misinterpreted the questions. Hence, caution should be exercised in the interpretation and analysis of this data.

1.4 RULES AND POLICIES (NOS. 11.1–11.6)

[In percent]

	City jail	County jail	Total
Facilities that provide:			
(i) Written rules for new prisoners	15	75	65
(ii) Non-English rules for new prisoners	0	3	3
Facilities that explain rules to new prisoners	23	74	65
Inmate grievances are:			
(i) Submitted in writing by the prisoner	15	19	19
(ii) Handled by the shift supervisor	31	16	19
(iii) Referred to the facility administrator	23	49	44
(iv) Treated in other ways or not at all	31	16	17

Commentary

About 65 percent of Nebraska jails provide written rules to new prisoners. Officials of city jails appear to prefer verbal (23 percent) to written instructions (15 percent); whereas county jails provide both written (75 percent) and oral (74 percent) rules in equal proportion. Non-English rules are provided in only 3 percent of the jails and all these are county facilities.

Procedures for handling inmate grievances include written petitions by the prisoner and intercessions by shift supervisors and facility administrators for and on behalf of the inmates.

1.5 DISCIPLINARY SANCTIONS (NOS. 6.6; 11.7)

[In percent]

	City jail	County jail	Total
Types of disciplinary sanction:			
Isolation	33	11	14
Segregation	11	6	7
Loss of privilege(s)	0	33	27
Loss of good time	0	3	4
Other	22	35	32
All of the above	0	10	8
None	33	3	7

Commentary

In the Nebraska local correctional facilities disciplinary policies are established by facility administrators in most instances (82 percent) and disciplinary infractions are also determined, in the majority of facilities (82 percent), by its administrators.

The survey indicated that loss of privileges for infractions of rules is one of the chief (27 percent) disciplinary methods used in the Nebraska jails. Isolation is second on the list (14 percent). The data also indicated that about 25 percent of the county facilities placed no limits on the duration of isolation whereas most city facilities did so. A day limit appears to be the most frequently used limit in most facilities.

Hourly checks of prisoners in isolation are conducted in 30 percent of the facilities, while 12 percent of the jails have no established check-routine. Almost 37 percent of the facilities profess to conduct checks on an "as needed" basis and the remaining 21 percent conduct checks at count-time or according to other established schedules.

1.6 DISCIPLINARY INFRACTIONS (NOS. 6.6; 11.1–11.7)

[In percent]

	City jail	County jail	Total
Facilities that hold hearings in disciplinary cases	0	66	54
Facilities that give notices prior to hearings	0	34	28

Commentary

The above date are a good example of inconsistent and inaccurate recording of data: none of the city jails claimed to hold hearings in disciplinary cases; nonetheless 50 percent of these facilities supposedly give notices prior to hearings! However, despite these and other inconsistencies, the data indicate that very few facilities, if any at all, do hold disciplinary hearings and that they are usually county facilities.

1.7 PRISONER SUPERVISION (NO. 11)

[In percent]

	City jail	County jail	Total
Facilities that provide 24-hr, on-site prisoner supervision	85	85	85
Facilities that record "checks" on prisoners	23	23	23
Facilities that allow prisoners to supervise and control other prisoners	0	3	3

Commentary

Most (85 percent) Nebraska jails appear to provide adequate supervision of inmates. Further, it was noted that 97 percent of the facilities surveyed did not permit (prisoner) supervision by other prisoners thereby complying closely with U.S. Bureau of Prisons Jail Standards: "No prisoner should be allowed to have authority over any other prisoner." These standards further recommend that even trusties "be under the supervision of (jail) employees."

1.8 TRUSTIES (NOS. 11.3; 11.4)

[In percent]

	City jail	County jail	Total
Facilities that use trusties for maintenance, supervision and other purposes	0	43	35

Commentary

About 35 percent of Nebraska's county jails have trusties who are selected chiefly through administrative assignment procedures. These trusties assist in tasks related to the security and maintenance of the facility. It should be noted, however, that gross inconsistencies were noticed in the data pertaining to trusties in the local facilities. For example, it was recorded that none of the city jails utilized the trusty-system. However, the following question regarding the number of trusties in city facilities revealed that some city facilities did have as many as three trusties in them. This discrepancy and others like this tend to reduce the validity of this information and hence it is recommended that this data not be used for future analyses.

1.9 SAFETY PLANS (NOS. 4.6.c; 12.5)

[In percent]

	City jail	County jail	Total
Facilities that have adequate emergency plans	38	82	75
Facilities that include disposition of prisoners in their emergency plans	3	77	71

Commentary

Most (75 percent) of Nebraska's correctional facilities appear to have adequate emergency plans for the various emergencies that may arise. However, only 60 percent of these plans are (formally) in writing and only 71 percent incorporate the disposition of prisoners as part of the plans. "The fine line between good safety and good security practice is almost indistinguishable; and one complements the other."[1] The Illinois County Jail Standards recommend that an emergency plan be in effect and in writing in all facilities. It also recommends that the plan outlines the responsibilities of jail personnel, action to be taken with or for the prisoners and evaluation plans, predicated upon the type of disaster/disturbance.

II. FACILITIES

2.1 JAIL CAPACITY (NOS. 4.1; 4.2)

	City jail	County jail	Total
Number of jails included in survey	13	62	75
Jails which have a design capacity of (percent):			
(i) 4 to 8	46	32	
(ii) 9 to 13	15	27	
(iii) 14 to 18	24	10	
(iv) 19 to 46	0	21	
(v) 46 to 132	15	10	
Jails which include detention for (percent):			
(i) Adult males	100	100	
(ii) Adult females	92	87	
(iii) Juvenile males	62	52	
(iv) Juvenile females	62	37	

Commentary

Questionnaires were sent to 100 Nebraska incarceratory facilities. Eighty replied, five of which will not be discussed because those facilities were not classified as jails (e.g., juvenile detention centers). Thirteen city jails and sixty-two

[1] Illinois County Jail Standards, State of Illinois, Department of Corrections, Bureau of Detention Facilities and Jail Standards. July 1971.

county jails are included in the survey. The capacity of the majority of these jails is less than thirteen. Almost all of the jails surveyed have a capacity for adult females as well as adult males. Unfortunately, about 37 percent of the jails surveyed have a capacity for juveniles as well. The National Advisory Commission on Criminal Justice Standards and Goals as well as many other standard setters recommend that juveniles not be incarcerated in adult facilities.

"Juveniles should not be held in jails, but if committed should be definitely segregated and well supervised": Minimum Jail Standards, U.S. Bureau of Prisons.

2.2 CELL CAPACITY (NOS. 4.4; 4.5)

[In percent]

	City jail	County jail	Total
Jails which have at least 1:			
(i) 1-man cell	15	49	43
(ii) 2-man cell	92	74	77
(iii) 3-man cell	62	66	65
(iv) Dormitory	77	59	62

Commentary

Statistics on the numbers of one-man cells were inadequate to make an observation concerning city jails. However, only 49 percent of those county jails replying had any one-man cells. Furthermore, the statistics showed that the vast majority of bed space in Nebraska county jails is composed of cells which hold more than two offenders. Forty-one percent of those replying to this question indicated that they did not have any dormitories. National standards promulgated by the National Clearinghouse for Criminal Justice Planning and Architecture recommend that all cells be occupied by only one offender.

Statistics [2] pertaining to the age of Nebraska's county facilities reveal that 30 percent of the cells in these facilities are less han 25 years old, and approximately 29 percent are between 25 and 50 years old. Finally, it should be noted that 86 percent of Nebraska's jails share their premises with other agencies (i.e., courthouse, law enforcement offices, etc.) and only 14 percent are privileged to occupy the entire physical structure/building.

2.3 (APPROXIMATE) CELL SPACE PER INDIVIDUAL (NOS. 4.4; 4.5)

[In percent]

	City jail	County jail
25 ft² or less	24	27
26 to 55 ft²	76	45
56 to 70 ft²	0	17
Over 70 ft²	0	11

Commentary

Standards promulgated by the National Clearinghouse for Criminal Justice Planning and Architecture establish a 70 square feet minimum for every one man jail cell. The above statistics indicate that no city jails and only 28 percent of the county jails surveyed approached this space requirement. The psychological benefits of a larger living space may be reflected in an increased receptivety to attempts to treat and rehabilitate offenders.

2.4 "DRUNK TANKS" (NOS. 9.1–9.5)

[In percent]

	City jail	County jail	Total
Jails with "drunk tanks"	46	31	39
Capacity of tanks:			
(i) 1–4 individuals	30	68	55
(ii) 5 or more individuals	70	32	45

[2] National Jail Census, March 1970.

Commentary

As shown above, approximately 39 percent of the jails surveyed have drunk tanks. Although the capacity of the majority of the tanks is low, national standards recommend that those who are charged with simple inebriation not be incarcerated. A detoxification facility or infimary is recommended for handling those charged with serious crimes who are inebriated. In effect, these recommendations require that the further use of "drunk tanks" be eliminated.

2.5 SEPARATION OF (CLASSES OF) PRISONERS (NOS. 8.2; 8.3; 8.4)

[In percent]

	City jail	County jail
The following classes of prisoners are consistently or intermittently housed together in the following percentages of cases:		
(i) Sentenced and unsentenced offenders	46	88
(ii) Misdemeanants and felons	38	80
(iii) Juveniles and adults	0	28
(iv) Females and males	0	0
(v) 1st offenders and repeat offenders	85	92
(vi) Codefendants	31	77

Commentary

In many jails the capacity is small enough to preclude the separation of the above felony classes in all activities. However, the adoption of one-man cells by facilities could alleviate many of the problems resulting from mixing the above groups. The undesirable combinations of juveniles with adults and males with females, appear to be controlled in almost all cases. The facility administrator classifies prisoners as to security status, program needs, etc., in the vast majority of jails; only one facility reported the use of a specialized classification officer.

III. HEALTH AND SANITATION

3.1 MEDICAL SERVICES (NO. 12.1)

[In percent]

	City jail	County jail	Total
Medical complaints are handled by:			
(i) Physicians on call	77	56	60
(ii) Medical personnel	0	8	8
(iii) Other	23	36	32
Medical services are provided in:			
(i) Jail	0	7	5
(ii) Community hospital	77	26	35
(iii) Physician's office	0	16	13
(iv) Combination of above	23	51	47

Commentary

The U.S. Bureau of Prisons (1970) recommends that: "A competent physician be available to take care of the medical needs of prisoners, and give each prisoner a medical examination when admitted to jail." However, only about two-third (68 percent) of Nebraska's facilities adhere to the recommendation and most jails (72 percent) do not perform a medical examination when a prisoner is admitted. Community hospitals and (external) physicians appear to play an important role in providing appropriate medical services on an ad hoc basis to these facilities.

3.2 MEDICAL PERSONNEL (NOS. 12.1; 12.2)

[In percent]

	City jail	County jail	Total
Number of physicians employed:			
(i) Zero	8	32	28
(ii) 1	23	16	17
(iii) 2 or more	8	5	5
(iv) No response	61	47	50

Commentary

Twenty-eight percent of Nebraska's jails have no full-time physicians and 17 percent have one physician. Fifty percent of the returned surveys had recorded no information in this particular area. Moreover about three-fourths of the surveys had recorded no pertinent information regarding the number of nurses and other medical personnel employed in the jails, either.

Forty-two percent of the facilities reported that even when there were no regular medical staff, there was always a physician on call in emergency situations. In 16 percent of the facilities the shift supervisor is in charge in case of any emergency medical situations.

In 22 percent of the facilities medication is dispensed by the physician, and in 31 percent of the facilities the shift supervisor is delegated this responsibility. In the remaining instances, either a nurse or staff assignee fulfilled this task.

3.9 ADMITTING EXAMINATION (NOS. 12.3; 12.4)

[In percent]

	City jail	County jail	Total
Facilities that do not conduct admitting exams	85	69	72
Facilities that screen admissions for:			
(i) Communicable diseases	0	5	5
(ii) Suspected psychosis	0	26	23
(iii) Venereal diseases	0	5	5
(iv) Tuberculosis	0	5	5
(v) Infestations (i.e., lice, pediculi, etc.)	0	21	19

Commentary

It appears that less than one third (28 percent) of Nebraska's local correctional facilities conduct admitting medical examinations. City facilities appear to be susceptible to this deficiency in particular. Further, even those facilities that do conduct examinations do not appear to accomplish this in a thorough manner. A physician or a staff member is usually the person who conducts the examination.

Intoxicated and overdosed persons are treated like other non-intoxicated persons in about one-third of the facilities. Fourteen percent of the facilities place these persons in "drunk" tanks, while the remaining facilities either isolate the affected prisoners or utilize a combination of the above-mentioned treatments.

3.4 SICK CALLS (No. 12-6)

[In percent]

	City jail	County jail	Total
Facilities that have scheduled sick calls	0	14	12

Commentary

The survey information regarding the frequency and hours of sick calls appears to be inaccurately recorded and/or missing in most instances thereby greatly reducing the reliability and validity of the data. Hence it is advised that no conclusions be based exclusively on any information related to sick calls obtained in the survey.

3.5 TREATMENT OF PRISONERS (NO. 12.3)

[In percent]

	City jail	County jail	Total
Prisoners with communicable diseases are:			
(i) Isolated	77	21	31
(ii) Placed in a medical facility	23	56	51
(iii) Treated otherwise	0	23	18
Suspected psychotics are:			
(i) Isolated	31	3	8
(ii) Placed in a psychiatric facility	69	76	75
(iii) Treated otherwise	0	21	17

Commentary

"Prisoners with contagious diseases, hardened criminals, and the sexes should be segregated"; U.S. Bureau of Prisons, Jail Services, 1970.

In Nebraska prisoners with contagious diseases are usually either isolated or placed in a medical unit (82 percent). Similarly psychotic offenders are segregated in most instances (83 percent).

3.6 MAINTENANCE (NO. 14.1)

[In percent]

	City jail	County jail	Total
Facilities that are mopped/washed:			
(i) Daily	69	63	64
(ii) Every other day	8	18	16
(iii) On a weekly or biweekly basis	23	19	20

Commentary

"All parts of the jail should be kept immaculately clean": U.S. Bureau of Prisons, Jail Services, 1970.

Almost half (51 percent) of Nebraska's jails utilize inmate labor for cleaning (i.e., mopping and washing). The physical premise and most facilities (64 percent) are mopped and washed on a daily basis. Civilian contractual cleaning services are made use of in about 20 percent of the cases and about a third of the facilities use a combination of inmate, staff and civilian labor for this purpose. However, prisoners are almost exclusively (92 percent) responsible for the cleaning of detention areas.

Regarding the fumigation (and disinfection) of the jail premises, it appears that 21 percent of the jails have no specific fumigation programs while the remaining 79 percent report the existence of regular programs.

3.7 LAUNDRY SERVICES (NO. 14.7)

[In percent]

	City jail	County jail	Total
Jails that have their own laundry facilities	0	42	35
Jails that provide inmate clothing	0	32	27

Commentary

It was observed that very few, if any at all, of the city jails had in-house laundry facilities. However, on overall 35 percent of the state's jails do possess laundry facilities consisting of, in most cases, home washers and dryers (53 percent), and commercial washers (27 percent). Those facilities which do not have in-house washing capabilities generally contract with outside agencies (46 percent), or use inmate labor (18 percent). All of Nebraska's city jails appear to follow the former procedure (i.e., outside contracting).

It appears that less than a third of Nebraska's jails provide their own clothes. Denims, jumpsuits and uniforms appear to be the preferred kinds of clothing provided by these facilities. These clothes are cleaned both in-house (40 percent) and in outside laundromats via contracting procedures (28 percent).

3.8 BEDDING ITEMS (NO. 14.8)

[In percent]

	City jail	County jail	Total
Facilities that clean:			
(i) Mattresses before re-issue	23	56	51
(ii) Blankets before re-issue	46	89	81
(iii) Bed linens before re-issue	92	95	95
(iv) Towels before re-issue	92	97	96

Commentary

Nebraska officials should be commended for their attempts to maintain a fairly high level of cleanliness in their local correctional facilities. More than half (51 percent) of the facilities clean used mattresses before re-issuing them to new inmates and practically all the facilities appear to furnish fresh bed linen and towels to new arrivals.

Further, most facilities claim that they clean mattresses (62 percent), and blankets (60 percent), on an "as-needed" basis. Bed linen is cleaned on a weekly basis in about one third of the jails, and on an "as-needed" basis in about 45 percent of the others. Finally, it should be mentioned that although there do not exist any written rules regarding the cleaning of these and other such personal (inmate) items, in most facilities, there does appear to be an overall concern that these articles be cleaned as frequently as possible.

3.9 BATHING FACILITIES (NOS. 14.3; 14.4; 14.5)

[In percent]

	City jail	County jail	Total
Number of bathing facilities:			
(i) None	31	0	5
(ii) 1	46	32	35
(iii) 2 or more	23	68	60
Facilities that provide barbering services	0	65	53

Commentary

It appears that the majority of Nebraska's jails (85 percent) have showers in their bathing facilities and that most facilities (60 percent) have two or more such accommodations available for inmate use. However, almost 43 percent of the jails report that the most serious inadequacy in their bathing facilities is that they are too few in number. Another 19 percent report that plumbing deficiencies constitute their major problem area.

Further, regarding hygienic standards related to bathing procedures, it appears that almost 12 percent of the facilities do not require that their inmates bathe regularly. Another 32 percent permit inmates to bathe whenever the latter so desire, while 17 percent of the facilities specify that that regular bathing be strictly observed. One-fourth of the facilities have scheduled bathing procedures on daily, weekly and bi-weekly basis. Barbering services (utilizing both professional staff and inmate labor) are provided in 53 percent of the facilities.

Finally, it should be mentioned that almost 43 percent of the facilities provide their inmates with all the toiletries (i.e., soap, towels, razors, etc.) that the inmates require/need. In these few cases when these essential items are not readily available in th facility shelf, the inmate's family is permitted to furnish them (36 percent), or he is allowed to purchase them from the commissary, etc. (12 percent).

3.10 MEALS (NOS. 13.1; 13.3; 13.4; 13.5; 13.6)

[In percent]

	City jail	County jail	Total
Number of hot meals served per day:			
(i) 1	8	15	13
(ii) 2	23	34	32
(iii) 3	69	51	55

Commentary

"Prisoners should be fed three times each day. The food should have the proper nutritive value and be prepared and served in a wholesome and palatable way": U.S. Bureau of Prisons, Jail Services (1970).

All (100 percent) of Nebraska's city and county jails provide their inmates with at least three regular meals per day and 85 percent of the facilities attempt to include a variety of foods (i.e., meat, fruit, vegetables, etc.) in each meal, while 70 percent prepare special diets whenever necessary. Almost 55 percent of

the facilities report 3 hot meals per day for their inmates while the remaining 45 percent claim that inmates are served at least one hot meal per day. Further, 22 percent of the jails serve inmates snacks and beverages between meals. It was noted that the majority of the facilities (73 percent) serve food in individual apportionments.

3.11 PREPARATION OF FOOD (NOS. 4.5.f; 13.8)

[In percent]

	City jail	County jail	Total
Facilities prepare food:			
(i) In-house	0	63	52
(ii) Elsewhere than the jail	85	16	28
(iii) By other means	15	21	20
Dining area located in:			
(i) Cells	77	42	48
(ii) Dayroom/multipurpose area	23	44	40
(iii) Dining room	0	3	3
(IV) Other	0	11	9

Commentary

More than one half (63 percent) of Nebraska's county facilities prepare food in the facility itself while none of the city facilities do so. Food is served to inmates on hot carts or in the dining rooms, generally. Ninety percent of the city facilities purchase food from outside caterers while only 10 percent of the county facilities follow this procedure. Neither city nor county appear to utilize inmate labor for the preparation of food.

Prisoners in almost a half of the facilities (48 percent) eat their meals in their cells, while another 40 percent dine in the dayrooms and/or multipurpose areas. It is significant to note that none of the city jails lay claims to specific dining rooms per se, and that barely 3 percent of the county facilities can claim to do so, either.

Prisoners are served food in plastic, metal and paper utensils or in combinations of these, in 85 percent of the facilities. Food is allowed to be brought in from outside sources more often than not (52 percent) but in most instances (60 percent) strict restrictions are placed on the quantity and type of food permitted inside the facility.

IV. PROGRAM SERVICES

4.1 EDUCATION (NOS. 9.1; 9.2)

[In percent]

	City jail	County jail	Total
Facilities that have academic educational programs	15	16	16
Type of education provided:			
(i) Adult basic education	0	8	7
(ii) GED (high school equivalency)	0	6	5
(iii) Other	15	17	16
(iv) None	85	69	72

Commentary

The U.S. Bureau of Prisons states in their manual on Jail Services (1970) that "useful occupation (among inmates) stimulates self-respect (and that) idleness breeds trouble and leads to more crime." However, program services in Nebraska's correctional facilities do not appear to have been extensively developed. Only 16 percent of the facilities claim any kind of educational programs, and 8 percent provide vocational training programs for their inmates. However, it should be noted that inconsistencies have been noticed in the above data regarding inmate education and program services and hence caution should be exercised when attempting to analyze and interpret this information.

4.2 VOCATIONAL TRAINING (NOS. 9.1; 9.2; 10.10)

[In percent]

	City jail	County jail	Total
Facilities that provide vocational training programs	8	8	8
Facilities that have library facilities	0	37	31
Source of library materials:			
(i) Purchased by jail			4
(ii) Public library			12
(iii) Contributions			28
(iv) Combinations of the above			56

Commentary

As mentioned earlier, only 8 percent of Nebraska's local correctional facilities sponsor inmate vocational programs of any kind. Minimal information regarding the available programs preclude any kind of valid evaluations being made of these programs. Further, only 31 percent of the facilities have any kind of library services and it was observed that those which do are assisted in this program partially by public libraries and partially by contributions of sorts.

Regarding legal materials, 41 percent of the jails claim ready access to the Nebraska Statutes and 69 percent provide these documents whenever requested by inmates. Less than one third of the facilities make other legal material available for inmate use, but, generally, 78 percent of the jails provide inmates with most requested publications.

4.3 WORK RELEASE AND FURLOUGHS

[In percent]

	City jail	County jail	Total
Facilities with work release programs	0	63	63
Percent of sentence population on work release:			
0 percent	(1)	25	25
Less than 25 percent	(1)	62	62
Between 25 and 50 percent	(1)	8	8
Between 50 and 100 percent	(1)	5	5

[1] Not available.

Commentary

Nebraska's city jails do not appear to sponsor any kind of work-release or furlough programs but this could be on account of the fact that they are chiefly short-term, pre-trial holding facilities and do not really need any long-term programs of this sort. On the other hand, it is commendable to note that almost two-thirds of Nebraska's county facilities report inmate work release programs and most (70 percent) of these facilities have less than 50 percent of their inmate population involved in these programs. Furlough programs, however, do no appear to be used to a significant extent.

4.4 COUNSELING (NOS. 9.4, 9.5, 10.5)

[In percent]

	City jail	County jail	Total
Types of counseling:			
(i) Individual	8	11	11
(ii) Group	0	6	5
(iii) None	92	83	84
Counseling is provided by—			
(i) Jail officers	100	64	67
(ii) Other agency staff	0	27	25
(iii) Volunteers	0	0	0
(iv) Other sources	0	9	8

Commentary

Almost 84 percent of Nebraska's facilities provide no counseling services for their inmates. Jail officers (67 percent) and other agency staff (25 percent) constitute the main sources of counseling and guidance services in those facilities which do boast these services. Psychological, alcoholic, and religious counseling appear to be some of the more common services provided.

Formal religious services are provided in 13 percent of the facilities. It should be mentioned however that there appears to be an inconsistency in the recorded data regarding religious services as only 10 facilities provide religious services while almost 25 facilities reported having protestant, ecumenical and other kinds of religious services in the following question. One possible interpretation of this data could be that 15 of these facilities provide religious services on an informal, ad hoc basis, while 10 facilities provide regular, formal services.

4.5 RECREATION (NOS. 10.6; 10.8; 10.9)

[In percent]

	City jail	County jail	Total
Types of recreation areas:			
(i) Indoor	0	18	15
(ii) Outdoor	0	10	8
(iii) Both	0	9	8
(iv) None	100	63	69
Leisure time activities:			
(i) Cards	23	3	7
(ii) Newspapers	23	8	11
(iii) Combination	0	50	41
(iv) Other	8	2	3
(v) None	54	40	43

Commentary

The U.S. Bureau of Prisons (1970) recommends that "outdoor exercise be required" in correctional facilities. However, it appears that none of Nebraska's city facilities have any kind of separate recreation area and barely one-fourth of its county jails can claim the "asset," either. Cards, newspapers, or combinations of these appear to comprise the chief leisure time activities available to Nebraska's inmate population. However, those facilities which do claim separate recreation areas profess unlimited and/or daily use of these areas by inmates in more than half of the jails (55 percent).

4.6 COMMUNICATIONS (NOS. 10.1-10.6)

[In percent]

	City jail	County jail	Total
Rules relating to mail:			
(i) Unlimited sending and receiving	54	88	83
(ii) Restrictions	15	12	12
(iii) No mail	31	0	5
Facilities that censor inmate mail	15	32	29

Commentary

Censorship is limited in most Nebraska jails to checks for contraband or other such illicit items. Eleven percent of the jails, 20 percent of which are city facilities permit incoming calls in emergency situations and 32 percent allow a limited number of calls per inmate. Less than one-fourth of the facilities permit inmates to have an unlimited number of incoming calls.

94-420 O - 77 - 39

4.7 VISITATION (NOS. 10.2; 10.3)

[In percent]

	City jail	County jail	Total
Visitation is through:			
(i) Glass wall phone	15	8	9
(ii) Screened partitions	0	4	3
(iii) Partial partitions	0	6	5
(iv) Bars of cell	31	11	15
(v) Multipurpose area	8	48	41
(vi) Other means	0	19	16
(vii) No visitation	46	4	10
Facilities that supervise inmate visitation	54	98	91

Commentary

"Regular visiting by the family and friends of the prisoners should be permitted under reasonable conditions and under supervision": U.S. Bureau of Prisons, Jail Services, 1970.

Nebraska's city jails appear to support very stringent rules regarding visiting privileges with more than one-third the facilities not permitting visitation of any kind. The county facilities appear less strict and allow supervised visiting privileges in almost all their facilities.

4.8 VISITORS (NOS. 10.4; 10.5)

[In percent]

	City jail	County jail	Total
Facilities that restrict visitation privileges	85	91	89
Visitation is limited to:			
(i) Attorneys	23	16	17
(ii) Friends	0	2	1
(iii) Others	77	82	82

Commentary

The majority (89 percent) of Nebraska's jails place restrictions on visitors. About 17 percent of the facilities restrict visitors to only attorneys and legal persons but most (82 percent) facilities are fairly lenient and allow most friends, relatives and legal persons to visit. However, visiting privileges differ significantly for attorneys in a large percentage (75 percent) of the facilities and the security and legal status of an offender strongly influence his visiting privileges.

Only 5 percent of the facilities permit inmate visitation on all days of the week. Fifty percent of the facilities have one day per week designated for visiting and the remaining 45 percent allow visitation of inmates two to six days each week.

4.9 COMMISSARY (NO. 10.11)

[In percent]

	City jail	County jail	Total
Jails which have commissary programs	0	12	9
Jails which do not have commissary programs handle purchases via:			
(i) Jail staff	69	78	76
(ii) Family	31	13	16
(iii) Other sources	0	9	8

Commentary

Commissary programs do not appear to be in use in a significant proportion of the Nebraska jails. Inmate purchases are generally (92 percent) handled by either the jail staff or inmate's family members. The jail's chief administrators, a shift supervisor, or a staff assignee is usually responsible for this program which is made available to inmates daily (64 percent) or one to four times a week (36 percent). In most facilities (75 percent) commissary prices are not posted

but immediate cash payments are required for all purchases (77 percent). Generally (80 percent) inmates have no restrictions on the amount of money they are allowed to spend.

This system appears to be working extremely well as 92 percent of the facilities have received no complaints regarding the commissary program. However, inconsistencies have been noted in the data pertaining to commissary programs. For example, only 3 jails reported having commissary programs but 14 chief administrators are reported as the individuals in charge of commissary programs.

V. STAFF

5.1 NUMBER OF EMPLOYEES (NOS. 5.6; 5.7)

[In percent]

	City jail	County jail	Total
Administrative:			
(i) 1	46	33	35
(ii) 2	15	2[illegible]	24
(iii) 3 or more	39	41	41
Custodial:			
(i) None	69	30	36
(ii) 1	0	8	7
(iii) 2 or more	31	62	57
Clerical and maintenance:			
(i) None	46	21	26
(ii) 1	0	52	43
(iii) 2 or more	54	27	31
Professional:			
(i) None	100	87	89
(ii) 1	0	8	7
(iii) 2	0	6	4

Commentary

Jail Standards recommend a minimum of concrete and steel security "hardware". Direct contact with corrections staff who offer attention and surveillance to incarcerates can, in most instances, replace the necessary security "hardware". This does not mean custodial staff would perform surveillance; much of the attention and surveillance given inmates may be offered by psychiatric counselors, social workers and physical recreation workers, who, in the above chart, are classified as "professional employees." Use of purely custodial employees may then be de-emphasized. Currently, none of the city jails employ professional staff.

5.2 ASSIGNMENT PROCEDURES

[In percent]

	City jail	County jail	Total
Chief jailer position filled by:			
(i) election	0	93	77
(ii) Appointment	31	5	10
(iii) Civil service	69	2	13
Deputy positions filled by:			
(i) Appointment	43	90	83
(ii) Civil service	57	5	13
(iii) Other procedures	0	5	4
Custodial position filled by:			
(i) Appointment	0	84	68
(ii) Civil service	63	6	18
(iii) Other procedures	37	10	14
Clerical positions filled by:			
(i) Appointment	50	65	62
(ii) Civil service	0	11	9
(iii) Other procedures	50	24	29
Professional positions filled by:			
(i) Appointments	NA	63	63
(ii) Other	NA	37	37

Commentary

"The selection, appointment, and promotion of jail personnel should be by a merit system. If selection and appointment of personnel is not made by the merit system, then officials responsible for selecting aptitude, a minimum of a high school education (or equivalent), training and good character.": Illinois County Jail Standards, 1971.

"Correctional agencies should begin immediately to develop personnel policies and practices that will improve the image of corrections and facilitate the fair and effective selection of the best persons for correctional positions": Standards and Goals for Florida's Criminal Justice System, Bureau of Criminal Justice Planning and Assistance, p. 578. 1976.

5.3 MINIMUM EDUCATION LEVELS (NOS. 5.1–5.5)

[In percent]

	City jail	County jail	Total
Chief jailer:			
(i) No requirements	0	40	33
(ii) Some high school	18	6	8
(iii) High school	82	50	56
(iv) Some college	0	4	3
Deputies:			
(i) No requirements	0	24	21
(ii) Some high school	10	12	12
(iii) High school	90	60	63
(iv) Some college	0	2	2
(v) Graduate degree	0	2	2
Custodial officers:			
(i) No requirements	0	34	28
(ii) Some high school	18	28	23
(iii) High school	82	38	49
Clerical and maintenance:			
(i) No requirements	0	24	20
(ii) Some high school	33	28	29
(iii) High school	67	48	51
Professional staff:			
(i) No requirements	NA	0	0
(ii) Some high school	NA	0	0
(iii) High school	NA	38	38
(iv) Some college	NA	50	50
(v) College degree	NA	12	12
(vi) Graduate degree	NA	0	0

Commentary

It appears that, on an average, less than 27 percent of the jails have no specified educational requirements for jail officers, but 58 percent of the facilities require at least a high school degree for those positions. Even those facilities which do have educational requirements for all employees should "encourage and assist jail staff to take courses in the field of corrections at available universities and community colleges."[3] Further, it should be noted that since the survey data did not indicate that the staff rosters of Nebraska's city jails included professional personnel, this item of the questionnaire was not wholly applicable to these facilities.

[3] Illinois County Jail Standards, p. 9. July 1971.

5.4 STARTING SALARIES

[In percent]

	City jail	County jail	Tota
Chief jailer:			
(i) $5,000 to $7,499	8	0	1
(ii) $7,500 to $9,999	22	50	44
(iii) $10,000 to $12,499	8	36	31
(iv) Over $12,499	62	14	24
Deputies:			
(i) $7,499 or less	0	28	23
(ii) $7,500 to $9,999	60	65	64
(iii) Over $9,999	40	7	13
Custodial officers:			
(i) $4,999 or less	0	40	31
(ii) $5,000 to $7,499	33	40	38
(iii) $7,500 to $9,999	33	13	18
(iv) Over $9,999	33	7	13
Clerical and maintenance staff:			
(i) $4,999 or less	0	14	12
(ii) $5, 00 to $7,499	100	72	76
(iii) Over $7,500	0	14	12
Professional staff:			
(i) $7,500 to $9,999	NA	37	37
(ii) $10,000 to $12,499	NA	25	25
(iii) $20,000 to $22,499	NA	25	25
(iv) Over $25,000	NA	13	13

Commentary

The Florida Criminal Justice System's Standards and Goals recommends policies be developed within the system that will provide: "Salaries for all personnel that are competitive with other facets of the criminal justice system as well as with comparable occupation groups of the private sector of the local economy. An annual cost-of-living adjustment should be mandatory."

Hence it may be advisable for Nebraska officials to compare salary levels within and outside the local environment prior to reaching any decisions regarding salary standards for jail staff.

5.5 SECURITY (NO. 5.2)

[In percent]

	City jail	County jail	Total
Facilities that "have an adequate staff/inmate ratio"	100	85	88
Facilities that offer officers:			
(i) First-aid training programs	100	90	92
(ii) First-aid classroom training	62	26	39
Facilities that have at least 1 officer on each floor each shift	77	67	68
Facilities that have officers with first-aid training on each shift	92	59	65

Commentary

The personnel needs of any jail depends upon many factors such as the size of the facility and special problems which may be created by its special layout. Basic minimum standards for personnel vary from jurisdiction to jurisdiction. Standards in Illinois require that: "Each jail must have sufficient personnel, to provide adequate round-the-clock supervision of prisoners. No person shall be confined in a jail without an officer on duty, awake, and alert at all times. There should be a minimum of one jail officer for every individual floor, of detention area, and sections of a floor wherever separations by walls occur or where supervision by sight or sound cannot be made by one officer." [4]

In Nebraska 12 percent of the facilities claim that they do not have adequate staff: inmate ratios and 8 percent claim that detention area supervision is insufficient.

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[4] Illinois County Jail Standards. State of Illinois, Department of Corrections and Bureau of Detention Facilities and Jail Standards, p. 7, July, 1971.

5.6 FEMALE STAFF (NO. 5.7)

[In percent]

	City jail	County jail	Tota
Percent of female full-time staff:			
(i) Zero	43	23	27
(ii) 1 to 25	43	36	38
(iii) 25 to 50	7	23	20
(iv) Over 50	7	18	15
Number of female administrators:			
(i) None	100	89	91
(ii) 1 to 6	0	11	9
Number of female custodial officers:			
(i) None	20	35	33
(ii) 1	0	30	27
(iii) More than 1	80	35	40
Number of female clerks and maintenance staff:			
(i) None	22	16	18
(ii) 1	11	49	41
(iii) 2 or more	67	35	41
Number of female professionals:			
(i) None	NA	38	38
(ii) 1	NA	50	50
(iii) 2 or more	NA	12	12

Commentary

U.S. Bureau of Prisons, Jail Standards specify that: "Women prisoners should be under the supervision of a matron at all times." Nebraska jails appear to be deficient in the area of female personnel with 27 percent of the facilities having no full-time female employees. However, when female offenders are in the facility, part-time matrons are hired in most (87 percent) of the facilities.

"Correctional agencies should develop policies and implement practices to recruit and hire more women for all types of positions in corrections, to include . . . assumption by the personnel system of aggressive leadership in giving women a full role in corrections": Standards and Goals for Florida's Criminal Justice System, p. 582, 1976.

VI. PRISONER POPULATION

6.1 AVERAGE DAILY POPULATION (ADP) (NOS. 6.9; 6.13)

[In percent]

	City jail	County jail	Tota
Facilities that had a 1976 average daily population of:			
(i) Zero prisoners	14	6	8
(ii) 1 prisoner	37	23	25
(iii) 2 prisoners	21	10	12
(iv) 3 to 10 prisoners	14	42	37
(v) 10 to 50 prisoners	14	16	15
(vi) 50 to 100 prisoners	0	3	3

Commentary

As the above chart indicates, the average daily population of county jails is considerably higher than city jails. Analysis of the average daily population, like analysis of the average length of stay, is difficult without statistics on the availability of pre-trial release programs, diversion programs and charges for which offenders are incarcerated. The most important data, however, is the design capacity of each jail as compared with the ADP; from this information, it can be determined whether the jail is overcrowded or not.

6.2 PRETRIAL LENGTH OF STAY (NO. 6.13)

[In percent]

	City jail	County jail	Total
Facilities with an average length of pretrial stay of:			
(i) Zero days	38	2	8
(ii) 1 day	54	21	27
(iii) 2 days	8	28	24
(iv) 3 to 45 days	0	49	41

Commentary

Every person charged with an offense is constitutionally guaranteed the right to a speedy trial. Although the length of stay in city jails before trial is short, pre-trial stay in county jails may be much longer in comparison. Such a long stay may be unnecessary and undesirable for many felons and almost all misdemeanants. Information pertaining to the types of offenders in the various facilities may be valuable for future analysis.

6.3 POSTTRIAL LENGTH OF STAY (NO. 6.13)

[In percent]

	City jail	County jail	Total
Facilities with an average length of posttrial stay of:			
(i) Zero days	NA	3	3
(ii) 1 to 2 days	NA	7	7
(iii) 3 to 10 days	NA	20	20
(iv) 10 to 30 days	NA	48	48
(v) More than 30 days	NA	22	22

Commentary

Although there are no offenders sentenced to city jails, a large number of offenders are sentenced to county jails. The majority of the sentences are less than 30 days which, while being a laudibly short period of stay, indicates that many of these sentences may be for minor offenses. Incarceration for minor offenses can often be de-emphasized with little or no danger to the community.

Senator BAYH. Mr. Marvin, would you proceed?

STATEMENT OF C. RAY MARVIN, COUNSEL, NATIONAL ASSOCIATION OF ATTORNEYS GENERAL

Mr. MARVIN. Senator Bayh, I thank you for the opportunity to say that the National Association of Attorneys General is opposed to this particular form of the bill. We would like the opportunity to work with your staff in developing proposals which might be compatible to the various interests represented here today and in the hearings. That's all I have to say.

Senator BAYH. You're invited to do so certainly. You are urged to do so. I would like for our staff to understand the importance of getting those people involved who have the responsibility, ultimately, for treating this problem as it exists now and as it will exist even after a law, whatever that law is, is passed.

I think we have a goal where the commonality of purpose is such that we should be able to resolve some differences. Maybe none of us will be 100 percent satisfied with the outcome. Certainly we are not going to be 100 percent satisfied with the conditions that exist in these

institutions, even with the best efforts. But it seems to me that we ought to make the best efforts we can, so I appreciate the willingness of your organization to cooperate with us; we want to cooperate with you.

TESTIMONY OF ROBERT B. HANSEN, ATTORNEY GENERAL, STATE OF UTAH

Mr. HANSEN. Mr. Chairman, I would like to make it clear that while Utah has its problems and we recognize those problems, I have given to counsel for distribution to the committee a brochure that our Governor has prepared for the special session of the legislature that was held just this week. I have not even been advised as to whether they funded as he requested that they fund the money necessary to solve a slight overcrowded condition at the Utah State Prison. That is a condition that generally exists nationwide.

The administration is addressing that. I think Utah, like the other States that attorney general Burch of Maryland indicated, is taking a much more active role in fulfilling its State's duties and not simply relying on the fact that the States rights are such that they ought to preclude Federal intervention.

I am really more concerned because I am chairman of the special committee of the National Association of Attorneys General which deals with abuse of Federal-civil actions involving State prisoners. I can assure you that the experience that Maryland has had with the Justice Department is not atypical. In consulting with the other attorneys general that has been a rather common experience.

I recall specifically General William Scott of Illinois telling me that he had about the same experience as attorney general Burch related here today.

When I first learned that the Justice Department was interested in State prisons, I called the Justice Department personally and asked the person in charge of that to call me back. They never did. Six months later we suddenly received an order from our chief Federal judge putting Justice Department in the case. The Justice Department has not decided whether or not they really want to get involved as a party in our Federal prison suits. Such suits are always ongoing at any given point in time for the last dozen years or so. I think your concern about whether or not the Justice Department could get involved at any institution at least as far as the penal institutions are concerned is more academic than real because there are always actions ongoing that they could intervene in without any authority to initiate such grants.

The main concern that I have about this bill is it is unconstitutional in my opinion. I think that if this bill is constitutional there is no drawing the line where the framers of the Constitution drew the line at the powers expressly granted.

If the Justice Department can constitutionally become involved in these cases, can it not constitutionally get involved in almost any type of problem.

Whenever you can put a horror story before the Congress—and that's not really much of a problem to find problem areas—for example the policing of the legal profession might be in order as the

last issue of U.S. News and World Report indicated. They were talking about what the State bars are doing post-Watergate with respect to that area. I see a lot of constitutional rights that the States through their State bar associations have not addressed that the Justice Department might well be involved in and that might have far greater impact socially than what we have in this present bill. In spite of *Miranda* and the other constitutonal rights of persons taken into police custody, there are still many complaints. There always will be many complaints of police brutality that involves the violation of Federal constitutional rights.

If the Justice Department can constitutionally come into the State prisons and the State institutions, then they can constitutionally come in and run our State police.

I can hardly conceive of any local responsibility that is exclusively the States under the Constitution that cannot be a proper area of invasion if this bill is constitutional, not only of Federal legislative authority, of which we have seen dramatic impact in this century, but now an intrusion of a much more invidious threat, in my opinion, when you have Federal executive power moving in.

In addition to the constitutional objection above, I object to this bill as a matter of policy because I think it is a sledge hammer approach. The commendable objectives of this bill could be handled much more adequately by other available remedies, more economically and with much less friction.

There is not any attorney general that I know of who is opposed to the objectives. Mr. Chairman, you have made several references to the fact that the attorney general, by having to defend these actions which he has an obligation to do, is in a conflict of interest where he cannot address the substantive problem. I suggest that that is not true because the attorney general is to State government largely what a private attorney is to his own client.

Many times the toughest thing a lawyer has to do is to tell his own client that he is wrong and that he has to shape up, that he has to "clean up his act" or whatever the case may be in order to come into compliance with law.

Here, it is Federal constitutional law. I believe in accountability. I believe it is bad when you do not have accountability. There has not been historically the accountability that there ought to be.

This is true particularly with respect to the mental institutions because they have not had the access to the courts that the prisoners have had. The prisoners have had, if anything, too much access to the court. Once you get a case in court, you do not have to draw much of a road map for a Federal judge. I can well appreciate the views of the judge who testified here this morning. He had his case moved more expeditiously because when the Federal Government comes in with their unlimited financial resources and with the FBI and the experts that they can hire, there is no doubt that they can make a real impact on the case.

But sometimes that is the very thing that is bad about them doing that because they come in with such resources and such expertise and with such ability that the result is an unbalanced presentation to the court. Or at least if it is balanced with respect to the parties litigants, at least it is unbalanced to other social needs and demands. There has

been some reference made to that here. My colleague from Nebraska has pointed out, and you yourself have experienced in your State legislative experience, the problem: How do you meet all these competing needs that are almost infinite in number and vast in scope so that tax funds are fairly allocated?

There is another aspect that seems to me to be objectionable about this bill.

I would think that if you're going to have a bill of this type that the Congress ought to set certain specific minimum standards, as has already been suggested by General Burch. I think the procedures by which those standards are implemented should be spelled out if you authorize the Justice Department ultimately to come into a case of this type.

However, I would think that you would have far less friction and far more cooperation by requiring the State to police itself. This is not a matter of correcting these conditions today in 1977. We ought to be concerned about 1978, 1979, and 1980 and so on. It's an ongoing thing. The executive branch of government, not the judicial, simply has to be responsible to achieve such ongoing reform.

I think we have a parallel here in OSHA. OSHA, as you know, is something that has been very much resented by a wide segment of our population but nevertheless it addresses a very critical problem—the health and safety of workers. That is a valid concern of government and one that the States should have done a better job about a long time ago.

But at least the Congress has had the wisdom to permit the States to do what is necessary to get the job solved without making it mandatory for Federal bureaucrats to do the job.

As it stands now, if the States will, adhering to Federal standards, set up their own programs for enforcement, then the Federal Government can stay out. I say that the same principle is valid and applicable in this area with respect to State institutions as it is with workers' health and safety.

I think that we would have to be candid in acknowledging that some of the States, despite the general effort of the States as a whole to do a much more adequate job in discharging their obligations to the citizens of their States and of this country, have not done the job to the point where you feel and many feel that the only solution to the problem is before us is this bill. The last resort will be the way it ought to be handled just so it is handled.

I think the States themselves, not with respect to this bill alone but with respect to all of their social problems and duties, are going to have to establish some vehicle by which they can police themselves much better in the future than they have in the past.

The article I refer to in the U.S. News and World Report points out that the State bar associations are very much aware of the fact that if they do not do the job themselves that the Government, and in that case the State governments, will come in there and do the job for them. I would agree that that would have to be ultimately done.

But if you had a vehicle which the States can establish by compact such as their peer State organizations, through organizations such as Mr. Marvin represents here as counsel for the National Association of Attorneys General then you could be sure the job would be done

without Federal intervention. I understand the States already use such a program with respect to private insurance companies. There are, of course, in almost every level of State government national associations to which the Governors belong, the mayors belong, the chiefs of police and so on, that they themselves could establish, I think, organizations to make independent investigations as to the conditions in their sister institutions which, again, meeting Federal guidelines and standards would achieve that same purpose without causing all the problems and bitterness that this bill is otherwise going to cause.

I would think that if you would not be satisfied with the States doing it themselves through their own institutions on a parallel with OSHA and if you wouldn't be satisfied with the States through compacts being exempted from that situation, then at the very least you should require before the Justice Department ever gets involved that the Federal Bureau of Prisons, the Federal agency with expertise in this area, be required to conciliate with their counterparts on the State level. Then you would not have, as you do have now, a resentment by the warden of the Utah State Prison and all the other State wardens when they have the legal experts from the banks of the Potomac to come there, who have had some experience but far less experience than the people they are dealing with, tell them how a penal institution is to be run.

In other words, doctors listen to doctors, and lawyers listen to lawyers, and wardens listen to wardens.

I think it would certainly be a far better system than to have the uncontrolled discretion of the Justice Department without the expertise and with extensive experience in this area, as attorney general Burch has alluded to already, making those decisions. Federal experts in applicable institutions should make the decision to involve Justice only after having made an effort to resolve those problems on a conciliatory cooperative basis.

The Governor of Utah as a matter of policy for many years, has asked the Federal Bureau of Prisons to come in and make an investigation of that institution. The recommendations that they have made have been helpful and implemented. I'm sure we have a much better prison as a result of that.

But that has been done without any Federal sledge hammer hanging over our head. I think that you may need to have some pressure, but I do not think you have to have this much pressure.

Senator BAYH. Without objection, your written statement will be inserted in the record.

I do not know how much pressure we need. I wish I could say that we don't need any, but this bill is not a figment of the imagination. If some of us could, we would figure out how to irritate you guys back home in response to some of these critical problems which have not been resolved by well-intentioned State officials saying "If you let us alone, we'll solve our own problems." But what we're trying to do is to find a way to get the Federal Government involved in a special way. If you could clean house at home without Federal involvement that would be good, but realistically it will not happen in such a way that at least the States will have had a chance to make a good-faith effort.

Failing that, then we will have to reach certain goals that the State refuses to reach.

Mr. HANSEN. They do not, Mr. Chairman.

When our association had its last meeting here, earlier in the month, and Judge Bell made the assurances to the attorneys general that even if they got the law passed that they need not worry about the Justice Department coming in like a bull in a china closet. Also they were going to give us plenty of time to work out our problems on our own turf first.

I called Drew Days and said that:

> Your boss says that we're going to have a chance to work that out. The special session of the legislature has been called. The only problem in the Utah prison suit that you have been invited to come into and you're in the process of starting an investigation on deals with our overcrowded prison. There is nothing that the Justice Department can do that will make us more aware of the fact that we have an overcrowded condition.
>
> We have a governor there who is dedicated to fulfilling his obligations and who has real compassion for the prisoners. He does not have to have a Federal bureaucrat holding a gun at his head to tell him what ought to be done.
>
> I think you ought to hold out, as Judge Bell had indicated to the attorneys general that he would do, until we see what comes out of our special session. You will see that we are in good faith in moving ahead.

He has agreed to come out to Utah and talk it over. But this would be after the Federal investigation has been completed. It is that type of insistence on bringing the power to bear which causes such friction between the Federal Government and the State governments.

Senator BAYH. I'm not familiar with the Utah problem. Is that in court now?

Mr. HANSEN. Yes.

Senator BAYH. The Justice Department must have been invited into court by a Federal judge; is that right?

Mr. HANSEN. Yes. We have a rather unusual situation. The Justice Department lawyers told me that they had had the Federal judge on their back for 2 years to get involved. He wrote to them to find out what sort of an order and forms he could use to get them involved. So they were somewhat reluctantly dragged in.

Senator BAYH. Would this be a capricious judge?

Mr. HANSEN. Yes and I think that's the kindest characterization you could give to him.

Senator BAYH. As I say I'm not familiar with the Utah situation. I am familiar with other examples. I think you are accurate in suggesting that in most prisons there are a number of opportunities for the Justice Department to get involved. Let's take the other extreme of the mental institution that houses the disabled or mentally retarded children. Oftentimes there is no opportunity at all to get involved.

We have had examples which almost defy description. I became aware of these before I became involved in this particular effort. In some instances, States absolutely refuse to do anything.

Mr. HANSEN. I suppose it is the principle of federalism that we are really fighting for. States which are doing the job should not be treated the same way as States who are not doing the job.

Senator BAYH. What about the States which are not doing the job?

Mr. HANSEN. Through one means or another it should be done. Mr. Chairman, I think the press is responsible for far more correc-

tive measures being taken than all the courts, both State and Federal, put together are responsible for. I think that is probably a healthy thing.

If we simply let the information be known, we have people who are concerned and who are dedicated. They do not have to be Federal judges to have that concern or compassion for the unfortunate. It simply has to be known. There has to be some form of accountability. It ought to be built right into the administration themselves.

But I will assure you that there is no attorney general that I know who would permit the type of conditions to exist that have gone on here. It is true that we do not know what all the problems are at all the institutions all the time. There ought to be ways that we devise so that we do know.

I think that through our national organizations, we can develop those mechanisms by which that can be done.

I would like to see that attempted before we go to the much more drastic remedies that are proposed. I think good legislation and good government is not different than good medicine in that respect. You try the more moderate and conservative measures before you move on to something that involves more drastic surgery.

Senator BAYH. I remember my State legislative days, when I found myself being forced as a State legislator to deal with problems that had not been resolved at home by the localities.

I get to Washington and I now find myself dealing with problems which have not been resolved by the States.

With all due respect to the attorneys general of this country, inasmuch as I think your suggestion is a good one, we are dealing with this problem because—as of this moment—it has not been resolved by initiation of solutions by the State attorneys general.

Mr. HANSEN. I do not know about problems in Maryland or problems in New York or problems elsewhere, but it would seem to me a rather important subject of investigation to determine why the various mechanisms, already existing in society, fail. Why did not the Governor know? I cannot believe that there is any Governor anywhere in this country who would think that that is a tolerable situation.

Senator BAYH. Neither can I, but I have to say to you that we have some rather dramatic examples where the horror stories have existed. The courts have gotten involved. The situation has been remedied. Now either the Governor knew or he did not know. If he did not know, he should have. If he did know, then probably he should have been impeached for not doing something about it.

But the facts are as they are. I don't like them and you don't like them but there they are.

Mr. HANSEN. I suspect, without knowing, that the hearing record will be totally lacking in any information on that subject. I would like to know who the State representatives and senators are. What about the Congressmen in that district? What about the church leaders?

Senator BAYH. Wait just a moment here. I think you have to understand that there are limits beyond which you cannot say "Okay, clean up your shop." Just because a church league or the local State representative is not doing what he ought to do does not mean that

we're going to let a lot of children be denied the constitutional rights guaranteed them as citizens of this country.

Mr. HANSEN. You misunderstand the point I'm trying to make. The point I'm trying to make is this. We do have people in a position who are there to see that wrongs and social evils do not exist. Why not look, before we get into the drastic surgery, to see if there is some sort of a legislative prescription that can solve the problems so that we do not have a failure of communication.

I say it is a failure of communication. You said yourself that the Governor ought to be impeached if he knew about this and allowed it to continue. I say that you would not have to cause anybody to be impeached. They did not know about it. Why didn't they know about it?

It seems to me that before you say, "Well, we will not worry about why that failed but we will simply bring in another remedy and not worry about that." I say that we should find out why the communication failure existed.

Senator BAYH. I want to find out also, but if my brother or my father or my child had been put into one of these institutions and perhaps should not have been there in the first place, then I would want to do something. We have stories about patients getting into institutions where a mistake was made in the first place and once they got in there was no way of getting out.

Given a situation like that, I would not want Senator Bayh or Attorney General Hansen to get into a big philosophical discussion about why somebody didn't know. I'd want to get him out. I'd want somebody to say, "Okay, all of you fellows are responsible and you're doing it, so how do we get a remedy?" That's what we're trying to do. I think we can do it in a way that is not going to be offensive, overly so. I think we can all go the same direction.

We have evidence of abuse. Somebody is not doing what he should be doing. So, I think the individuals who are being abused have a right as citizens to have that abuse redressed.

Mr. HANSEN. Yes, Mr. Chairman, but why leave a situation such that it has to be repeatedly redressed? You might have the root cause of it ascertained and the communication gap repaired so that it would be self-correcting as the situations come along. Whatever the situations are and whatever reasons there are for them arising, it seems to me that our alarm system has not been operating correctly to let them surface when they should have been surfaced.

I guess what I'm saying is this. Putting out the fire is awfully important once a house is on fire, but it seems to me that it is probably more productive of saving property from damage by fire to make sure that the fire wardens detect that smoke long before that smoke breaks into a destructive fire.

Senator BAYH. That is certainly true. There is no question about that. But given that, I still have to have insurance on my house.

Mr. HANSEN. Yes, we have to put out the fires. The only thing I'm saying is this. Who mans the firehose and who runs the firetruck?

Senator BAYH. Is it fair to say that every attorney general in the United States is aware of this bill?

Mr. HANSEN. Certainly everyone who was at Indianapolis at the first of this month is well aware of the bill. As Mr. Marvin said it

was passed unanimously with one abstention. It was not that the attorney general of Colorado really favored that bill. He just did not want to offend the U.S. Department of Justice, with whom he has a great love affair in Colorado, and jeopardize his relationship by making it look like he was opposed to their position.

Senator BAYH. Then at least in one State it is possible to have an amicable relationship with the Justice Department? [Laughter.]

Mr. HANSEN. I would not like to let the hearing record imply that we do not have good relations with our Justice Department.

Senator BAYH. I'm glad to hear that because I must say that from what you have said I would hardly find that in your testimony. [Laughter.]

Mr. HANSEN. I misstated myself if I implied anything to the contrary.

The third objection I have to this bill is this.

Senator BAYH. Let me interrupt. Everything that has been said here by any of you—and I know you're all dedicated—has been aimed at showing that the Justice Department has horns and that they have not made contributions as far as your job is concerned.

Mr. HANSEN. But, Mr. Chairman, there are many divisions of the Justice Department. They should not be broad brushed. I'm talking about the Civil Rights Division. That's where the problem is.

I have a third objection. It divides the natural crime fighting allies of the U.S. Department of Justice on the one hand and the attorneys general of the State on the other. We have a very good relationship with the Department of Justice who are involved in the fighting of crime. That's where we interface with them primarily.

But here we have a whole different unit. I do not think the Attorney General of the United States, frankly, is really philosophically in tune with the Civil Rights Division of his own Department. Rather I should put it the other way around, I don't think the Civil Rights Division is in tune with Attorney General Bell.

I do not think the Civil Rights Division fully appreciates or understands what Judge Bell's position has been on this. I think it is something that has to be worked out within the Department itself. I hope that we do not have the situation like Attorney General Levi said, according to General Burch, that he tells his people to do something but they don't pay any attention some times. I hope no Attorney General of the United States would tolerate that situation.

Senator BAYH. It's hard for me to believe. I've never been an Attorney General. But if I were an Attorney General and I asked someone to do something and he did not do it, then he would not have the responsibility for doing it a second time. [Laughter.]

Let me say this. Honestly, I think your third point is your weakest point. I cannot conceive of a situation where the Attorney General of the United States or the State attorney general, the local sheriff, or the chief of police and all these people out there who are prepared to fight the criminal element, are going to be any less determined to fight the criminal element to protect our society, because in some mental institution you have little girls tied to beds, spread-eagled like animals, and the Civil Rights Division of the Justice Department feels that that ought to be stopped.

It is a totally different responsibility. With all due respect I would stick to my stronger points if I were you.

We all want to fight crime and protect individuals who are being abused in those institutions that are supposed to be protecting them. I cannot see that this is a conflict.

You have been very kind here. I hope and I think that we can find a way to deal with this problem. I hope that all of us in public life are not naive enough to think that both the goal we would like to accomplish as well as the vehicles that we would like to see accomplish them are always going to be operating perfectly. What we are trying to do is to find a way by which we can nudge or, if necessary, sledge hammer people into doing what they ought to do anyhow. It's like the story of having to hit the old mule with a 2-by-4 to get his attention.

Mr. HANSEN. I think you have our attention, Mr. Chairman.

Senator BAYH. Unfortunately, *Wyatt* went public in 1971. That was 6 years ago. We still do not have the attention of all the States.

Mr. HANSEN. But when the Federal investigators came out to see the prison, one of our prisoners was in the State hospital, our mental institution, and we only have one in Utah. Our administrators there were very upset that they were not planning to spend a lot of time out there because they were so anxious to show them what a good institution they had.

I do not know if it is all that good that they were going to get a lot of brownie points for running a good shop out there, but at least with respect to our State, we did not have to have even this bill to alert us to the fact that we ought to take good care of our mental patients.

Senator BAYH. Are you inviting them to come back?

Mr. HANSEN. Yes. As a matter of fact, they will be rather offended if they are not rather closely scrutinized and get good marks.

Senator BAYH. Let's hope they do. I trust they will. Unfortunately, one of our first witnesses pointed out that a superintendent of one mental institution was bragging about the conditions that existed in his institution. While some of the most horrible things that you could imagine were happening there. In many cases, these abuses are discovered by the press. I think the press can play an important role in shedding some light on these situations. But unfortunately, even when light is shed in some instances, the necessary changes are not made.

All right, we will look forward to working with you gentlemen. I appreciate the contribution you have made here.

Mr. HANSEN. Thank you, Senator.

[The prepared statement of Attorney General Robert B. Hansen follows:]

PREPARED STATEMENT OF ROBERT B. HANSEN

At the outset I would like to make it clear that there is no dispute concerning the desirability of achieving the objectives of this bill, namely to secure humane treatment for all who are incarcerated or in protective custody in State or local institutions, whether they be mentally ill, physically handicapped, prisoners, detainees, or juveniles. My opposition as an official of the State of Utah, together with other officials of this State and most of our counterparts in other States, is the method of achieving those objectives. No matter how desirable an end may be, it cannot justify improper means and it is our contention that this bill is an improper means.

I believe that this bill is improper for the following reasons:

1. It is unconstitutional:

2. It creates friction between the various States on one hand and the U.S. Government on the other;

3. It divides the natural crime fighting allies of the U.S. Department of Justice on one hand and the Attorneys General of the States on the other hand;

4. It is inefficient because it provides a judicial remedy in an area where legislative and executive solutions are more appropriate and the benefits more long lasting.

I would like to briefly comment on each of these reasons.

1. S. 1393 is unconstitutional.

As United States Senators you have taken an oath to support and uphold the Constitution of the United States to the same extent as have Federal judges. While this question is a matter of law and not of fact, many of you have had distinguishing careers in the legal profession before becoming senators, and even those who have not have acquired a practical expertise in legal and constitutional matters. In addition, this particular question is far less technical than most since it involves a basic conceptual issue as to whether there is an inherent power in the Federal Government to take such action as it deems necessary to protect Federal constitutional statutory rights of certain citizens detained for various reasons within the several States. The Justice Department does not contend that there is any express authority in the Constitution for them to take action which this bill presumably confirms, at least Drew S. Days, III, the Assistant Attorney General in charge of the Civil Rights Division of the Justice Department, failed to cite any in his statement on April 29, 1977, before the House Judiciary Subcommittee, which held hearings on H.R. 2439, a nearly identical bill.

Inasmuch as there is no express power granted to the Federal Government in this area, I respectfully submit that the tenth amendment to the U.S. Constitution is controlling. It states: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." To enact this statute in the fact of that constitutional provision is a clear violation of the Constitution itself.

If this bill is constitutional, can any bill be unconstitutional which enables the Justice Department to initiate suit against a private corporation or individual who violates any provision of the Constitution (which are numerous) or any provision of any Federal law (which are nearly numberless)? Then why not any Federal regulation (which are even more astronomical in number and in scope)? If you don't hold the line where the framers of the Constitution did at the expressly granted powers, where can you draw it short of total and absolute Federal dominance? The Constitution aimed most of all to create a limited government. Is this Congress to do the ultimate violence to that concept? Is such a radical departure from fundamental constitutional principles consistent with your oath to uphold the Constitution?

Ultimately all questions of constitutional law must be resolved by the U.S. Supreme Court. However, every enactment of the Congress of the United States is presumed to be constitutional and it is my opinion that the Congress, itself, ought to be satisfied that there is a substantial possibility, if not probability, that the Court would uphold such an enactment. Otherwise, two injuries are done. First, the courts are burdened with cases working themselves up from many of, if not most of, the 93 district courts, through the 11 courts of appeal, and finally adding to an already overburdened case load of the U.S. Supreme Court. The second damage is the expenditure that both the Department of Justice and the respective attorneys general must make to litigate these cases until a decision of the United States Supreme Court is rendered, which may be several years after the statute is enacted. During that period, the relations beotween the Justice Department and the States' attorneys general will be strained considerably, as noted in the second and third objections below.

Regardless of how commendable the underlying social policy may be in support of this proposed law, it is the duty of this committee to reject it if it is unconstitutional. I submit that it is.

2. This bill will create friction between the U.S. Government on the one hand and the several States on the other.

Historically the management of prisons, jails and institutions for mental patients, physically handicapped and juveniles has been a local function. The intrusion of the Federal Government in this area will necessarily create animosity and ill will. The local officials naturally resent dictation and domination from the seat of government often far removed from the local conditions which

are being addressed. Added to the hostility toward "superior officials" is the increased economic burden imposed upon the local citizens to supply the mandated improvements in this area which necessarily compete with other pressing social needs in other areas. It is also unfair to the competing beneficiary groups who lack the weight of Federal officialdom to balance the scales in support of their social needs and claims. Where claims and demands are virtually limitless and means and facilities limited, if not scarce, the State legislators, under Federal and State constitutions, are charged with the responsibility of resolving these competing and conflicting interests of their various citizens for governmental support of programs affecting them. A society which relies so heavily upon voluntary compliance with law and the self-motivation of its citizens as ours does can ill afford any unnecessary anti-government feelings.

Thus, even if the U.S. Senate concludes that this bill is consistent with the U.S. Constitution, it ought not to enact it by reason of the policy considerations just mentioned, which I submit outweigh the benefits to be gained by the Justice Department involvement in these cases.

3. It divides the natural crime fighting allies of the United States Department of Justice on one hand and the Attorneys General of the States on the other hand.

The last objective set forth above dealt with the Federal and State governments generally, whereas this objection relates only to the legal offices of those respective governments. It is within these legal offices that the proposed bill will create adversary and antagonistic positions which will be detrimental to our offices working together as we should on major criminal investigations, especially in the field of organized crime. It's obviously difficult to be allies in a war against crime at the same time we are doing battle with each other in Federal court on State prison cases.

4. It is inefficient because it provides a judicial remedy in an area where legislative and executive solutions are more appropriate and the benefits more long lasting.

Although I have no personal experience in any of the situations to which Senator Bayh referred to in his remarks of April 26, 1976, when this legislation was introduced, I am quite confident that the root cause in all of them was lack of adequate financing. The officials in charge of the subject institutions were not sadists, they simply had to make do with the facilities and funds their legislators gave them to work with. It would be an interesting and I think helpful study to ascertain whether the governors of those States had urged their legislatures to provide more adequate funds, whether the opposition party controlled the majority of the votes, whether the officials in charge had sought to enlist private foundations, civic groups and interested charitable organizations to alleviate the plight of the subject inmates and, if so, why those efforts were not effective.

This bill will not increase the funding necessary to upgrade those institutions. Neither can the Federal courts which entertain the proposed suits. Of course, the orders of the Federal courts which release criminals will compel the legislatures to spend the $30,000 to $50,000 per each additional cell in the prison in order to protect the public safety. Are such compulsory methods necessary? Is it not insulting to every governor, to every State legislature, to every citizen even to imply that only Federal judges have the compassion or means to appreciate or remedy these situations. Are we so inarticulate or so callous or so selfish that we can not persuade the decision-makers and the voters that justice and humanity, as well as the Constitution, requires us to spend the sums necessary for the worst and the most unfortunate among us to live in a decent environment? Before we resort to force because we are so base, let us exhaust our efforts to persuade our people that they should do the right thing for the right reason. If we succeed we will not only remedy the bad but put in motion forces which hopefully will even seek an increasing good. In that we could be properly proud.

I find it difficult to address the specific provisions of this bill because I so dislike the thought that such awesome power will even be granted, but the State attorneys general would most assuredly be here en masse for limiting provisions if it does pass, hence these comments:

First, the words "or laws of the United States" in Sections 1, 2 and 3 should be deleted so that only constitutional rights of the persons in question will invoke this drastic intervention of Federal interference.

Second, Section 1 should be amended to require exhaustion of State remedies.

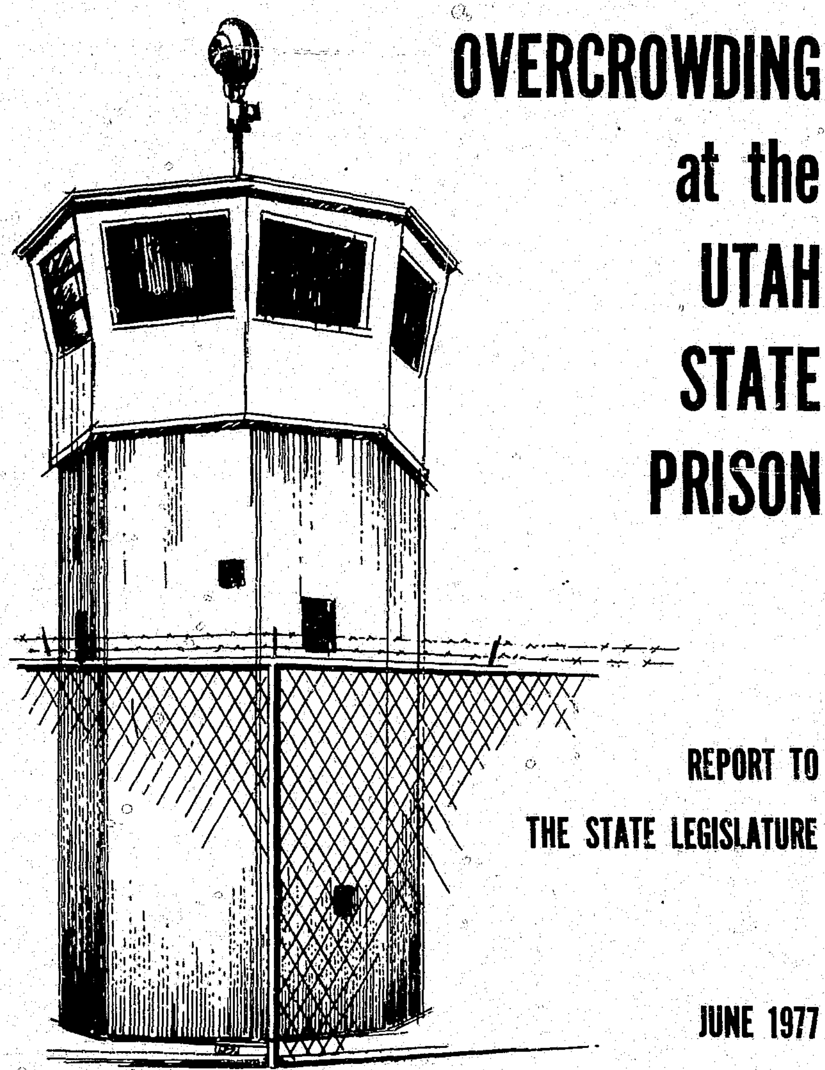
Third, Section 2 should expressly require that the specific allegations which are claimed to support a charge of unconstitutional practices and patterns should be communicated to both the institutional officials and the State's attorney general.

Fourth, Section 2 should require the attorney general to set forth his recommendations and specify which of the same must be corrected and within what time frame in order to avoid the filing of a suit or a motion to intervene.

Fifth, an additional section should be added which requires the court to enter an order staying proceedings if the court is satisfied that the corrective measures are being undertaken in good faith which will eliminate any unconstitutional practices as soon as reasonably possible to do so.

These proposed amendments to the bill are self-explanatory, but I would like to mention that my second objection would be much less applicable if the orders of enforcement were issued by State court judges rather than Federal court judges. Perhaps there was a time when State judges were less sensitive to Federal constitutional issues than were Federal judges, but I believe that time is behind us and State judges properly resent the implication that this is so. Even more, the people will respond in a much more constructive manner to remedies mandated by their own judicial authorities.

[EXHIBIT No. 28]



OVERCROWDING at the UTAH STATE PRISON

REPORT TO

THE STATE LEGISLATURE

JUNE 1977

FORWARD

The data in this report is the compilation of three months of research on overcrowding at the Utah State Prison. Individuals from the Utah Department of Social Services Executive's Office, Division of Corrections, Office of Planning and Research and the Utah Council on Criminal Justice Administration were involved in the preparation of the report.

A public hearing on the overcrowding was held May 26, 1977. More than 50 persons attended the hearing. Recommendations were presented to Governor Scott M. Matheson for his review on May 27, 1977 and to the interim Social Services sub-committee on June 7, 1977.

TABLE OF CONTENTS

Overcrowding

Causes

Inflow Diversion

Prison Diversion

Expansion

Map

Outflow

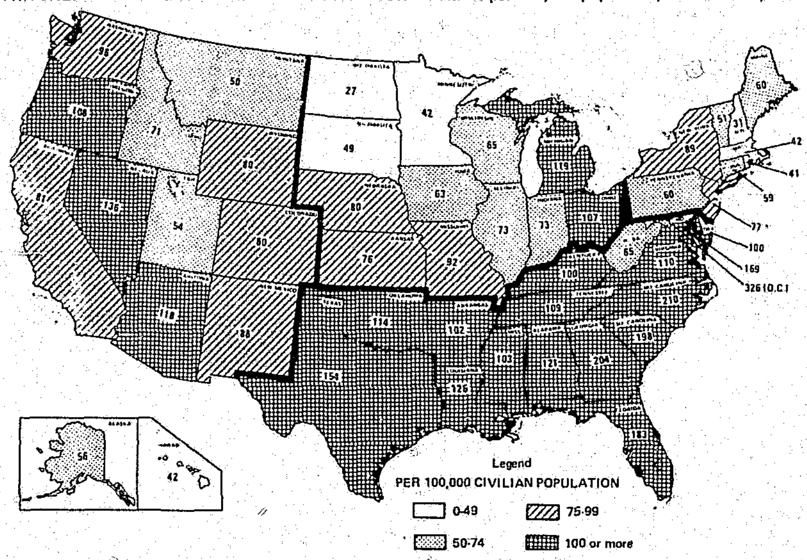
Master Plan

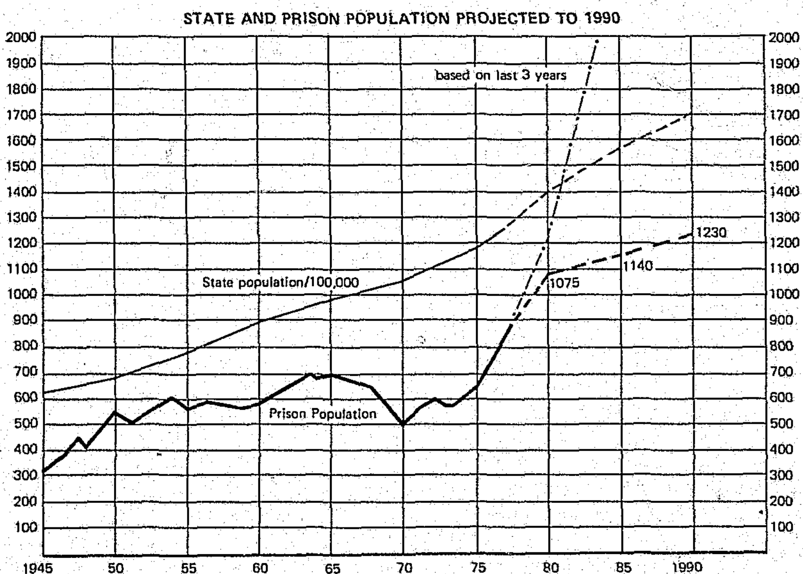
Budget

Questions/Answers

Memorandum

PRISONERS IN STATE AND FEDERAL INSTITUTIONS: number per 100,000 population, December 31, 1975





Note: The populations of Utah and the prison since 1900 were compared to develop the future prison population projections.

Overcrowding

The Utah State Prison is overcrowded. It is the result of people being sentenced to prison at a faster rate than they are being released and being incarcerated for longer periods of time. For the past few months the population of the prison has been increasing at an average of 10 inmates per month. Conservative projections indicate that by 1980 the population of the prison will be 1,075, and 1,230 by 1990.

The prison currently has a total bed capacity of 862 inmates, but an operational capacity of only 798 beds. Beds in maximum and medium security must be available for the transfer of inmates who are safety or management problem, hence the difference between total and operating capacity.

On June 9, there were 914 inmates sentenced to prison. A total of 825 were residing at the Draper facility. An additional 25 were being housed in county jails. 23 reside out-of-state. There were 41 other inmates who are currently housed at correctional centers and halfway houses.

This means, then, that as of right now, the prison is short 96 beds if it had to house every prisoner now in the community. Projections for the future show the bed deficit increasing.

Year (June)	Operational Capacity	Projected Population	Number Deficient	Percent Deficient
1977	798	914	116	15
1978	798	960	162	20
1980	798	1,075	277	35
1985	798	1,140	342	43
1990	798	1,230	403	51

Causes

The Division of Corrections has 2 major purposes: 1. To protect the public and 2. To work with the offender to help him attain the level of internal control and the educational and vocational skills needed to succeed in society.

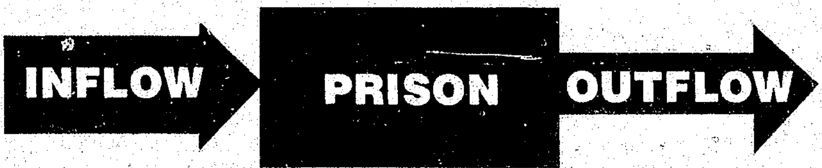
The Governor, the Department of Social Services and the Division of Corrections are concerned that their ability to meet these two major objectives is seriously being jeopardized because of the overcrowding conditions.

Prison overcrowding is not unique to Utah.

It is occuring throughout the nation and is expected to continue for many years. Many factors contribute to the increase in the number of individuals being sentenced to prison. They include:

- There are more people.
- Adults, ages 18-35, are high risk for criminal activity.
- The nation is not at war. The draft served a useful purpose. The military offered a structured setting for many individuals in the high risk category.
- The crime rate has increased.
- A "get tough" attitude towards crime has resulted in more individuals being locked up.
- Law enforcement officials are more efficient in the apprehension and processing of criminal offenders.

The methods recommended to relieve the overcrowding at the Utah State Prison constitute a flexible approach. The intent of the study committee has been to find short-term solutions to the overcrowding that do not limit or foreclose on long-term solutions that must look at elements and factors outside the control of the Division of Corrections.



PRESENT CONDITION: At the present time, inflow into the prison is high, increasing by 10 inmates a month. The capacity of the prison to house inmates is small. Outflow and release is limited.

PROPOSED ACTIONS: Short term solutions will take some of the burden off of the prison. Some offenders will be diverted before they reach the prison to slow the inflow. The capacity of the prison will be expanded. Inmates will be diverted to community programs from prison. More inmates will be released sooner to broaden the outflow.

PRISON OUTFLOW

Inflow Diversion

Utah has a crime rate slightly above the national average, yet it has one of the lowest incarceration rates in the country. Only 20% of Utah's felony offenders are sent to prison. The rest are referred to community type alternatives or placed on probation.

Despite Utah's already high use of alternative programs, more individuals could be diverted from the prison.

An initial action would be to relocate the 90-day Diagnostic program to a community-based facility. This would free up to 60 beds in the prison's minimum security area.

Diagnostic inmates are still under court jurisdiction pending the court's decision to grant probation or to incarcerate. Only 25% of these offenders are sentenced to prison following the evaluation in the diagnostic unit.

A sufficiently secure residential facility can be acquired to house the inmates.

Ten correctional counselors would be needed to provide 24-hour staffing. A psychologist and support personnel would also be required.

Estimated Completion Date .... Sept. 1, 1977

Staff costs	$183,000
Lease, food and other current expenses	121,000
Travel	9,000
Security devices, etc.	14,000
TOTAL	$327,000

Prison Diversions

Prison can be a starting point for many inmates. Following counseling and time in controlled atmosphere of the prison, many inmates are ready to begin working their way back into the community.

The increased use of community programs would aid in the resocialization process.

Inmates are normally admitted to medium security. They work their way to minimum security. Eventually an individual can work his way into community work, education or treatment programs.

There are currently 60 inmates involved in the community work release programs. These individuals work and go to school in the community during the day. They return to the prison at night.

Selected inmates from this program could be moved from the minimum security facility to another site. The program would be staffed for 24-hour coverage. Security in the community programs is obtained through a higher staff to inmate ratio.

The project would require 10 correctional officers, 4 correctional counselors a social worker and staff support workers. Community support programs would be utilized to insure that the resocialization process is meeting offender as well as community needs.

A sufficiently secure residential, community-based facility needs to be acquired. Some equipment must be purchased to maintain security.

Estimated Completion Date	Dec. 1, 1977
Staff costs	$153,000
Lease and current expenses	29,000
Equipment & security devices	18,000
TOTAL	$200,000

Approximately 20 alcohol and drug offenders could be transfered from the prison to community programs offering specialized treatment. Community programs such as Odyssey House and the Salvation Army are willing to contract with the state for the housing and counseling of offenders.

No direct staff costs would be required for this program.

The Utah State Hospital should have a new sex offenders program in operation by January, 1978. The inmates who could benefit from the specialized services of this unit, could gradually be transfered to the Utah State Hospital.

Item	Amount
Contract with Utah State Hospital	$50,000
Contract with Community Treatment Center	51,000
TOTAL	$101,000

Expansion

Overcrowding is most serious in medium and maximum security areas.

The need for additional prison housing is immediate. New construction takes several years. The proposed short term solution is to remodel space currently in use at the prison. These modifications can be done at one-tenth the cost of construction of new cells.

All of the additions will provide more humane living conditions than are generally available in the 3-tier cell blocks.

PHASE ONE

A phased approach can add housing for 58 medium security inmates over the next 5 months.

Recently the "alcohol unit" was moved from B-North so that 28 maximum security inmates could be housed there. The first step is to rennovate B-North. This requires painting and restoring bars. Currently B-North is being staffed by officers working overtime. 9 regular staff need to be hired to provide 24-hour coverage for this unit.

Map: No. 1

Estimated Completion Date	July 1, 1977
Rennovating costs	$5,000* from Governor
Staffing costs to 7/78	$124,000 from Legislature
TOTAL	$129,000

The next step is to provide satisfactory housing for the "alcohol unit" which is currently living in the kitchen of the old dormitory. A six unit trailer complex has been found. This complex, when located in the medium security compound, appears adequate. The trailers will require some furnishing and staffing. Six additional staff will also be required to control the flow of inmates from the medium security building to the trailers.

Map: No. 2

Estimated Completion Date	Sept. 1, 1977
Cost to purchase & prepare trailers	$56,000*
Cost for staff to 7/78	68,000
TOTAL	$124,000

* Not requested from legislature.

Currently, a remodeling project is under way to expand and to remodel the old infirmary and the surrounding area. Funds were appropriated by a previous session of the legislature. This remodeling will provide 30 additional cells.

It is anticipated that this unit will become the home of the "alcohol unit" and that a group of well behaved inmates with long sentences (lifers group) will then occupy the trailers. It would be necessary to furnish the cells in the remodeled unit and to staff the newly created lifer unit.

Map: No. 3

Estimated Completion Date	Dec. 1, 1977
Cost for furnishing	$5,000*
Cost to staff to 7/78	50,000
TOTAL	$55,000

PHASE TWO

Phase two will add 117 beds to the medium security area by July, 1978.

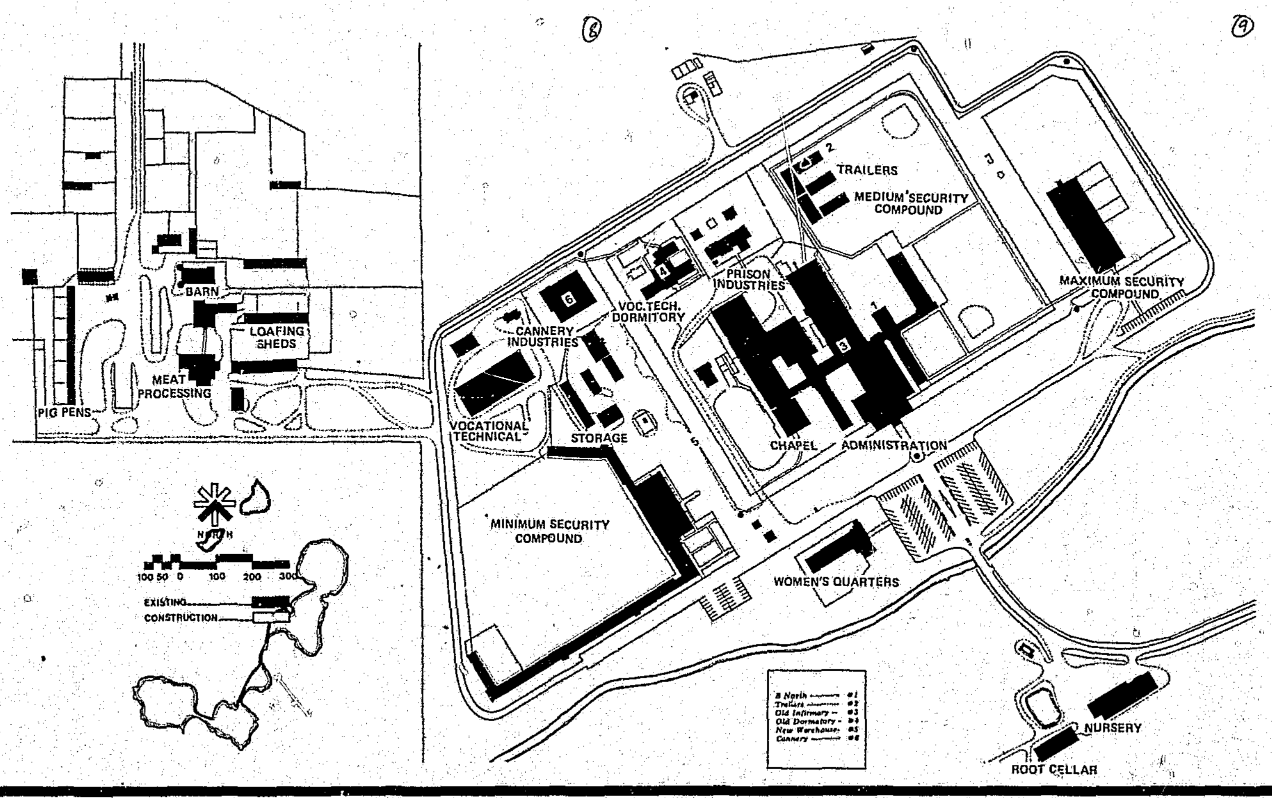
The old farm dormitory in the medium security compound currently houses the prison's vocational training program. An old cannery is being used as a warehouse. Step one is to build a new warehouse which frees the cannery. Step two is to move the vocational training to the cannery. Step three is to remodel the old dormitory to house 117 medium security inmates.

		Map
Estimated Completion Date	July 1, 1978	
Cost for warehouse	$150,000*	No. 5
Cost to remodel cannery	65,000*	No. 6
Cost to remodel dormitory	181,612*	No. 4
Cost to furnish dormitory	21,537*	
TOTAL	$418,149	

Staff costs will be submitted at the next regular legislative session as part of the expansion budget.

The above actions should result in a maximum of 175 medium and maximum security beds becoming available within the next year.

Hopefully, these actions will prove adequate until a master plan can be developed and accepted.



UTAH STATE PRISON

EXISTING CAMPUS PLAN 1977 PREPARED BY THE UTAH STATE BUILDING BOARD

Outflow

The setting of parole and release dates involves many factors including the individual's progress, motivation, type of crime committed, availability of employment, family support and community resources available to aid the offender.

Inmates are evaluated by prison staff and their recommendations are made to the Board of Pardons. The Board of Pardons sets release dates.

This month, the Board of Pardons agreed to re-examine cases of individuals whose progress merited more special attention. During their June 14 meeting, the Board of Pardons released 5 earlier than anticipated, cutting 44 months of the 5 offenders sentences.

While the cost of the actual early release is insignificant, the release of the inmates frees up additional space at the prison. Services to an inmate on probation or parole costs approximately $750 annually compared to $10,000 to house an offender at the prison.

It is hoped that the re-evaluation of inmates who the prison consider have progressed faster than anticipated will continue and that the Board of Pardons will continue to release these individual early.

Master Plan

These proposed short term solutions will ease the immediate overcrowding at the Utah State Prison hopefully for the next year. Division of Corrections population projections indicate that the availability of these beds will mean that we will be able to alleviate current overcrowding but only be able to keep up with the influx of new inmates through the 1977-78 fiscal year.

In order to meet future needs, a longer range plan is needed.

At the present time, there is no comprehensive corrections plan for which the Department of Social Services and its Division of Corrections can work within.

The proposed master plan would include: goals and objectives; data collection relating to the overcrowding problem; population forecasts; a systems model; alternative plans and a detailed analysis of options—expansion, regional facilities, early release, community-based programs, parole—to ease future overcrowding.

The staff of the Department of Social Services can be utilized to develop the master plan. It would be necessary to assign staff members to the project full time to develop a complete and detailed plan by which the Division of Corrections and the Department of Social Services could be held accountable.

The utilization of some outside consultants is recommended to insure that the best and most cost-effective alternatives are included in the master plan.

Estimated Completion Date .... Jan. 7, 1978

Staff, support services and consultant costs $100,000

BUDGET SUMMARY

Estimated Completion Date	Number of Months Budgeted	Action	Request
Sept. 1, 1977	10	Move 90-day Program to Community Center (Includes 12 FTE staff, lease, food, travel, security devices, etc.)	$327,000
Dec. 1, 1977	7	Move Work Release Program to Community Center (Includes 18 FTE staff, lease, travel, security devices, etc.)	200,000
Continuous	NA	Move 25 inmates to Community Centers	
		a. Odyssey House, Salvation Army, etc. (contract)	51,000
		b. Sex Offenders to State Hospital (contract)	50,000
July 1, 1977	12	Expand Medium Security	
		a. Rennovate B-North (9 FTE staff)	124,000
Sept. 1, 1977	10	b. Operationalize trailers (6 FTE staff)	68,000
Dec. 1, 1977	7	c. Remodel Infirmary (6 FTE staff)	50,000
Jan. 1, 1978	6	Master Plan (Contract and support services, and staff)	100,000
		TOTAL	$970,000

Question's

1. Does Utah have a high crime rate?

Utah's crime rate is slightly above the national average. The rate of crime is not highly related to the rate of incarceration. Despite Utah's above average crime rate, it has the eighth lowest rate of incarceration.

2. What kind of person is committed to prison?

The average inmate is 29 years, 3 months old. He stands 5 feet 8 inches tall and weighs 159 pounds. He has an average intelligence quotion of 100 but has an educational achievement level of 8.6 school years. He was arrested for the first time at the age of 16 years 7 months. At time of commitment, he had 12 entries on his rap sheet. He can come from any sector of Utah.

3. What kinds of crimes result in commitment to the Utah State Prison?

Fifty-three percent of all inmates are committed for crimes against property. Burgulary, robbery, theft and forgery are the top four. A total of 39% of all inmates are committed for violent crimes. Rape, followed by Murder 1, aggravated assault, murder 2 and manslaughter are the top five. The remaining 8% are for other crimes.

4. How long is an inmate in prison?

An inmate at the Utah State prison will spend an average of 2.3 years incarcerated. However, length of commitment depends on the crime committed, the individual and his progress through the system and the parole board. Murder 1 offenders spend an average of 13.7 years incarcerated compared to theft, embezzlement, distributing a controlled substance for value offenders who spend an average of 1.8 years incarcerated.

5. How do you determine whether an inmate is placed in minimum, medium or maximum security?

Each inmate is evaluated by staff. Initially, inmates are placed in medium security and work into minimum. The time an individual has left to serve is also critical. Normally inmates with only a short time left on their prison sentence will be placed in minimum security or community programs.

Maximum security is for those inmates who are control, safety, management or security problems. The prison also has a protective custody unity.

6. How does someone get paroled?

The inmate is evaluated by staff. Recommendations are made to the Board of Pardons. They set release dates.

7. Are all criminals violent?

Some offenders are violent and can do harm to others or themselves. Less than half the inmates at the Utah State Prison are committed for violent crimes. Residing in a prison, peer pressure and stress can alter even a nonviolent person's behavior if the situations and pressures are wrong.

Normally, offenders who are sentenced for violent crimes do not repeat their crimes.

Individuals who commit burglary, forgery, fraud and theft are more likely to return to crime when they leave prison.

8. How much does it cost to house an inmate at the Utah State Prison?

At rock bottom, it costs approximately $10,000 to house, feed, cloth, counsel and treat an inmate. There are an undeterminate amount of welfare costs that are related. They include the cost of maintaining an inmate's family. To build one prison cell costs approximately, $30,000 to $40,000 plus special services.

Needed is a method of restitution where inmates are able to contribute to the cost of their board, room treatment as well as support their families and reimburse their victims.

9. How much does probation or parole cost?

The Adult Probation and Parole office handles approximately 6,000 cases. The average expenditure per case is less than $750 annually.

10. What does it cost to maintain an offender in a community corrections center?

The cost is higher than if the inmate were on independent probation or parole. But the cost of maintaining an offender at a corrections center is less than half that of maintaining him in prison.

11. Does the Prison's work release program work?

It does not work for all inmates. It does help them to get re-established in the community. There is a lower recidivism rate among work-release inmates.

12. What happens if the population of the prison goes down?

All population studies show the number of prisoners will rise, not decline. But the additional space, regardless, could be utilized. It would allow for more flexible planning and better management.

13. Wouldn't regional correctional facilities solve the problem better?

Possibly, but it would take at least three years to construct a new facility. A master plan would validate and determine if a future correctional needs facility were the best solution.

14. What is operational capacity?

Operational capacity is the maximum level the prison can operate at with good management practices in force. It does not mean the more restrictive custody levels are full. At operational capacity, there must be some empty cells in case troublemakers need to be transferred to maintain security, safety or control.

15. What are community correctional centers?

They are correctional centers located in the community which house inmates. Offenders who reside at the centers are carefully selected to insure that they are ready for re-entry into the community. Inmates reside at the facility but are allowed to go to work, school or treatment program outside of the center. Utah currently has three correctional centers.

16. Why aren't more offenders diverted to community programs?

Offenders are not diverted because there are not enough alternatives providing both the security and rehabilitation needed. Like other individuals, offenders do not fit a single mold.

Community support is also a factor. Many persons are in favor of community correctional centers as long as they are not established in their neighborhood.

17. Are offenders sent to prison rehabilitated?

The primary role of a prison is to protect society. A prison gives an inmate time to get himself under control and an opportunity to improve himself. Change or rehabilitation occurs only if an inmate wants to change.

18. Why do we need a master plan?

There is no correctional plan past June, 1978 which has official sanction or approval. With no formally accepted goals, it is difficult to evaluate the Division of Corrections and hold them accountable.

A master plan will examine the problem, the objectives of correction and determine the best methods to reach those objectives. It will sort through alternatives such as regional facilities, expansion, an industrial park and recommend the best, as well as most cost-effective, actions.

Memorandum

TO: Anthony Mitchell,
Executive Director, Department of Social Services

FROM: Earl F. Dorius,
Assistant Attorney General

RE: Possible Legal Consequences if the Overcrowded Situation at the Utah State Prison is not resolved.

DATE: June 17, 1977

You requested a memorandum for me outlining the possible legal consequences if we do nothing to remedy the overcrowding problem at the Utah State Prison. I see two major areas of concern: (1) federal court intervention into the administration of our state prison; and (2) intervention by the United States Department of Justice.

1. Recently, the attitude of the federal courts toward prisoner lawsuits based upon conditions of confinement has dramatically changed from a policy of "hands off" (or non-intervention) to one of heavy involvement. The previous attitude of the courts was that:

a. Matters of prison administration were concerns of the executive branch of government and the judicial branch should not become involved in the day-to-day operations of prisons.

b. Federal courts lacked sufficient expertise in the corrections area, and the issues were better left to the discretion of experienced corrections personnel.

c. Federal courts should not become involved in *state* prison matters on a theory of federalism and comity between the federal and state branches of government.

d. Since prisoners necessarily lose many constitutional rights upon their commitment to prison, they have no standing to raise claims of deprivation of constitutional rights in the federal courts.

However, within the last decade, the federal courts have increasingly entertained lawsuits filed by state prisoners to the extent that approximately 22% of the federal court caseload is now prisoner oriented. Correctional personnel as a class of defendants are presently sued more than any other class of defendants in this country, including police officers. Utah is no exception. Our annual caseload of federal suits instigated by state inmates has increased approximately seven fold in the last three years.

The problem of overcrowding not only generates lawsuits based on the issue of overcrowding, but generates lawsuits in collateral areas such as: inadequate medical treatment (due to the large inmate population and insufficient staff); lack of rehabilitational programs; lack of adequate protection; delay of mail delivery; etc.

Recently, federal district judges in several states have gone so far as to order state corrections departments to construct more adequate facilities under the threat of releasing inmates if nothing was promptly done to correct the overcrowding situations.

2. More recently, the United States Department of Justice, Civil Rights Division, despite a lack of statuatory authorization, has successfully intervened in several prisoner civil rights lawsuits. They have obtained orders from the court giving them the full rights of a party, and have unanimously sided with the plaintiff inmates in the lawsuits.

Currently, the Justice Department has several bills pending in Congress to legitimize what they are already doing.

A lawsuit is presently pending in the United States District Court, District of Utah, Central Division, in which the Justice Department has been ordered by Judge Willis Ritter, to enter the case with full rights of a party to assist the court in investigating the inmates. One of the issues is that the overcrowded situation at our prison constitutes cruel and unusual punishment. Our office has filed motions opposing the Justice Department's involvement in the case.

Senator BAYH. Our next two witnesses will serve as a panel: Mr. Alvin Bronstein, the executive director of the National Prison Project and Mr. William Nagel, the executive vice president of the American Foundation.

Gentlemen, we're happy to have you.

TESTIMONY OF ALVIN J. BRONSTEIN, EXECUTIVE DIRECTOR, THE NATIONAL PRISON PROJECT, AMERICAN CIVIL LIBERTIES UNION FOUNDATION

Mr. BRONSTEIN. Before I begin I cannot let General Hansen's comment about a distinguished Federal judge remain in the record with a characterization that he placed on Chief Judge Willis Ritter. The problem in Utah is that Judge Ritter believes that the Constitution of the United States takes precedence over the tenets of the Mormon Church which is a politically bad thing to do in Utah.

Senator BAYH. What are you talking about?

Mr. BRONSTEIN. Mr. Hansen characterized the judge in answer to a question from you as being——

Senator BAYH. I'm talking about the tenets of the Mormon Church.

Mr. BRONSTEIN. Judge Ritter believes in the Constitution first and that is a very unpopular thing to do in the State of Utah. I could not let the record be left with the impression that Chief Judge Willis Ritter was something worse than that according to General Hansen.

Senator BAYH. How long has he been a judge?

Mr. BRONSTEIN. I believe he has been a judge for almost 20 years. He is the chief judge in the district of Utah and from time to time has been appointed by Chief Justice Burger to sit in other courts and other various courts of appeal. He has a distinguished judicial record. I wanted to make that clear. That's my opinion.

Mr. Chairman, I've read the prepared statement of the four State attorneys general and have heard them testify here today. They apparently have three things in common. First, they share an expressed concern for the rights of the institutionalized citizens in their States which is commendable. Second, they seem deathly afraid of the Department of Justice and the Federal courts which, considering the terrible institutions they have to defend, is understandable. Most remarkably they all seem to suffer from amnesia. They seem to have no memory of what goes on in their respective States.

Attorney general Mendicino who is not here and whom I know in his written statement said on page 1:

> I do not wait for others to initiate action against our State institutions. I am pleased to relate, for example, that in the past year the rules and regulations for the Wyoming State Penitentiary have been revamped in accordance with constitutional guarantees.

He forgot all about the case called Bustos against Governor Herschler in which he was lead counsel for the State and in which I was lead counsel for the prisoner plaintiffs and which was settled just this April. I have the file and the court orders here. As a result of that settlement the rules and regulations of the State penitentiary were revamped. It was not something that was initiated by the attorney general. It resulted from a lawsuit.

Senator BAYH. When was the case brought?

Mr. BRONSTEIN. The case was brought in August of 1976. It was settled expeditiously after the lawsuit was filed.

In fact, on page 2 of his statement he refers to responding to the strong recommendations of the Herschler administration that the Wyoming State Legislature appropriated funds this year for the construction of a new penitentiary. That also resulted from a lawsuit; that was on February 28, 1977.

Governor Herschler sent a message to me through another State corrections commissioner and I quote,

> The best thing that happened to us was the lawsuit filed by ACLU. We would never be able to get the legislature to move without the lawsuit.

So it's a little disingenuous for Mr. Mendicino to indicate to the committee that all this action was sui sponte and was taken on their own initiative. It resulted directly from the lawsuit.

Finally, he did not mention that we had to file another lawsuit, *Dodge* v. *Herschler*, to put an end to the unconstitutional treatment of women prisoners. We sat down with the attorney general's office before we filed suit. They refused to budge on their practice of sending women prisoners out of the State of Wyoming and refused to budge on the fact that women prisoners in Wyoming were not eligible for any community programs or work release as men were. Two months after the lawsuit was filed the attorney general went to the legislature and got legislation passed to take care of that problem. Now women are provided equal treatment with men and are retained in the State of Wyoming. But again, it resulted directly from the filing of a lawsuit which we attempted to negotiate before filing.

Senator BAYH. You had talked with the Attorney General before filing suit?

Mr. BRONSTEIN. Yes; we had.

In the State of Utah Mr. Hansen did mention briefly a prison suit which he referred to as involving slight overcrowding. That was quite a characterization of six consolidated lawsuits which challenge conditions at the 109-year-old, 1868, State prison at Draper and the State mental hospital where some offenders are sent and which deals with a range of conditions, lack of medical care, lack of proper sanitation in food handling, general environmental quality being very inferior, idleness, no programs. He did not mention the prisoners who were discovered by the FBI on their investigation who had spent 7 months in what was characterized by them as a dark hole-like dungeon. Seven months these men had been there and they were discovered by the FBI.

Senator BAYH. Where was this?

Mr. BRONSTEIN. Utah State Prison at Draper.

Senator BAYH. When?

Mr. BRONSTEIN. They were discovered about 2 months ago. This is all in the six consolidated lawsuits pending before Judge Ritter.

Senator BAYH. This was the characterization of the FBI?

Mr. BRONSTEIN. Right. I should add this. I believe this is to the credit of the attorney general that once that condition was brought to his attention he got the State officials to close down those dungeons and remove those people.

Senator BAYH. I guess it's only normal that a State attorney general would take this kind of thing personally. But the problem is that they have more immediate responsibilities. This kind of thing goes on unnoticed.

It ought to be noticed by someone but the fact of the matter is that it has not been.

Mr. BRONSTEIN. Senator Hatch commented that, given some notice, he thought all responsible State officials would clean these problems up if brought to their attention in 6 months or 1 year I believe he said. The attorney general of Utah has been fighting a case dealing with alleged unconstitutional practices and conditions at the State Training School for Children at Odgen, Utah. He's been fighting that case for 2 years. He's been fighting the prison cases.

Senator BAYH. When you say "fighting" what does that mean?

Mr. BRONSTEIN. They are not discussing or negotiating. They have been attempting to delay this litigation. They have been up to the court of appeals twice in the prison case already objecting to all discovery orders issued by Judge Ritter. They have filed a mandamus action against Judge Ritter claiming that his order permitting the plaintiff's lawyers and the Department of Justice to examine records, interview prisoners, interview staff was improper. In other words, they are not going to the merits of the complaints but rather litigating on behalf of their clients which illustrates a conflict of interest problem that they have.

Senator BAYH. What are we talking about here? What are the kinds of prisoners or detainees? What are the conditions? What is the goal that is sought by the lawsuit?

Mr. BRONSTEIN. In the Utah lawsuit?

Senator BAYH. In the correctional case. I'm talking about the training school.

Mr. BRONSTEIN. In both cases it is an attempt to enjoin the unconstitutional practices that exist there, the claims of brutality and things like the dark hole dungeon in order to bring them up to proper sanitary standards, in order to improve the environmental quality, to provide some adequate degree of medical care which is what the Supreme Court in *Estelle* v. *Gamble* ordered State institutions to do in the prison context.

Senator BAYH. We're talking about a 2-year period where you said the attorney general has been fighting the case. If you don't have the information could we have a more definitive description of, first of all, what kind of inmates are we talking about?

Mr. BRONSTEIN. That's a State training school which is 2 years. The other is more recent.

Senator BAYH. Maybe we could confine our attention to the training school situation since that has been in process for 2 years. Are we talking about boys, girls, men, women who are we talking about?

Mr. BRONSTEIN. I believe there [illegible] just boys although I may be wrong. We are not personally involved in that.

I'll be glad to furnish that information.

Senator BAYH. I'd like to know if we're talking about capital offenses or major felonies or are we talking about——

Mr. BRONSTEIN. I think many of these are status offenders.

Senator BAYH. I'd like to find that out. I'd like to find out just exactly what are the constitutional deprivations that Judge Ritter—is Judge Ritter hearing the case or has he issued orders in the case?

Mr. BRONSTEIN. I believe he is hearing that case as well as the prison case. But I can ask the Utah Legal Services people and the National Juvenile Law Center that provided me with this brief information, to send a complete set of papers to the committee on that case.

Senator BAYH. I think that's important because here is something that has gone on for 2 years. I would like to know what conditions exist that the State attorney general has been aware of for 2 years that apparently he feels cannot be remedied and why he believes the case has to be continually fought. It seems to me that that's the kind of thing that this legislation is designed to deal with.

Mr. BRONSTEIN. That's right.

I should continue to comment because there has been some concern by Senator Hatch expressed about the constitutionality of this statute and whether the Congress has the power to do this. Attorney General Hansen spends a lot of time in his written statement claiming that it is unconstitutional.

Senator BAYH. I didn't spend a lot of time talking to him about that because I think the ground is clearly weak. It is unconstitutional.

Mr. BRONSTEIN. Section V of the 14th amendment gives Congress that power.

Senator BAYH. Attorney general Burch I think very eloquently and vigorously pursued the attorneys general point of view that this was a bad way for the Federal Government to get involved. When asked, he did not deny that the attorney could—constitutionally—be given this authority by the Congress.

Mr. BRONSTEIN. In Nebraska, Senator Bayh, I have some recent news clippings from Nebraska newspapers which characterize their State prison as being horribly overcrowded with resulting psychological stresses, a growing problem, inadequate medical and kitchen facilities, and a remark by the commissioner at the trustee dormitory described as "an abomination" by Correctional Services Director Joseph Vitek.

The long dormitories house 260 men in spaces originally designed for 150 or 200. More than 507 men now live in the cellblocks inside the penitentiary. In many cases four men must live in a 9 by 11 foot cell.

Senator BAYH. Could we put that in the record?

Mr. BRONSTEIN. Yes.

Senator BAYH. You're talking about an abomination and that was the characterization of the person running the system.

Mr. BRONSTEIN. Yes. What's the attorney general of Nebraska doing about that other than waiting for somebody to sue and then complain to this committee and to the press and everyone else about people suing them and making life difficult. That's the thrust of this legislation. There is no evidence that State officials have the inclination or perhaps the resources to clean up their own houses. It's for that point that I mention all these things.

I could also mention the four lawsuits that we were involved in personally in Maryland; all but one of them brought successfully to

conclusion challenging various unconstitutional conditions in their men's, women's, and delinquency facilities.

Again, there is no indication that the State officials clean their own houses without the threat or pressure of a lawsuit or a court order.

Senator BAYH. Was the attorney general's office aware of the conditions that existed?

Mr. BRONSTEIN. Oh; yes, indeed. In one case the attorney general had been aware of it for some time because there had been a matter of some concern before the legislature. That was the Patuxent Institution for Defective Delinquents.

Senator BAYH. What does "defective delinquents" mean in this context?

Mr. BRONSTEIN. Not juvenile delinquents. It was an aberration in Maryland law whereby if a psychologist at the Patuxent Institution characterized a person who had been convicted of a criminal offense as a "defective delinquent". He was someone who might pose some danger to society. He was then committed indeterminately up to life to the Patuxent Institution. Our particular client was convicted of joyriding. He had been there 15 years in the Patuxent Institution because he had been classified as a "defective delinquent". After the lawsuit was filed the legislature, I must say with the prodding of Governor Mandel, abolished the defective delinquency statute in Maryland and turned over this institution to the corrections department to run it the way it ought to be run as a correctional facility and not some special kind of neither here nor there mental facility or prison.

Senator BAYH. What sort of communication did you have with the attorney general?

Mr. BRONSTEIN. We had all kinds of meetings with the attorney general's office but not with General Burch himself but some of his officials, with the State corrections department, with the Patuxent governing board, with the legislature. No one was prepared to take any action until after we filed the lawsuit.

This has been going on, at least with our office, for 3 years and with the Baltimore Legal Aid Society for 3 years before that.

I have responded to what the attorneys general have said but now I will summarize some of the points of my statement which I would ask be inserted in the record.

Senator BAYH. Without objection, your written statement will be inserted in the record.

Mr. BRONSTEIN. The point is that S. 1393 is necessary because in most cases private litigants cannot marshal the enormous resources necessary to prove an institutionwide or systemwide violation of constitutional rights. It is important that we keep in mind what this legislation is about. It is not, as Judge Walinski feared about the individual case of a prisoner or mental patient who complains that his law books were taken 2 weeks ago or he didn't get his insulin shot last Thursday. That is not the pattern and practice of deprivation of constitutional rights. This legislation is designed and I think the language is very clear that we are talking about patterns and practices of deprivation, large numbers of people.

I must say that although I agreed with almost everything else Judge Walinski said that I must take slight issue with his comment

that there were plenty of public interest and public service lawyers around to bring these things to the courts' attention. There are not.

Mr. Chairman, you may know that we are the largest national prison litigation project in the country. We just have seven lawyers to cover the entire country. There is no one else who has a bigger project than ours.

In Judge Walinski's State of Ohio, the legal services lawyers and private lawyers have pleaded with us for years to come in and do something about the State prison at Lucasville which is a terrible abomination. We don't have the resources to go into Ohio at the same time that we're in the other States.

So I think we must keep in mind that without the Department of Justice many of these problems will go unanswered.

To give you an example of the kind of litigation that we're talking about, let me speak a moment about the Alabama statewide prison case which has been cited in my written statement and which has gotten a great deal of publicity. In that case in which we were involved the out-of-pocket expenses to date, not counting the salaries of my staff and time of local lawyers, exceeds $25,000. An additional sum in excess of that figure was spent to conduct an economic analysis of the impact of the court decision.

I have provided the committee with one copy of that economic study because I know that you, Mr. Chairman, had been interested in the cost for some of the States of this kind of litigation. The study showed that the actual costs were substantially less than what the State was predicting.

There are five lawyers including two from my staff and they devoted a substantial amount of their time for the past 3 years to the case. At the trial we submitted over 1,000 stipulations of fact, five volumes of photographs, 39 documentary exhibits, 15 depositions, and live testimony which, in addition to prisoners, included eight nationally recognized experts in the field of corrections, psychology, and public health. It's that kind of thing that Judge Walinski was talking about, not necessarily legal expertise but substantive expertise.

Clearly private litigants, even with counsel, cannot afford to undertake this kind of presentation. Clearly my office cannot undertake more than a few of those cases at a time. If we did nothing else it would take us 50 years to address these issues nationally.

The participation of the Attorney General in these cases would conserve judicial resources by speeding up litigation processes and by facilitating settlement. It would encourage settlement. It would save money for all concerned. The importance of this access by prisoners and by mental patients cannot be underestimated. I have attached to my statement an article by Judge Frank Johnson, the Chief Judge in Alabama who points out quite clearly the more that people are affected by government controls and become dependent upon government services and programs, which is certainly the plight of any institutionalized person, the more they must look to the Federal courts for the guarantee of their rights and protection against unconstitutional conduct on the part of the government.

I do not believe this bill will create a flood of litigation or place a substantial burden on the Federal courts. In fact, it has been my

experience that an institutionwide or a systemwide or a Statewide suit of the kind that this legislation is geared to will reduce the number of cases pending.

In Alabama Judge Johnson was able to consolidate a great number of pro se cases because of the pendency of one large class action. The flood of litigation in Alabama has reduced for the prison system since he handed his decision in January of 1976.

In Rhode Island in another case we just finished litigating the Federal judge was able to consolidate 150 pro se cases and will dispose of them when he issues a decision in the next month or two.

There has been some discussion in these hearings about the need for requiring institutionalized persons or the attorney general to exhaust State administrative remedies before being able to proceed in Federal court.

First of all, I think singling out institutionalized persons is illogical and probably unconstitutional and unrealistic as well. It is unclear to me just how the young girl tied spread-eagled on the bed that was mentioned earlier, how that person would exhaust their administrative remedies or how a mental patient drugged to near oblivion would exhaust their administrative remedies. Certainly prison officials should establish fair grievance procedures. It is in their interest as well as for that of the prisoners.

But the kind of deprivations we're talking about are not geared to exhausting administrative remedies. You can visualize how the State correction official or the Governor or the attorney general of Alabama would have responded if a group of prisoners came to them and said "For the past 10 years you have been engaged in a pattern and practice of depriving us of our constitutional rights." They would have laughed them out of their respective offices assuming they could have gotten there in the first place.

In fact, in Alabama at the conclusion of the trial even though the State conceded the total unconstitutionality of their system on eighth amendment grounds, they promptly appealed the decision. When I argued that case in the court of appeals for the Fifth Circuit about a month ago, they were talking about their "alleged" concession before the court of appeals. There too they are fighting and resisting all the way.

Furthermore, in spite of the protestations by State attorneys general about their concern for the rights of institutionalized persons, the record indicates otherwise. First of all, there is a clear conflict of interest. They are paid by and charged with defending State officials, the very people who it is claimed are violating the rights of the people in those institutions.

Secondly, if one looks at the recorded decisions you will see that in almost every case the State officials defended by the attorney general were found to have violated constitutional rights of their confined citizens.

Finally, I know of no State attorney general who has publicly declared that an institution in his or her State was depriving people of their constitutional rights and then attempted to remedy the situation.

I should mention since Mr. Kammerlohr is here that when he argued *Wolff* v. *McDonnel* in the Supreme Court 3 years ago, and I

was sitting just 6 feet from him, in response to a question from Justice Marshall as to whether a State could even engage in torture Mr. Kammerlohr said "Prisoners had no rights in the State of Nebraska once they were confined in the State prison." That seems to me to express the attitude of some attorneys general.

The National Association of Attorneys General have talked about the running of State prisons, hospitals, juvenile facilities, and similar institutions, as being peculiarly a matter of local concern to the States. That may be a valid theoretical proposition but it necessarily must give way to the Constitution when "local concern" is evidenced, for example, by what Judge Johnson found to be the facts of confinement in Alabama. I quote:

> The indescribable conditions in the isolation cells required immediate action to protect inmates from any further torture by confinement in those cells. As many as six inmates were placed in 4 foot by 8 foot cells with no beds, no lights, no running water, and a hole in the floor for a toilet which could only be flushed from the outside.

Mr. Chairman, I came here early this morning and measured that table where the press is sitting which is the table to my extreme left [indicating]. The table is 3 feet by 8 feet. If that table were 1 foot wider, that would be the size of the cell in which six men were confined. That was the kind of condition that Judge Johnson characterized as torture. I submit that it clearly is.

One member of this committee, Senator Scott, has expressed some skepticism of some of the horrors inflicted on institutionalized persons recited by the witnesses. He was particularly concerned about the story told by Dr. Clements about the mental patient who had been killed when a garden hose had been inserted in his rectum. I provide in my written statement the exact citation to the court fact finding on that particular instance and they both came from the *Wyatt* case. He also indicated that he didn't believe that American people could be so callous or so indifferent. One would like to share that belief but unfortunately the evidence indicates that the community ordinarily has as little interest in the people it sends to State institutions as most of us have in our garbage. We want it disposed of safely, quickly, and without much mess. We don't particularly care how.

I would like to provide to the committee and ask that it be placed in the record eight photographs which were taken in the Alabama prison system. They are each labeled on the back. They include a photograph of the 4 by 8 cell in which people were housed. They include a photograph of the hole in the floor toilet. They include a photograph of the windowless building in which these cells were contained. They include a photograph of an aged geriatric patient who had not been out of the second floor dormitory in the Draper Prison for years. He is in a wheelchair. He could not have gotten out if he wanted to.

They include a photograph which actually shows four men in a cell with two men on the floor and two on their bunks.

And they include photographs of the tremendously overcrowded dormitories.

Senator BAYH. Without objection, the photographs will be included in the record.

Mr. BRONSTEIN. I must mention that those photographs were a part of a large number of photographs taken in connection with the Alabama prison case. The horrible ones were offered into evidence. These are the least horrible photographs that were taken in the Alabama prison system.

It seems to me that the manner in which we treat our institutionalized people in this country is really a reflection of our civilization. These are the most powerless people, people in mental hospitals, people in prisons, people in juvenile institutions. The powerless people and the way we treat them is a measure of our civilization.

If we abdicate our responsibilities, we abdicate our right to call ourselves a civilized society. I believe firmly that favorable action on this bill by this committee will be the beginning of bringing light into the darkness of our country's closed and total institutions.

Senator BAYH. Thank you very much, Mr. Bronstein.

[The prepared statement and exhibits submitted by Alvin J. Bronstein follow:]

PREPARED STATEMENT OF ALVIN J. BRONSTEIN

I am pleased to appear before the Subcommittee, in response to an invitation from the Chairman, to testify on S. 1393. I am appearing in my capacity as Executive Director of the National Prison Project of the American Civil Liberties Union Foundation.

The National Prison Project, for the past five years, has been engaged in efforts, through staff attorneys and other employees, to develop rehabilitative and other programs and facilities, devise model prison procedures and regulations, and otherwise to improve prison conditions in the United States.

In furtherance of the activities described above, the Project's staff attorneys and other employees are engaged in the counseling and representation of prisoners incarcerated in penal institutions throughout the country. The Project has been and is presently involved in many important cases concerning the rights of prisoners.[1] In addition, the Project's staff has been consulted by corrections officials and legislative committees in various states to assist them in evaluating the effect on prisoners of the conditions of their prison system and proposed correctional programs and in developing new correctional and alternative programs in those states[2] I personally have been a consultant to the National Institute of Corrections of the Department of Justice and to the American Bar Association's Joint Committee on the Legal Status of Prisoners.

S. 1393 is necessary because, in most cases, private litigants simply cannot marshal the enormous resources necessary to prove an institution-wide or system-wide violation of constitutional rights. Without the assistance of the Attorney General, many legitimate cases could not be brought. It is important to keep in mind exactly what this legislation covers, as well as what it does not include. This legislation deals with deprivations, pursuant to a pattern and practice of interference with the full enjoyment of constitutional rights. It does not contemplate Justice Department action because a single prisoner claims his law books were taken away or that he did not receive his insulin shot last Thursday. We are talking about important constitutional rights of large numbers of institutionalized citizens. I would like to give you an example of the kind of litigation we are talking about.

The Alabama state-wide prison case cited earlier is in its third year. To date, the out-of-pocket expenses of that case, not counting salaries for lawyers or support staff, probably exceeds $25,000. An additional sum in excess of that

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[1] For example, *Pugh v. Locke*, 406 F.Supp. 318 (M.D.Ala. 1976) (entire state prison system in Alabama declared unconstitutional) ; *Palmigiano & Ross v. Garrahy*, C. A. Nos. 74–172, 75–032, U.S.D.C., D.R.I. (current challenge to the constitutionality of entire Rhode Island prison system).

[2] For example, in the past year I made a presentation to the Annual Congress of the American Correctional Association on "Correctional Administrators and Judicial Intervention" and to the Midwestern Governors Conference on "Correctional Policy in the States and Recent Court Decisions"

figure was spent in conducting an economic analysis of the impact of the court decision.[3] Five lawyers, including two from my staff, have devoted a substantial amount of their time over the past three years to the case. At the trial, we submitted over 1,000 stipulations of fact, 5 volumes of photographs, 39 documentary exhibits, 15 depositions and live testimony which, in addition to prisoners, including 8 nationally recognized experts in the fields of corrections, psychology and public health. Clearly, private litigants, even with counsel, cannot afford to undertake this kind of presentation. Similarly, most private organizations such as the Prison Project cannot undertake more than a few of these cases. If we did nothing else, it would take us 50 years to address these issues nationally.

The participation of the Attorney General in these cases would conserve judicial resources by speeding up the litigation process and by facilitating settlement. If the Attorney General is not involved, the strategy of many public defendants is to delay the litigation (through unnecessary discovery, frivolous appeals, etc.) until the private litigants exhaust their funds, or their public interest lawyers move to other careers. But if the case is not going to go away, the strategy of delay makes less sense. Similarly, the involvement of the Attorney General provides sufficient credibility to the litigation to enable sympathetic public defendants to settle the litigation through stipulations or consent judgments. Often those settlements will require expenditure of substantial funds, and it is easier for institution officials to justify such expenditures to governors or legislatures if the Attorney General is taking the position that such expenditures are constitutionally required.

The participation of the Attorney General would also provide much needed continuity. Court-ordered institutional reforms often take several years to be fully implemented. Modifications must be made along the way to meet changing conditions. The participation of the Attorney General would provide stability and continuity to that process.

I believe that this bill is both important and timely. For the past several years, there has been a tendency to make prisoners the scapegoats for the administrative problems of the courts. The effect of this attitude has been to gradually cut down on prisoners' access to the courts. It is our hope that this bill will give prisoners equality of access to the courts.

The importance of this access cannot be underestimated and is well expressed in the attached article by Judge Frank M. Johnson, Jr. As he points out, the more that people are affected by government controls and become dependent upon government services and programs—which is certainly the plight of any institutionalized person—the more they must look to the federal courts for the guarantee of their rights and for protection against unconstitutional conduct on the part of the government.

I do not believe this bill will create a "flood of litigation" or place a substantial burden on the federal courts. Institutionalized persons have always had the ability to bring lawsuits under various jurisdictional statutes. It is only recently that their right of access to the courts has been dramatically limited by Supreme Court opinions on standing and comity. This statute should have the effect of giving back to institutionalized persons the right to bring actions in federal court. If anything, there will be a return to the status quo. Furthermore, it has been my experience that an institution-wide or system-wide lawsuit, like those which will be instituted by the Attorney General, will ultimately reduce the number of individual lawsuits filed and heard in federal courts. For example, as a result of hearing state-wide pattern and practice suits in Alabama and Rhode Island, those courts were able to consolidate large numbers of pro se cases into just one case and reduce the overall caseload of the court.[4]

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[3] Some members of this Committee have expressed interest in the cost to the states resulting from federal court orders. The State of Alabama estimated that it would cost them 200 million dollars to comply with the Court's decision. As a part of our continuing service to the Court and, indeed, to the State, we prepared a detailed economic study of the decision. Our study, done by a team of experts, demonstrates that the actual cost of compliance would be 28.5 million dollars and, projecting population, etc. through 1985, a cost of 46 million dollars. I am providing a copy of the study to the Committee and I ask that it be made part of the record.

[4] To illustrate the relatively small number of pattern and practice prison cases filed in the past ten years, I attach a chart prepared for the Committee chaired by Rep. Kastenmeier considering the House version of this bill. You will note that of the fourteen cases listed, the Department of Justice was involved in three cases and the American Civil Liberties Union was involved in eight cases.

There has been some discussion in these hearings about the need for requiring institutionalized persons, and/or the Attorney General, to exhaust state administrative remedies before being able to proceed in federal court. Not only is this singling out of institutionalized persons illogical constitutionality, it is unrealistic and inappropriate. It is unclear to me just how some juveniles—an eight year old—and some mental patients—a person being drugged into near oblivion—would go about "exhausting their available administrative remedies." Prison officials should certainly establish fair grievance procedures to deal with minor matters. It is in their interest as well as that of prisoners. But the kind of deprivations that this legislation is attempting to reach cannot be addressed by an "administrative remedy." Can you visualize any state responding administratively to a claim by a prisoner that he or she was being subjected to cruel and unusual punishment because of a pattern and practice of deprivations by state employees? Indeed, only after years of litigation and a full trial did the State of Alabama concede in open court the unconstitutionality of their prison system. *Pugh* v. *Locke*, 406 F.Supp. at 322. In spite of that concession, the state officials have appealed Judge Johnson's decision and refer to an "alleged concession" in their appellate brief.

Furthermore, in spite of the protestations by State Attorneys General about their "concern" for the rights of institutionalized persons in their states, the record indicates otherwise. First, because a State Attorney General represents state officials there is a clear conflict of interest which prevents him or her from advocating the rights of persons who are maintained in institutions by those same state officials. Second, one need only look at the reported decisions of federal courts dealing with state mental hospitals, juvenile institutions and prisons to see that in almost every case, state officials, defended by their Attorney General, were found to have violated the constitutional rights of their confined citizens. Finally, I know of no State Attorney General who has publicly declared that an institution in his or her state was depriving people of their constitutional rights and then attempted to remedy the situation.

According to recent news reports, the National Association of Attorneys General strongly opposes this legislation and one state Attorney General is quoted as saying that "the running of state prisons, hospitals, juvenile facilities and similar institutions is peculiarly a matter of local concern to the states."[5] That may be a valid theoretical proposition, but it necessarily must give way to the Constitution when "local concern" of "the states" is evidenced for example by what Judge Johnson found to be the facts of confinement in Alabama:

"The indescribable conditions in the isolation cells required immediate action to protect inmates from any further torture by confinement in those cells. As many as six inmates were placed in four foot by eight foot cells with no beds, no lights, no running water, and a hole in the floor for a toilet which could only be flushed from the outside." *Pugh* v. *Locke*, 406 F. Supp. at 327.

One member of this Committee has expressed some skepticism of some of the horrors inflicted on institutionalized persons recited by other witnesses,[6] and indicated that he did not believe that American people could be so callous or indifferent. One would like to share that belief but unfortunately the evidence indicates that the community ordinarily has as little interest in the people it sends to state institutions as most of us have in our garbage—we want it disposed of safely, quickly and without much mess, but we don't particularly care how.

The manner in which we treat institutionalized people in this country is a reflection of our civilization. If we abdicate our responsibilities, we abdicate our right to call ourselves a civilized society. Favorable action on this bill by this Committee will be the beginning of bringing light into the darkness of our country's closed and total institutions.

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[5] New York Times, May 2, 1977, p. 20.

[6] The particular incident recited by Dr. James Clements who testified on June 23, 1977 had to do with a mental patient who died as a result of a hose being inserted in his rectum. I quote from the factual findings approved by the United States Court of Appeals for the Fifth Circuit in *Wyatt* v. *Aderholt*, the case dealing with mental patients in Alabama:

"One of the four [patients] died after a garden hose had been inserted into his rectum for five minutes by a working patient who was cleaning him; one died when a fellow patient hosed him with scalding water; another died when soapy water was forced into his mouth; and a fourth died from a self-administered overdose of drugs which had been inadequately secured." 503 F.2d 1305,1311 n.6.

THE NATIONAL PRISON PROJECT
OF THE AMERICAN CIVIL LIBERTIES UNION FOUNDATION,
Washington, D.C., June 22, 1977.

Memo to: Tim Boggs.
From: Roberta Messalle.
Re H.R. 2439.

Major Litigation involving a pattern and practice of constitutional deprivations in state prisons (not including jails).

Decided cases:

1. Arkansas [1]—*Holt* v. *Sarver*, 309 F.Supp. 362 (E.D.Ark. 1970), affd 442 F.2d 304 (8th Cir. 1971), and see *Finney* v. *Arkansas*, 505 F.2d 194 (8th Cir. 1974).
2. Alabama [1]—*Pugh* v. *Locke*, 406 F.Supp. 318 (M.D. Ala. 1976).
3. Mississippi [2]—*Gates* v. *Collier*, 501 F.2d 1291 (5th Cir.1974).
4. Louisiana [2]—*Williams* v. *Edwards*, 547 F.2d 1206 (5th Cir. 1977).
5. Puerto Rico—*Martinez Rodriguez* v. *Jiminez*, 409 F.Supp. 582 (D.P.R. 1976).
6. Nevada [1]—*Craig* v. *Hocker*, 406 F.Supp. 656 (D.Nev. 1975).
7. Oklahoma [1, 2]—*Battle* v. *Anderson*, 376 F.Supp. 402 (E.D.Okla. 1974).
8. Florida—*Costello* v. *Wainwright*, 397 F.Supp. 20 (M.D.Fla. 1975).
9. Delaware—*Anderson* v. *Redman*, 76–364 (D.Del. 2/16/77).
10. Wyoming [1]—*Bustos* v. *Herschler*, settled by stipulation, C76–143 B (D.Wyo. 4/14/77).

Pending cases:

1. Arizona [1]—*Harris* v. *Cardwell*, Cvi. 75–185 (D. Ariz.).
2. New Hampshire [1]—*Laaman* v. *Helgemoe*, CA 75–258 (D.N.H.).
3. Tennessee [1]—*Trigg* v. *Blanton*, A-6047, Chancery Court of Davidson County, Tennessee.
4. Rhode Island [1]—*Ross* v. *Noel*, C.A. No. 75–032 (D.R.I.).

[EXHIBIT NO. 29]

[From the New York Times, April 9, 1977]

THINKING ABOUT THE FEDERAL JUDICIARY

(By Frank M. Johnson Jr.)

> Following are excerpts from an address, titled "The Role of the Judiciary With Respect to the Other Branches of Government," given at the University of Georgia School of Law. Frank M. Johnson Jr. is a United States District Court judge from Birmingham, Ala.

The attacks now being made [on the Federal judiciary] are the same as those that have been made since the adoption of the Constitution. In many instances the individuals and groups making the most vocal attacks against the courts are those who have forced the courts to take positive action in the first place.

The renewal of the criticism is prompted by the fact that the past several decades have been extremely active and dynamic ones for the Federal judiciary in the area of constitutional law. The general citizenry, demonstrating a new awareness of rights or increasingly affected by government controls and dependent upon government programs and services, has looked more and more to the Federal courts for the guarantee of rights or for protection against unconstitutional conduct on the part of the states' and Federal executive and legislative branches.

True to its constitutional imperative, the Federal judiciary has responded cautiously but unwaveringly, adjudicating and upholding the rights of, among many others, black persons and women to equal educational and employment opportunities; the involuntarily committed mentally ill to minimum care and treatment; and incarcerated offenders to a safe and decent environment.

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[1] The ACLU participated in this case.
[2] The Department of Justice participated in this case.

The power of the Federal judiciary to review and to decide matters involving the legislative and executive branches of government is circumscribed by two basic constitutional doctrines. The first, the doctrine of separation of powers, reflects the deeply held belief of our Founding Fathers that the powers of government should be separate and distinct, with the executive, the legislative, and the judicial departments being independent and coordinate branches of government.

It is this doctrine which is responsible, in great part, for the creation and maintenance of the Federal courts as courts of only limited jurisdiction.

The second doctrine, which also reflects the Founding Fathers' distrust of centralized government, is commonly referred to as "Our Federalism." This doctrine, incorporated in the 10th Amendment to the Constitution, restricts the power of the Federal courts to intervene in the functions and affairs of the states and their political subdivisions.

The Founding Fathers prudently and discerningly perceived that the survival of our republican form of government depended on the supremacy of the Constitution and that maintaining the supremacy of the Constitution depended, in turn, on a strong and independent judiciary, possessing the power and the authority to resolve disputes of a constitutional nature between the states, between the states and the national Government, and, most importantly, between individuals and governmental institutions.

In granting to the Federal judiciary the power to decide cases arising under our Constitution and laws, the framers of the Constitution fully recognized that the exercise of such power would inevitably thrust the courts into the political arena. In fact, as the writings of the Founding Fathers illustrate, this grant of power was, in effect, a mandate to the Federal courts to check and to restrain any infringement by the legislative and executive branches on the supremacy of the Constitution.

Once having decided the issues, the court must then concern itself with the second and final phase of the adjudicatory process—the formulation and entry of an appropriate decree. If the evidence fails to disclose a constitutional violation, or if the evidence discloses a constitutional violation which can effectively be remedied by an award of damages or the issuance of a prohibitory injunction, the court's role is a limited one terminating upon entry of the decree. If the constitutional or statutory violation is one, however, which can be adequately remedied only by the issuance of a decree providing for affirmative, ongoing relief, the court's involvement is necessarily enlarged and prolonged.

The Federal judiciary finds itself today being increasingly called upon to fashion and to render this latter type of decree, that is, one of an ongoing, remedial relief.

A significant development in the substantive area has been the shift in subject matter from business and economic issues to social issues. During the latter part of the 19th century and the first half of this century, the major focus in the area of constitutional law was on the power of Congress and the states to enact statutes regulating and restricting private businesses and property.

During the past several decades, however, there have been in our society a growing awareness of and concern for the rights and freedoms of the individual. This awareness and this concern are reflected in the steady shift in emphasis in constitutional litigation from property rights to individual rights. Congress has enacted social welfare statutes in such areas as education, voting, consumer protection, and environmental protection.

The traditional forms of relief—an award of damages and the issuance of a prohibitory injunction—while adequate to remedy most constitutional violations of a business or economic nature, are but ingredients in remedying constitutional and statutory violations of a personal and social nature.

The prisoner, who lives in constant fear for his life and safety because of inadequate staffing and overcrowded conditions, will not have his rights protected merely by an award of damages for the past injury sustained by him. If we, as judges, have learned anything from Brown v. Board of Education and its progeny, it is that prohibitory relief alone affords but a hollow protection to the basic and fundamental rights of citizens to equal protection of the law.

Once a constitutional deprivation has been shown, it becomes the duty of the court to render a decree which will as far as possible eliminate the effects of the past deprivations as well as bar like deprivations in the future. Because of

the complexity and nature of the constitutional rights and issues involved, the traditional forms of relief have proven totally inadequate.

The courts have been left with two alternatives. They could throw up their hands in frustration and claim that, although the litigants have established a violation of constitutional or statutory rights, the courts have no satisfactory relief to grant them. This would, in addition to constituting judicial abdication, make a mockery of the Bill of Rights. Utilizing their equitable powers, the Federal courts have pursued the only reasonable and constitutionally acceptable alternative—fashioning relief to fit the necessities of the particular case.

With the acknowledgment that they are professionally trained in the law, not in penology, medicine, or education, the Federal courts have approached these areas cautiously and hesitatingly. Further recognizing that many of the issues they are being asked to decide call for sensitive social and political policy judgments, the courts have shown great deference to those charged with making these judgments and have intervened only when a constitutional or statutory violation has clearly and convincingly been established.

Nor have the courts attempted to enter these often murky and uncharted waters without navigational aids. In addition to evidence from experts, the parties, intervenors, and *amici* are invited to submit their recommendations and suggestions, usually in the form of proposed plans.

The courts have also turned to outside sources for advice and assistance.

[Exhibit No. 30]

THE ALABAMA PRISON SYSTEM

AN ANALYSIS AND ESTIMATE OF
THE COST AND ECONOMIC CONSIDERATIONS
RESULTING FROM THE ORDERS OF
THE UNITED STATES DISTRICT COURT
IN
PUGH V. LOCKE, (CIVIL ACTION NO. 74-57-N)
AND
JAMES V. WALLACE (CIVIL ACTION NO. 74-203-N)
406 F.Supp. 318 (M.D.Ala. 1976)

Prepared For
The National Prison Project of The
American Civil Liberties Union Foundation
By
The American Foundation, Inc.
Philadelphia, Pennsylvania
March, 1977

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Report Was Made Possible By A Grant From
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Washington, D.C. 20036

Copies - $15.00
Prepaid from the
National Prison Project

TABLE OF CONTENTS

	PAGE
1.Introduction	1
2.Alabama Prison Population Projections	7
ADDITIONAL ANNUAL COSTS	
3.Classification Staff	11
4.Mental Health Staff	12
5.Custody Staff	14
6.Food Service Staff	19
7.Recreation Staff	19
8.Maintenance Staff	20
9.Affirmative Action	20
10.Staff Training	21
11.Medical Care	22
12.Inmate Personal Items	24
13.Clothing and Linen	26
14.Additional Food	29
15.Summary of Additional Annual Costs	31
CAPITAL COSTS	
16.Single Cell/Living Space	32
17.Public Health Standard Improvements	35
18.Offices and Equipment	36
19.Visiting Space	39
20.Recreation Equipment and Facilities	41
21.Outdoor Recreation Areas for Segregated/Isolated Inmates	42

22.Food Service Area and Equipment 45

23.Summary of Capital Costs 51

PROGRAM COSTS

24.Prison Industries 52

25.Education & Vocational Training Programs 59

26.Transitional Program 65

27.Work Release, Pre-release Centers and Road Camps 66

28.Future Scenarios --Costs of Accomodating 1980 & 1985 Inmate Population Projections in Additional Institutions, Community Facilities, and/or Non-residential Sentence Alternatives 70

29.Total Costs Incurred by the Order -- In the Format of Our Report 82

30.Total Costs Incurred by the Order-- In the Format of the Order 83

ADDITIONAL COMMENTS AND APPENDICES

31.Additional Comments 86

32.Appendix A: Information and Suggestions for Further Population Projections 89

33.Appendix B: Available Cost Estimates for Standard Facility (400 capacity) 92

34.Appendix C: Recommended New/Expanded Industrial Programs and Anticipated Equipment Costs 93

35.Appendix D: Calculations and Costs Related to Future Scenarios 108

Introduction

The following report has been prepared by The American Foundation in response to a request by the National Prison Project of the American Civil Liberties Union. The National Prison Project wanted an independent, nationally respected group to estimate how much Alabama must spend to meet the constitutional standards established for its prisons in Pugh v. Locke (Civil Action No. 74-57-N) and James v. Wallace (Civil Action No. 74-203-N).*/ The National Prison Project also asked that the final report indicate what savings might be derived from maximum use of community-based facilities and what a similar cost analysis for other states facing court orders should include. The American Foundation agreed in the end of December 1976 to produce the requested report by mid-February 1977.

The American Foundation, Incorporated, is a privately endowed nonprofit organization founded in 1924 by Edward Bok. Since its inception, the foundation has worked to fulfill its founder's intentions -- to help make representative government responsive to the needs of the people. Since 1962 corrections has been the major social interest of the Foundation. During 1971 and 72, the Foundation conducted a nationwide evaluation of new correctional institutions. This study resulted in the publication, in 1973 of The New Red Barn, a critical appraisal of 103 of America's newest prisons. The Foundation has since conducted a number of correctional studies for various state and local governments and private citizen groups. The Foundation also provides consultation to these public and private associations.

For this particular study, The American Foundation brought together a small team of correctional consultants. Ms. Laurel Rans directed the Iowa Women's Reformatory from 1968 to 1972. Since then she has provided consultation

*/ 406 F. Supp. 318 (M.D. Ala. 1976)

in the human services sector as a member of Entropy Limited, conducted training sessions for correctional personnel, and participated as a member of the Pennsylvania Board of Pardons. Mr. Paul Keve was Director of Court Services in Hennepin County, Minnesota before becoming Commissioner of the Department of Corrections in Minnesota and then in Delaware. Mr. Keve has written four books, given numerous lectures, and participated in several long-range planning processes in the field of corrections. Mr. Frank Farrow, a consultant for the Management & Behavioral Science Center of the Wharton School of Business and Finance, the University of Pennsylvania, did not participate in the field work, but assisted the development and completion of the project at home. He has degrees in business administration, engineering, economics, systems analysis and operations research. Mr. Robert Christie of Mentoris Inc. assisted with the prison industries recommendations, as he took part in a national study on this subject. Ms. Polly Smith is a full time staff member of The American Foundation. She has organized community groups working for criminal justice. During 1975-76, she used a Thomas Watson fellowship to study criminal justice issues in Sweden, the Netherlands, England and New Zealand.

We at The American Foundation were assisted in this project by the preliminary work of the National Clearinghouse for Criminal Justice Planning and Architecture, the Centers for Correctional Psychology and for Business and Economic Research at the University of Alabama, and the Alabama State Department of Education. The National Clearinghouse estimated the cost of renovation and construction necessitated by the court order. The University of Alabama incorporated the Clearinghouse's estimate in its cursory analysis of the total cost of the order. The State Department of Education estimated the costs of educational and vocational training programs. We analyzed these useful reports and received helpful, additional inputs from the authors.

With these reports as a starting point, other literature was gathered on the Alabama prison system; costs of constructing and operating penal institutions, costs of alternatives to prisons, and various state reports/budgets/etc. We also spent a week in Alabama where we visited all the major institutions, spoke with approximately thirty people who had information about the prison system or relative costs, and gathered up-to-date budgets, population counts, and relevant figures. To complete this report we have also drawn on individuals who might help us generate reliable estimates and on our experienced judgement where specific figures have failed to materialize.

The estimate of cost to the State of Alabama for the court order is at best an educated guess. First of all, our task was hampered by Alabama's own confusion over amounts spent to date for ordered improvements and the source of those monies. Secondly, the cost of any implementation depends on the directions, procedures, and management strategies used during that implementation. As this process is still very much in flux (the court order is still under appeal at the time of this writing), our cost projections must proceed on the basis of information available to date and our stated reasons for selecting one figure over another. Readers, therefore, should be advised of our modest intentions to provide the best estimate possible, given a situation with missing information, poor accounting and budgeting procedures, lack of specific goals and priorities, and disputed directions on the part of Alabama corrections.

There were other problems, too. Certain cloudy areas remain in the conclusions due to the impossibility of knowing in some instances which expenditures are truly occasioned by the court order, or which would have been incurred anyway. Secondly, there are always certain choices available in making improvements in physical structures, and different observers will argue

for different approaches with different costs. Also, we found that an effort to upgrade a facility in one specified respect had the effect of making some other expenditure necessary, even though the latter was not directly a part of the court order. Sometimes we could calculate fairly well the cost of present operations but could not determine with reliability the pre-court order level of expenditure. Thus, we had difficulty in determining what net gain in cost has been necessitated by the court order.

At times, it is easy enough to calculate the specific cost of building a certain building or paying salaries for a specific number of new positions. However, we became very conscious that our figures for such are mythical, because buildings are seldom built within the time span of the price originally projected, a new complement of personnel can never be hired all at once, nor can we predict how long it will take to recruit for all required new positions.

We faced several dilemmas with regards to the effect of time on costs. Some costs are non-recurring capital or start-up costs, but others are annual and escalating. The question arises whether our calculations are to reach a cost figure for one year, or some other period of time. We decided to indicate additional operating costs necessitated by the order for one year subsequent to this order, 1976-77 initial capital costs necessitated by the order, plus one year operating costs for institutions or alternatives to accomodate population projections for 1980 and 1985. Our report will essentially follow this format of categories - additional annual costs, initial capital costs, program costs which span annual and capital costs., and both capital and one year operating costs for new institutions and/or alternatives.

And finally, we face the dilemma of a choice between calculations of improvement on the basis of literal and minimal compliance with the court order

or on the basis of the spirit and hope which any concerned person would want to read into the court order. It is a choice between a calculation of what it will require to "get by" in complying with the court order, or calculating what the Alabama correctional system really should do to give itself a quality program. We tried, where possible, to indicate both figures.

We had some questions about the inclusion of Frank Lee Youth Center. This center seems to be one of the brighter lights of the system and therefore required only one capital cost for compliance, sewage system improvements. We did include the center's population figures in costing out food and personal items. We did not include the center in considering capital additions. And finally, we treated youths under the responsibility of the Board as a separate category for future scenarios.

In summary and in general, we have found it necessary to go ahead and develop mythical figures for costs of initial expenditures plus first year operating costs as if it all could be ordered fulfilled on a start-up date. We have also in most cases calculated costs on the basis of the limited and literal compliance with the court order. Where appropriate we have tried to show the literal compliance figure and also a figure for a more acceptable level of quality. Where the court's order is not clear or specific on a particular recommendation, we have tried to refer to other known correctional standards, usually national in scope.

Finally, we are concerned about meeting the Prison Project's request to provide a way for estimating costs to be incurred by other states under similar court orders. Our primary focus has been the cost to Alabama, as this situation was more tangible, complete, and immediate than any proposed case. Where we were able to uncover general formulas we have included them. However, we

caution that each case in each state will be distinct, due to different correction administrators, judges, orders, legislative response, community attitudes, conditions of the prison buildings, etc. We did, where possible, attempt to estimate the cost of implementation for a standardized sample of 400 inmates, the maximum institutional size suggested by the National Clearinghouse and the National Commission on Criminal Justice Standards and Goals. These costs may provide the means for extrapolation to other states, with estimates adjusted appropriately. Also, a good deal of effort was spent deriving figures for alternative ways of implementing Alabama's orders once initial cost estimates for the existing system were available. We believe this issue of Alabama corrections' future direction to be of utmost importance and immediacy.

All items and possibilities considered, we estimate the cost incurred by the court order to reach approximately $28,500,000, excluding the cost of providing additional options for populations projected to 1980 and 1985. With these projected costs, the total could come to $44,000,000 for 1980 and $46,500,000 for 1985. The future costs could reach about $50,600,000 depending on the decisions made by the Board of Corrections.

Alabama Prison Population Projections

The Alabama Board of Corrections is shaping its planning to its estimate that by 1980 the state will have a prison population of 9,277.

The only other existing projection was done by Ed Rutledge of the University of Alabama. His report, "Projections of Alabama Prison Population to 1980 and 1985", dated March 26, 1976, cites 3,667 as his lowest and 4,940 as his highest estimate for 1980. He comments,

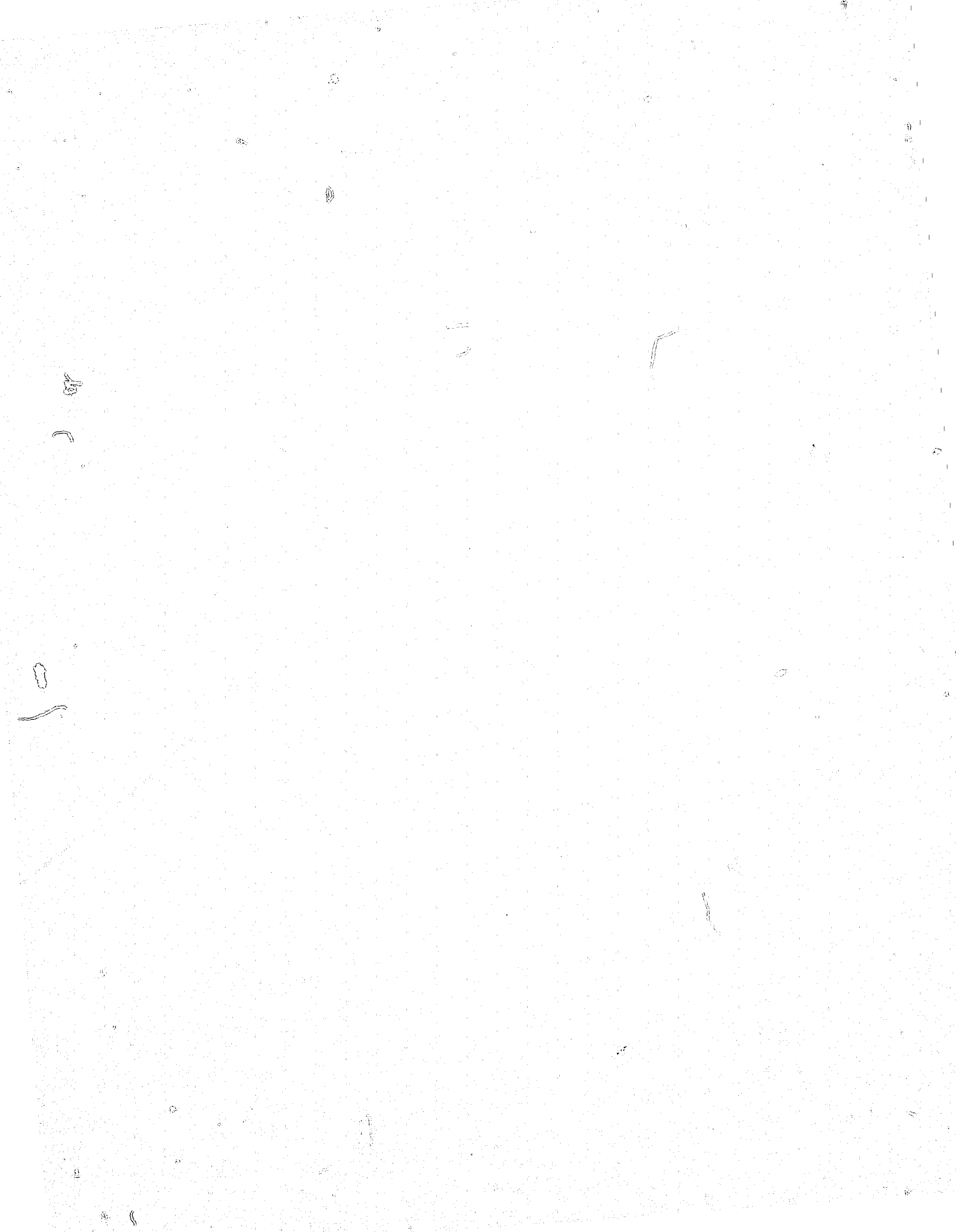
> "Due to the lack of appropriate flow data my own analysis in this instance has been immediate and pragmatic. Without knowledge of how system changes will impact, I have essentially projected the expected numbers of persons to be incarcerated if the system continues as it has in recent history. Someone knowledgeable in corrections can probably assess system changes and modify my projections accordingly."

We have tried to asses[s] the figures from both the Board and Mr. Rutledge in the light of our correctional and research experience.

Probably the Board of Corrections used a technique similar to straight line linear regression, based on past incarceration trends which have risen rapidly in recent years in Alabama and nationwide. For Alabama, the prison population moved from 4,000 in 1974 to 5,334 in 1976. This gives a high average annual increase percentage, which upon projection, might yield such a figure as 9,277 by 1980.

In challenging the Board's calculation, Rutledge noted that a prisoner count of 9,277 in 1980 would represent a nation of prisoners. Per 100,000 of general population that would be 88.4 percent higher than the actual rate in 1975.

Since 1950 the highest Alabama prisoner rate per 100,000 was 171.2, and in most years it has been substantially less, ranging as low as 109. This



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7 OF 12

rate would jump to a figure of 247.6 if the prisoner population were 9,277. We agree with Rutledge that an increase to this extent is unlikely.

Rutledge applied six different methods in making his projections, as follows:

Method 1 was the 1975 prison rate per 100,000 of total population applied to 1980 and 1985 estimates.

Method 2 was the 1975 prison rate per 100,000 of male population applied to 1980 and 1985 estimates.

Method 3 was the 1975 prison rate per 100,000 of males aged 20-34 applied to 1980 and 1985 estimates.

Method 4 uses prisoner rates per 100,000 total population since 1950 with least squares straight line linear regression.

Method 5 same as 4 only with 100,000 males aged 20-34.

Method 6 same as 4 and 5 but using ratio between total population rates and male aged 20-34 rates.

Rutledge suggests that the average of the last two methods may produce the best estimate. From the various methods he developed the following figures:

	Lowest estimate	Highest estimate	Average of 5 & 6
1980	3,667	4,940	4,794
1985	3,332	5,544	4,505

We suspect that the findings of methods 1,2, and 3, using the 1975 incarceration rate, are low. As seen in the data in Table I on the next page, there have been higher prisoner population rates than that of 1975. (171.2 in 1955, and 164.4 in 1960). So use of the 1975 rate as a basis for calculation may give a projected figure that is too low.

The figures in parentheses in Table I for 1980 and 1985 are our estimates projecting from the 1955 rate for the male prisoner population and then raised further by an arbitrarily selected amount to cover contingencies of unexpected factors.

TABLE 1: ALABAMA PRISON POPULATIONS 1950-1975

	Alabama Populations			Prisoners Per 100,000 Population				Alabama Prison Population	
Year	Total Pop.[1]	Male Pop.[2]	Male Pop. 20-34 yrs[2]	U.S. Total[4]	Total Pop.	Male Pop.	Male 20-34 Pop.	Prison Pop.[3]	Males 20-34 Prison Pop.
1950	3,061,743	1,502,640	328,598	110.3	145.5	296.4	412.5	4,454	1,355.5
1955	3,050,000			113.4	171.2			5,222	
1960	3,266,740	1,591,709	289,183	118.6	164.4	337.3	642.2	5,369	1,856.6
1965	3,443,000			109.5	127.1			4,377	
1967	3,458,000			99.1	112.2			3,881	
1968	3,446,000			94.3	116.6			4,017	
1969	3,440,000			97.6	120.4			4,140	
1970	3,444,165	1,661.941	329,030	96.7	110.0	228.0	350.1	3,790	1,151.9
1971	3,487,000				112.0			3,904	
1972	3,521,000				109.1			3,842	
1973	3,546,000				111.5			3,953	
1974	3,575,000				111.9			4,000	
1975	3,614,000	1,730,600	390,500		131.4	274.4	311.4	4,748	1,215.9
1980	3,746,500	1,800,500	441,900		(158.6)	(330.0)		(5,942)	
1985	3,827,900	1,869,900	456,000		(175.8)	(360.0)		(6,731)	

[1] Source: 1950-1975, U.S. Bureau of the Census; 1980 and 1985, National Planning Association, Report Number 72-R-1, Washington, D.C., October 1972

[2] Source: 1950, 1960, 1970, U.S. Bureau of the Census; 1975, 1980 and 1985, National Planning Association.

[3] Source: 1950-1970, U.S. Department of Justice, Federal Bureau of Prisons; 1971-1975, Alabama Board of Corrections.

[4] Source: U.S. Department of Justice, Federal Bureau of Prisons.

Accordingly the calculation shown by this table produces a prison population figure of 5,942 by 1980 and 6,731 by 1985.

As a supplemental calculation we computed figures on the basis of differing incarceration rates for the males aged 20-34 and for males of all other ages. The resulting figures are shown in Table II. In considering the results in Tables I and II together, we think it likely that the 1980 Alabama prison population will reach a level between 6,000 and 6,500.

TABLE 2: PRISONER POPULATION PROJECTIONS - 1980
LEVELS OF INCARCERATION

	MALES 20-34		ALL OTHER MALES		
	Rates per 100,000	Est. Total of 441,900	Rate per 100,000	Est. Total of 1,358,600	Prison Population Estimates 1980
Low	350	1,547	330	4,483	6,030
Med	400	1,767	360	4,891	6,658
High	600	2,651	400	5,434	8,085

The above calculations can be checked by still another method of projection which is based on the 1976 rate of incarceration. When the back-log of new sentences, escapes and parole violators in county jails is included, the 1976 prison population would be 5,334. Projecting this rate to 1980 we get a figure of about 5,942, and this, like our other figures, falls between the Rutledge estimate and the Board estimate. This seems to further support our decision to hold to our estimated prison population figures of 5,942 - 6,658 in 1980, and 6,731 by 1985.

ADDITIONAL ANNUAL COSTS

STAFF COSTS

A. Classification Staff

The first and non-recurring cost of this item is the payment made to the University of Alabama for the initial task of classifying all inmates in the system. The expected amount of this charge is roughly $159,000.

In addition to the initial task of classifying all inmates in the system, there is to be the cost of continuing to classify new inmates as they are received and to review all cases periodically. This cost is mainly reflected in the Board's plans to hire new classification staff at all institutions.

There are four categories of personnel involved; psychologists, psychologist assistants, classification officers and clerk-stenos. The Board employed people in most of these classifications prior to the court order, but as a result of the court order, the complement in each category is to increase as follows.

Psychologists:	from 7 to 18,	with net gain of	11.
Psychologist Asst.	" 0 to 2,	"	2.
Classif. Officer	" 10 to 24,	"	14.
Clerk-steno	" 6 to 24,	"	18.

Total cost of these positions for the first full year of employment is shown on the next page. The base figure for each category represents the equivalent of what is currently paid for the employee's first year during which he has a salary increase at the six month point. The package of fringe benefits in Alabama amounts to a fraction less than 19% of the base salary.

Psychologists	$15,178 + 19% = $18,060 X 11 =	$198,660.
Psychologist assts.	11,057 + 19% = 13,150 X 2 =	26,300.
Classification officers	11,057 + 19% = 13,150 X 14 =	184,100.
Clerk-stenos	6,864 + 19% = 8,160 X 18 =	146,880.
	Total annual cost	$555,940.

We feel that the Board's number of required classification staff is excessive. The Board's ability to house or assimilate this level and number of trained professionals within the existing operational structure is extremely questionable, and it definitely would not be cost effective.

Given the centralized system of classification and the rate of flow of persons being admitted to Alabama's prisons, we propose the following staffing additions to classification:

Board Employed

1 Ph.D Psychologist @ $15,178 + 19%	18,060
5 Classification Officers @ $11,057 + 19%	65,750
4 Nurses @ $7,143 + 19%	34,000
6 Clerk Stnos @ $6,864 + 19%	48,960
Sub Total	$166,770

Consulting

1 Consulting Psychiatrist (½ time)	20,000
1 Consulting M.D. (1/3 time)	20,000
1 Consulting Dentist (1/3 time)	12,000
	$52,000
TOTAL	$218,770

B. Mental Health Staff

The cost analysis prepared by the University of Alabama suggests that

this section of the court order be met by the employment of one psychiatrist, three psychologists, four social workers and twelve correctional counselors. These numbers are in compliance with standards established in Newman v. Alabama, 349 F. Supp. 278 (M.D. Ala. 1972), which was confirmed by the Court of Appeals, 503 F. 2d 1320 (5th Cir. 1974). A supplementary order to Pugh v. Locke, etc., dated March 5, 1976, required these standards to apply to this case. Using average salaries for equivalent positions in state institutions, costs are as follows:

Psychiatrist - 1 @ $40,000		$40,000.00
Psychologist II-2 @ $12,436		$24,872.00
Psychologist I-1 @ $15,595		$15,595.00
Social Worker- 4 @ $11,980		$47,920.00
Psychiatric Counselor - 12 @ $9,000		$108,000.00
	Sub-Total	$236,387.00
19% Employee Benefits		44,914.00
	Sub-Total	$281,301.00

Support staff would be four clerk/typists at $6,500 each plus 19% benefits.

Sub-Total	$ 30,940.00
Total	$312,241.00

Our cost estimates presented below are based on the recognition that probably 90% of the mental health problem will be alleviated by the effects of other provisions in the court order; the elimination of overcrowding, the improvement in work and recreation, the training of custody staff, and the establishment and operation of a staffed classification system. We also note that the twelve correctional counselors proposed by

the University would be just three at each of four institutions, and after distribution over the many shifts per week, there would be only one at a time on duty. This dilution of impact makes this group of too little value to be included, in our opinion.

Instead, it is our belief that the mental health needs can best be served by the hiring of one (equivalent) psychiatrist and five social workers. The psychiatrist position would probably be used for two part time psychiatrists; one (2 fifths time) in the Mobile area, serving Fountain and Holman, and one (3 fifths time) in the Montgomery area for Tutwiler, Draper and Kilby. The five social workers (one each at the five institutions above mentioned) would be a part of the treatment unit now being organized as a system-wide service under Dr. Warren. However, these social workers, working closely with and receiving professional advice from the above mentioned psychiatrists, would give their attention to any measures needed for the continued care of the disturbed and retarded inmates.

Salaries for the five social workers, including fringe benefits, would be $14,250 each for the first year, and a total of $71,250 for the five. The salary for the psychiatrist would be $39,270.

We do not presume that clerical staff would be needed beyond the staff proposed for the classification services.

Our Proposed Staff and Costs

1 Psychiatrist	@ $33,000 plus 19% benefits	$39,270
5 Social Workers	@ $11,975 plus 19% benefits	$71,250
	Total	$110,520

C. Custody Staff

The court order provides that the custody staff at the four institutions

are to be no less than the following strengths.

Draper	184
Kilby	159
Fountain	178
Holman	171

(Note: The court order inadvertently reversed two of the above figures, with no change in the total)

As a result of the court order, the institution at Kilby has installed a trailer complex to house a number of prisoners, and this has required the addition of 29 staff positions. For all intents and purposes, these 29 need to be added to the total being required by the court order. However, the judge did not so specify, so we have not included them.

The ordered, additional positions include officers (correctional counselors) and those of higher rank including lieutenant and captain. To compute the costs of salaries, we took a base figure of $8,970 for the officers and added to it 19% for fringe benefits, making a total of $10,670 as the first year cost for each position.

The other positions are computed at a base salary of $10,000, representing a reliable average of the different levels. With the addition of the 19%, this is a first year cost of $11,900 for each of these positions which the personnel office refers to as middle management custodial positions.

Table No. 3 gives the probable distribution of the new positions, which represent a new gain of 326 positions, the total cost of which would come to $3,498,100.

TABLE 3: CUSTODY STAFF
pre-order and ordered totals and associated additional cost

	Pre-Order	Ordered	Increased	Cost of Increase	
Holman					
Correctional Counselors	81	165	84	$896,280	
Middle Management	6	6	0	0	
	87	171	84		$896,280
Kilby					
Correctional Counselors	65	144	79	$842,930	
Middle Management	10	15	5	59,500	
	75	159	84		$902,430
Draper					
Correctional Counselors	83	164	81	$864,270	
Middle Management	15	20	5	59,500	
	98	184	86		$923,770
Fountain					
Correctional Counselors	94	160	66	$704,220	
Middle Management	12	18	6	71,400	
	106	178	72		$775,620
			GRAND TOTAL		$3,498,100

Total Increase

Correctional Counselors	310	@$ 8,970 + 19%	= $3,307,700
Middle Management	16	@$10,000 + 19%	= $ 190,400
Total	326		$3,498,100

The University of Alabama staff sought information on staff-inmate ratios in a number of representative institutions in other states and compiled averages as follows.

Juvenile/Youth	1: 4.2
Long Term Adults (+ camps)	1: 7.8
Intermediate Adults	1: 7.0
Short-Term Adults	1: 8.7

Table No. 4 looks at Alabama's custodial staff-inmate ratios (1) under pre-order staff conditions compared to existing capacity and (2) using court ordered staffing numbers compared to capacity if the institutions are altered to single cell facilities in compliance with the court order.

We feel that the staff/inmate ratios for custody are too high. Our recommendation would be to seek a staffing level ratio of 1 to 5. We feel that the cost of implementing court ordered levels will drain resources from other areas offering greater potential to impact positively on the inmate and institutional operations. Staffing numbers should be considered on an institution by institution basis and determined by using criteria such as population capacity, facility layout, programming, security, age, other characteristics of the resident populations, institutional goals, etc. Though the change from dorms to single cells would reduce overall capacity, we think it would not reduce staffing requirements.

For many states the primary cost of operating an institution is staff salaries. In many states, wages and benefits approach 80% of the operating budget. Therefore, court imposed minimum staff/inmate ratios are crucial. It is not clear that above a certain level, increase in staff size results in better care and supervision (population control and reduction probably have the greatest impact).

Thus, if the staffing requirements were to be modified by an amended court order to be a one-to-five ratio for present institutional capacities, the total increase for the four institutions would be 90 correctional officers and 5 middle management personnel, as follows.

90 Correctional officers	@ $10,670.00	=	$960,300.
5 Middle Management	@ $11,900.00	=	$ 59,500.
	Total	=	$1,019,800.

TAB[illegible] 4

CUSTODY STAFFING REQUIREMENTS AND RECOMMENDED ADJUSTMENTS

FACILITY	COMPLIANCE CAPACITY		STAFFING RATIOS						
			PRE-COURT ORDER		COURT ORDERED		OUR RECOMMENDATIONS *		
	PRESENT STRUCTURE	IF SINGLE CELLS	NUMBER	RATIO	NUMBER	RATIO WITH SINGLE CELLS	NUMBER	RATIO	NET INCREASE
HOLMAN	540	392	87	8.96	171	2.3	108	5.0	21
FOUNTAIN	632	342	106	10.34	178	1.9	126	5.0	20
DRAPER	632	336	98	11.21	184	1.8	126	5.0	28
KILBY	503	442	75	9.54	159	2.8	101	5.0	26

*WHETHER FOR PRESENT STRUCTURES OR SINGLE CELLS.

D. Food Service Staff

The University points out that additional personnel is needed in order to meet the requirement of adequate food of proper quality. What the Board has done is to make some new assignments in this regard without any substantial addition of new positions. Probably the only new position that represents the effect of the court order is a dietition at a base salary of $11,200, or a full annual cost of $13,328.

We feel these changes represent weak but adequate efforts at court order compliance, depending on how the court order is read. Stronger compliance would be achieved by providing either training for present stewards or higher salaries to attract qualified stewards at each institution.

E. Recreation Staff

The court order specifies a recreation director at each institution with a BA in recreation or physical education - then it adds - "or equivalent."

The Board is meeting this requirement by hiring one recreation director at the Board headquarters, and one extra correctional counselor at each institution. They claim that the correctional counselors are being selected for their interest and experience in recreation. With supervision from the recreation director, this can be considered compliance. Probably so.

Recreation director	@	$11,900 +19% =	$14,161
4 Correctional counselors	@	$ 8,970 +19% x 4 =	42,696
		TOTAL	$56,857

F. Maintenance Staff

Although additional maintenance staff was not explicitly called for in the court order, we feel they are a necessity for the state to reach, and continue, compliance with public health standards -- sanitary, heated, ventilated, and serviced institutions. At present, all institutions are severely understaffed in the maintenance category. We suggest the following additions: one engineer and one maintenance man at each of five institutions.

Position	Base Salary		Total Salary
Engineer	$14,000 + 19%	=	$16,660
Maintenance man	10,000 + 19%	=	11,900
TOTAL EACH INSTITUTION			$28,560
X FIVE INSTITUTIONS			$142,800

An increased inventory of equipment would probably facilitate maintenance work. However, instead of citing a figure out of the hat, we have considered equipment to be an on-going institutional cost necessary regardless of the court order. Therefore, no equipment cost is attached for the purposes of our study.

G. Affirmative Action

To meet the order in terms of affirmative action hiring, the Board of Corrections has hired a personnel director and assistant. A second assistant and clerk steno were already salaried prior to the order. The director's salary is $14,500 plus 19% benefits ($17,255 total); the assistant's salary is $10,100 plus 19% benefits ($12,019). Therefore, the court order has incurred an additional $29,274 for Alabama to meet affirmative action hiring requirements. We accept the Board's position and salaries as sufficient.

H. Staff Training

The court order requires that "appropriate and effective training programs" be provided for all employees.

Presently, the Alabama Board of Corrections provides training for its custodial personnel. They are trained at the Law Enforcement Training Academy and are essentially receiving the same training curricula as the State Police. Much of this training seems of questionable value and may even result in negative effects on staff performance in institutional settings.

We have assumed the need for several on-going types of training:

1) Initial Orientation and Basic Staff Training
2) Correctional Officer Training
3) Supervisor Training
4) Management Training
5) Specialized Training

A variety of special types of training programs will be needed, e.g., food service related, maintenance, first aid, therapeutic techniques, planning and evaluation, budgeting, information technology, community resource development/utilization, alcohol and drug use, legal, etc.

Several approaches for providing on-going staff training by the Alabama Board of Corrections would seem to be the most cost effective. For the first two components mentioned above, Orientation and Correctional Officer Training, in-house with Board of Corrections Training staff would seem most efficient. Provision of Supervisory and Management Training can best be accomplished by contracting on a course by course basis with local colleges/business schools. For other specialized training courses, contracts could also be negotiated on a case by case basis with special trainers or local community colleges/universities.

Further, regular correctional training programs are offered through the Southern Correctional Training Council (University of Georgia, Athens), LEAA, National Institute for Corrections, and other funding sources. Many LEAA programs now include monies for attendee travel and subsistence.

Estimated Annual Cost

Director of Training	$16,000
Instructors (3 @ $12,000)	36,000
Clerk/Typist	6,500
Fringe Benefits (19%)	11,115
Operating Expenses/Supplies	18,000
Travel (.15 per mile)	6,000
Subsistence ($30/day)	15,000
Training Materials	6,000
Contract Training	12,000
Total	$126,615

I. Medical Care

The court order stipulates that each person in segregation and isolation be "afforded adequate medical and mental health care, including examination by a physician and a qualified mental health care professional at least every third day". (Mental health care has been considered elsewhere under staffing in annual costs). The court order prescribes nothing concerning medical care for the general population.

The University of Alabama's cost analysis cited $97,500 needed to provide an average daily segregated/isolated population of 75 inmates with a physical

exam every third day at $10 per exam.

To evaluate this cost estimate, we consulted a reputable doctor who witnessed the Alabama prisons' health scene in conjunction with the classification procedure and who has had extensive experience with another state's prison health system. At his suggestion, we find this cost estimate figure to be unnecessary. Physicians are currently employed and available to do these daily exams at no extra cost.

This denial of any additional funds for medical care for the segregated/isolated does not constitute an endorsement of Alabama's prisons' health care system. Instead, the prison health care system is afflicted with major problems. These problems, as this doctor sees it (and we accept his informed opinion) include:

1) The lack of a system of accountability for anyone in the medical system. This results in unsupervised, unlicensed physicians delivering most of the care. The quality of the care is therefore poor, and the inmates' distrust is unusually high.
2) An extremely limited use of consultation services.
3) No medical care for inmates at pre-release or work release centers.
4) No gynecologist-obstetrician at the women's institution.

These problems are critical issues, but, alas are not addressed in the court order. It seems that in this court case, medical needs and services "fell between the cracks". Therefore, we have not assigned related costs. [1]This absence of medical standards from the court order is an extremely unfortunate oversight. Medical care has been, and should be, a separate topic of other court cases concerning prison conditions.

Without assigning any price tags, we still feel it is important to pass

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[1] The statement on this page that "[T]his absence of medical standards from the court order is an extremely unfortunate oversight." is an error. The same court had previously set forth detailed medical standards in its earlier decision in *Newman* v. *State of Alabama*, 349 F.Supp. 278 (M.D.Ala. 1972), *aff'd in part* 503 F.2d 1320 (5th Cir. 1974), and it would have been a duplication to repeat them in *Pugh* and *James*.

along to the National Prison Project and concerned others recommendations for improving medical care in Alabama prisons. First, a system of accountability must be immediately established and used. This should include strong administrative medical leadership. In addition, an Advisory Board to oversee Prison Health care should be considered, to aid in the formulation of medical policy and guidelines. Each doctor would then be responsible directly to the Commissioner of Corrections, and adequate supervision would be provided for unregistered physicians. Secondly, consultation on a contract basis should be established with medical schools and needed specialists to cover gynecological needs at Tutwiler, general needs at pre-and work release centers, and special needs at major institutions. Thirdly, the physicians' staff could be reduced and upgraded if a training program were started to train paramedical personnel. Lastly, inmates could be educated on how to use the medical facilities and care at their disposal. The largest additional expense would be consulting services, although this could be somewhat diminished by using medical school students and residents. The additional cost of paramedics could be slightly offset by a reduction in the number of physicians. The initiation of a system of accountability with strong, central leadership is costless and imperative.

J. Inmate Personal Items

The court order specified that the following items be supplied by the state to all inmates: razors, razor blades, soap, toothpaste, tooth brushes, combs, and shaving cream. (Shampoo was initially included but excluded in a later order). According to another supplementary order, the State is to supply postage and stationery for two letters per inmate per week.

Razor blades and soap are not included in the cost accounting here

because these two items were furnished before the court order was issued. Therefore, they presumably do not represent new costs caused by the court order.

The Board is buying some surplus lockers at $1.00 each, but this is not considered essential as a part of the court order, so no estimate on lockers is included here. To provide all inmates with padlocks the Board has incurred a one-time cost of about $3,000. We will include this cost of padlocks.

We based our calculation of an annual figure on a capacity population total of 3884. This population total includes all facilities under the auspices of the Board of Corrections, work release centers and Frank Lee Youth Center included.

One final note: The prisoner population of 3884 includes the female prisoners. These would not be issued shaving cream but they would be issued other toilet articles. For the convenience of calculating, it is assumed that the difference will cancel out.

Padlocks for lockers				
Recurring costs on an annual basis.				$3,000
Razors	1 per year	@ 60¢ each	2,330.	
Tooth paste	8 " "	@ 2.40 per doz.	6,214.	
Tooth brushes	2 " "	@ 1.00 " "	647.	
Combs	1 " "	@ .60 " "	194.	
Shaving cream	4 " "	@ .45 " "	6,991.	
Total annual recurring cost of articles				$16,376.

Stationery;	2 letters per week, or about 404,000 letters annually at about $2.00 per 100.	$ 8,080.	$8,080.
Postage;	404,000 letters at 13¢ each	$52,520.	
	Four postage meters at annual rental of $331 each.	$ 1,324.	
	Total postage cost		$53,844.
	Total cost of personal items chargeable to the court order		$81,300.

K. Clothing and Linen

According to the court order, the State of Alabama is responsible for providing "adequate clean clothing" and a weekly supply of "clean bed linen and towels".

Clothing costs are very difficult to compute accurately. It seems nearly impossible to determine the value of clothing that was being issued prior to the court order, though we know that it was very limited. During the year since the court order, the Board has purchased the basic materials to expand clothing production at the Tutwiler garment factory. Purchases have included $50,377 for blue denim for shirts and pants; $10,125 for gray drill; $19,200 for blue chambray; $11,200 for white herringbone drill; $5,800 for white shirting. Nothing has been purchased for making underwear.

The use of these figures does not tell us how much it actually will cost to make these materials into clothing items, nor do we know the cost of utilities and other expenses at the garment factory. Therefore, we sought relevant prices elsewhere.

In the federal prison industries all costs of utilities, equipment replacement, building maintenance and staff in the industry buildings are charged

against the cost of the manufactured products. With this accounting the federal industries currently charge as follows for clothing items which they make.

Everyday shirt, short sleeved	-	$3.20
Everyday shirt, long sleeved	-	$3.80
Kahki pants -------	-	$5.55
Coveralls -------	-	$8.25
White culinary shirt --	-	$3.20

To further supplement these figures, we solicited comparable costs from the Philadelphia Prison System. The Philadelphia Prison System currently manufactures and charges for similar items as follows:

Short sleeved shirt ---	-	$2.26
T Shirt -------	-	$ .55
Pants -------	-	$5.15
Underpants -------	-	$ .83
Shoes -------	-	$6.50

To figure how many of each item should be allotted to each individual, we ascertained from the Business Manager, the clothes allowances provided by Delaware's Department of Corrections. The cost to Alabama of total year's clothing estimate was found by multiplying the appropriate number of inmates needing each item (i.e. farm hands only allotted coveralls) by Delaware's clothes allowance, and again by the average of Philadelphia and Federal Prison prices.

2 short sleeved shirts for 3,884 inmates	@ 2.73	$21,206.64
4 long sleeved shirts for 3,884 inmates	@ 3.80	59,036.80
6 pants for 3,884 inmates	@ 5.35	124,676.40
6 * underpants for 3,884 inmates	@ .83	19,342.32

* Our estimate

3 shoes for 3,884 inmates	@ 6.50	$75,738.00
4*coverall for 350* inmates	@ 8.25	11,550.00
5 white kitchen shirts for 400* inmates	@ 3.20	6,400.00
Clothing Total		$317,950.16

Annually per inmate -------- $76.24

Additional for farmers ----- 33.00

Additional for kitchen help - 16.00

* Our estimate

For towels and sheets, the Philadelphia prisons charge 74¢ per towel purchased and $2.87 per sheet sewn in their industries. The Federal Bureau of Prisons estimates $1.19 per towel. Averaged towel cost is 97¢. Figured as we figured clothing costs, the total comes to $52,123.28.

2 towels per 3,884 inmates	@ .97	$ 7,534.96
4 sheets per 3,884 inmates	@ 2.87	44,588.32
		$52,123.28

$13.42 annually per inmate

We expect laundry costs to remain relatively unchanged. Any cost in laundering more clothes could be offset by the fact that the laundries were cleaning clothes for above capacity populations before the court order.

Lastly the harshness of laundering, durability of cloth, and care by the wearer will determine the life of each piece of clothing. Therefore, we can't designate specifically how much an annual cost will be, except to guess that annual replacements of clothes, sheets, and linens will probably be necessary.

Clothing Total	-------------------------	$317,950.16
Linen Total	-------------------------	52,123.28
	Total	$370,073.44

L Additional Food

Annual costs for food services include monies spent on food supplies, associated salaries and wages, and food service supply expenses. "Food supplies" account for both cash purchased and prison produced food. Annual food service costs should also consider (1) equipment maintenance costs which we have included under Maintenance and (2) additional staffing salaries listed under Staff.

Before the court order (FY'74-75), the Board of Corrections spent a total cost for food services per inmate per day of 98¢. (See Report of the Board of Corrections, State of Alabama, Financial and Statistical Report, 1974-75). This figure includes all categories cited above, excluding maintenance and additional salaries.

To ascertain whether or not this figure would be sufficient to provide "three wholesome, nutritious meals per day" as ordered by the court, we sought comparative prices. The Federal Bureau of Prisons spends $1.35-$1.40 for food per prisoner per day (probably a 1975 figure). The Alabama Department of Mental Health spends $1.81 per patient per day for food (1976). The reported national average daily food cost per inmate per day is $1.92 (probably a 1975 figure). It might be argued that the prison system's figure is lower due to its reliance on farm products. However, the Federal Bureau also relies on farm products, but still spends 37-42¢ more per prisoner. Additional funds could be funneled into farming or direct food purchases. Whatever way, it seems clear that the Alabama prison system falls below comparative figures in food service expenditures.

An estimate figure for additional food costs to be incurred by the Board of Corrections can be derived from the following formula:

average number of inmates x 365 days x (comparative food cost per person per day - Board of Corrections food cost per person per day before order) = additional food costs for compliance.

Possible estimates for Alabama

1.	3884 x 365 ($1.35 - .98)	=	$ 524,534
2.	3884 x 365 ($1.80 - .98)	=	1,162,481
3.	3884 x 365 ($1.92 - .98)	=	1,332,600

ADDITIONAL ANNUAL COSTS

Our best point estimates based on our recommendations

Salaries	
Classification	$ 218,770
Mental Health Staff	110,520
Custody	1,019,800*
Food Service	13,328
Recreation	56,857
Maintenance	142,800
Affirmative Action	29,274
Staff Training	126,615
Inmate Personal Items	81,300
Clothing and Linen	370,073
Additional Food	1,162,481
Initial Classification Charge (cited in text but not technically an annual charge)	159,000
	$3,490,818

* Custody staff figure would be $3,498,100 if the court order remained unchanged to fit our recommendations.

CAPITAL COSTS

A. Single Cell/Living Space

Judge Johnson's order and supplementary orders establish the following requirements for personal living space:

1. All but minimum security prisoners must be housed in single cells.
2. All cells constructed subsequent to the court order will measure a minimum of 60 square feet.
3. Each inmate shall have access to a minimum of 60 square feet of living space. This means that an inmate may be assigned to a 40 square foot cell for sleeping and storage of personal items, if s/he can move to a larger total area during most hours. Two exceptions to this order are as follows -- A) existing cells of 40 square feet may be used without providing access to a larger area for punitive isolation of limited duration, and B) cells of at least 60 square feet must be used for people under administrative segregation and people with a mental or physical disability.

Alabama currently houses by far the largest percentage of its inmates in dormitories. Only 14% of Alabama's institutional accomodations are single cells, and this figure includes death row and hospital single cells. In light of the court order, these housing facilities are acceptable only for those classified for minimum custody.

Members of the Department of Correctional Psychology, University of Alabama responsible for the new classification system, allege that the Board of Corrections has cooperated in assigning people to minimum custody in hopes (the Board's) of skirting potential costs involved in making dormitories into single cells. The Board's attorney reports that the Board of Corrections is seeking a supplementary order from the judge to the effect that with the

implementation of the classification system and isolation of maximum and close security people, medium as well as minimum custody people could be safely housed in dorms. We, however, must proceed on the basis of the court order as it presently stands.

Therefore, we feel the Board's lack of any intentions to provide single cells is shortsighted in light of their projected demand for medium, maximum, and close security housing. We see little reason for the existence of a prison for minimum custody inmates. Those inmates whose classification reflects that they pose little or no security problem to the community should be released, paroled, or transferred to work release or community based facilities. Considering the projected prison population numbers and the comparatively limited number of secure prison cells, this transfer out of minimum security people is even more urgent. The Board would stand to save money by converting all dormitories to single cells for medium and maximum custody inmates and housing minimum custody inmates in community facilities or not at all. Minimum custody facilities can be rented or constructed at lower costs than secure facilities. Another section of this report will further illuminate the relative economies of community facilities. The point made here is that the conversion of dormitories into single cells is a wise, long-term investment in light of new construction costs.

The National Clearinghouse for Criminal Justice Planning and Architecture advised similar plans for single cell renovation/construction at all five, major institutions. Essentially, their plans are to construct individual cells of a minimum of 70 square feet around the perimeter of the existing dormitories. The dormitories would be converted into dayrooms. Only the segregation units at Holman and Kilby prisons need be abandoned as impractical to renovate. Each

proposed housing unit would have a toilet, hot and cold running water as ordered by the court, at least for segregation cells. The Clearinghouse went beyond the court's orders so that renovations/construction would comply with Law Enforcement Assistance Administration guidelines -- namely, institutions of no more than 400 inmates, minimum cell space of 70 square feet, and a minimum total living and program space of approximately 400 square feet per inmate. The Clearinghouse advises that since renovation/construction is by definition expensive, all building should be done cost effectively but so as not to be below new standards almost immediately upon completion. The Clearinghouse plans are to protect against this possibility. The Clearinghouse also points out that alternative plans to provide the required amount of space and toilet/ shower facilities in the dormitories would be almost as expensive as constructing single cells, but nowhere near as advisable for personal safety of staff and inmates.

The Clearinghouse estimated the capital costs of renovating/constructing residential areas as follows:

Draper Correctional Center (maximum capacity from 632 to 336)	$ 3,526,320
Kilby Correctional Facility (maximum capacity from 503 to 442)	5,819,320
Fountain Correctional Facility (maximum capacity from 632 to 342)	2,294,285
Holman Unit Prison (maximum capacity from 540 to 392)	5,337,360
Julia Tutwiler Prison (maximum capacity from 200 to 175)	1,515,780
TOTAL CAPACITY-1,691	$18,493,065

(816 less than capacity of original design)

This figure may initially seem exorbitant. However, the Clearinghouse claims the cost of meeting living space and toilet/shower facilities on the most minimal, renovation plant budget would cost something lower but nevertheless akin to this figure. We concur with the Clearinghouse that the converted dormitory plan costed out here is by far the wisest investment.

B. Public Health Standard Improvements

This item deals with general building maintenance of heat, light, ventilation, screening and wiring. The court mandated that institutions be "adequately heated, lighted, and ventilated" as well as "properly screened" and safely wired.

The Board considers it necessary to include roof repairs, and we concur. The University has proposed modest amounts for roof repair, but the Board considers those estimates appropriate only for minor patching, whereas substantial rebuilding of roofs is required. The Board is requesting the following amounts for the first year's roof repairs.

Kilby	$48,000
Holman	75,000

Also, to ensure court order compliance, the Board requests $35,000 to renovate the water system at Fountain, and $150,000 to replace the electrical system there. We concur.

A related cost that may or may not be attributable to the court order will be the renovation of sewage systems. After studying the estimates from both the Board and the University, we propose the following cost estimates that may be related to the effect of the court order.

Sewage system renovation	
Fountain and Holman	$350,000
Kilby	200,000
Draper	200,000
Frank Lee Youth	150,000
	$910,000

All the institutions have a continuing pest control service, and this should be sufficient to keep insects and rodents under control with no additional cost, having reduced populations and completed required painting, renovation and new construction.

Finally to meet the toilet requirement, the Board claims to have purchased between $100,000 and $150,000 (we'll use $125,000) for pipes, fittings and plumbing fixtures. The installations and repairs have been done by inmate and maintenance crews. Theoretically, this cost would be made unnecessary by the renovation of dorms into cells, but we have included this figure since it has already been incurred.

TOTAL FOR PUBLIC HEALTH STANDARD IMPROVEMENTS: $1,343,000

C. Offices and Equipment

Office space is currently in short supply and must be expanded to house classification and mental health personnel. To minimize capital additions as much as possible, we suggest that professional mental health staff share classification staff space, and staff training personnel find accommodations with the education program staff.

The Board plans to expand and renovate space at minimal cost with use of inmate and maintenance crews. Costs estimated by the Board are as follows:

Draper	$20,000
Kilby	10,000
Holman	2,000
Fountain	2,000

We tend to think this figure is low. Accordingly, we are arbitrarily estimating that at least an additional amount of $6,000 for office space will be needed. So our final estimate for this item is $40,000.

We estimate office equipment for classification staff at the size proposed by the Board as follows:

Typewriters	@ $600 x 18	=	$10,800
Secretary desk	@ 150 x 18	=	2,700
Secretary chair	@ 75 x 18	=	1,350
Executive desk	@ 150 x 27	=	4,050
Executive chair	@ 75 x 27	=	2,025
File cabinet	@ 75 x 8	=	600
Dictaphone recorder	@ 250 x 4	=	1,000
Dictaphone trans.	@ 150 x 4	=	600
			$23,125

Equipment cost for the required mental health staffs would be an additional $400 per social worker, or $1,600 total.

To have office equipment reflect our proposed classification staff complement, we suggest the following numbers and costs.

Typewriters	@ $600 x 6	=	3,600
Secretary desk	@ 150 x 6	=	900
Secretary chair	@ 75 x 6	=	450
Executive desk	@ 150 x 6	=	900

Executive chair	@ 75 x 6 =	450
Dictaphone recorder	@ 250 x 4 =	1,000
Dictaphone trans.	@ 150 x 4 =	600
		$7,900

We estimate office equipment for social workers at $400. A total of $2,000 would be necessary for all five.

Additional operation costs (telephone, travel, incidentals) are estimated at $50,000.

Equipment costs for staff training should include the following:

2 Automobiles @ $5,000	$10,000
Audio Visual and other equipment	5,000
Office Equipment	5,000
	$20,000

Therefore capital/start-up total costs for classification, mental health, and training staffs are as follows:

	To Meet Order	Our Preferred Cost
Expansion of space	$ 40,000	$ 40,000
Office furniture	29,725	9,900
Staff training equipment	20,000	20,000
Operations	50,000	50,000
	$139,725	$119,900

D. Visiting Space

At the time of the court order with overcrowding and limited staff, the visiting rooms were insufficient. Visits, were therefore, restricted to every other week. With capacity populations and adequate staffing, existing visiting areas would probably be sufficient, except possibly at Kilby. The Board of Corrections in its '77 proposed budget requested $50,000 for a new and equipped visiting room for Kilby. We accept that figure as reasonable but optional.

To estimate the adequacy of visiting facilities in other states, the following must be considered--capacity population, required frequency of visits, required length of visit (farther distances traveled should result in longer visits), mean distance from hometowns, average age of inmates (younger inmates receive more visitors), and staffing patterns. Inadequate staffing should not restrict visits but should, like space, be adjusted to meet the institutional needs dictated by the preceding factors.

The National Clearinghouse suggested the following formulas for determining visiting space needs and costs.

1) Capacity population x recommended total visiting hours each inmate per week ÷ number of days on which visits are permitted ÷ number of hours each day of visiting = number of visiting space required.

2) Visiting space required x % capacity population in segregation or close security requiring non-contact visits = number non-contact spaces needed. Visiting space required x % capacity population available for contact visits = number contact spaces needed.

3) Non-contact spaces needed x 14.9 square feet per space x $34 = Cost for non-contact visits.

4) Contact spaces x 14.9 square feet per space x $40 = Costs for contact visits with some built-in furniture.

5) Cost for non-contact visits (3) + cost for contact visits (4) = Total cost for visiting space, excluding some additional furnishings.

For an institution with 400 inmates, 10% of which are in need of non-contact visits, visiting needs would be as follows, assuming seven days a week visiting for four hours a day (probably a low figure) and each visit of two hours duration.

400 x 2 = 800 ÷ 5 ÷ 4 = 40 x 10% = 4 for non-contact x 14.9 x $34 = $ 2,026.40
x 90% = 36 for contact x 14/9 x $40 = 21,456.00
$23,482.40 plus additional furnishings

Some of this space and cost might be avoided if other program areas were made available for visiting.

E. Recreation Equipment and Facilities

The court ordered that "adequate equipment and facilities shall be provided to offer recreational opportunities to every inmate." This statement leaves quite a margin for interpretation.

The University of Alabama understood the order to call for gymnasiums. Its cost analysis includes $525,000 to provide a gymnasium each at Kilby, Draper, Fountain, Holman, and Frank Lee facilities. No source was given for the cost estimates, and no explanation was given for not building a gymnasium at Tutwiler. Women require exercise as much as males.

The National Clearinghouse specifically proposed converting a dormitory into a gymnasium at Kilby. The cost of this reconstruction is included in the $2,676,500 for program/activity areas at Kilby. It is unclear whether the program/activity areas for the other institutions would include gym facilities.

It is also unclear whether the Board of Corrections' plan for converting the old Fountain kitchen into a "rec hall" would constitute the provision of a gym. We think this would not be the case as the ceiling is too low for an adequate gymnasium.

We understand the importance of vigorous, physical exercise. However, generally, Alabama's weather is not like northern sections of the United States, even though rain might substitute for much of the snow. Thus, we feel that gyms are a borderline issue in this case and are not necessitated by the court order. If gyms are to be provided, institutions for both sexes should be equally equipped. A reliable way to figure gym costs would be to use the National Clearinghouse's suggested cost of approximately $34 per square foot of gym space. This figure is the median cost for constructing regular gym facilities which run from $11.60 to $77 per square foot. Furthermore, the Clearinghouse suggests 21 square feet per

inmate as an appropriate gym space allotment. For 400 people, that would come to 8400 square feet and a total of $285,600. This cost and area would include locker and shower space, full-size basketball court and weight room. We suspect that the Clearinghouse's cost estimate runs higher than the University's figures because the former's plans include complete facilities on the consideration that capital investments should be as complete as possible on initial construction: i.e., they should be good investments.

We emphasize again that these costs for gyms should be optional and not figured into the total cost of implementing the court order. Only a broad reading of the order would necessitate gyms.

However, we do feel a budget for recreational equipment should be included. We would concur with the University of Alabama's figures of $2500 per institution, or a total of $12,500 (including Tutwiler but not Frank Lee). With a little ingenuity this money could stretch a long way.

F. Outdoor Recreation Areas for Segregation and Isolated Inmates.

The court order calls for people in segregation and isolation cells to be "allowed at least 30 minutes outdoor exercise per day."

At present, February 1977, the provision of adequate outdoor recreation space for these inmates is as follows:

Draper -- closed its segregation unit subsequent to the order and now transfers those in need of segregation to Kilby therefore, has no need for a separate recreation unit.

Tutwiler -- uses single cells in hospital area for segregation and the separate visitors' area for exercise--sufficient in size.

Kilby -- prior to the court order had no easily accessible outdoor area for its one segregation unit -- has fenced or has plans to fence off a separate recreation area using inmate labor-- status of construction unclear.

Holman -- has one segregation area with a small, attached sun yard.

Fountain -- has one segregation area (two facing units) with a small sun-yard accessible.

It appears then that the enclosure of the Kilby area should be costed into the court order. Simple enough, but two prices have been given for this item, neither one probably exact. The Board of Corrections asked for $15,000 to cover this item in its '77 revised budget requests to the legislature. Also, the Board's fiscal manager reported that $5,000 has already been spent on needed fencing materials for areas at Kilby and Draper. No area was or should be constructed at Draper, and the warden at Kilby considers $5,000 to be high for his institution's area since all installation was done by inmate labor. However, neither he nor we have a better figure to offer. We will therefore accept this figure as what Alabama claims to have spent on needed recreation space for segregated/isolated inmates.

This one bit of construction would probably cover a tight reading of the recreational needs of segregated/isolated inmates. However, we hesitate to endorse the meager allotment of area as adequate for true exercise. We have developed an alternate estimate based on the following determinants: 1) how many segregation/isolation units are used and need associated recreational space, 2) how large an area is needed for vigorous outdoor exercise, and 3) how much fencing, posts, and permanent sporting equipment cost.

Kilby, Holman and Fountain would all need recreational areas for segregated/isolated inmates if more than a cell size area is required. The actual number of enclosed areas would follow the number of in-use, designated segregation units. This currently means 3 areas.

Solitary, vigorous outdoor exercise might consist of jogging, shooting baskets, or playing handball. A regulation free throw line is approximately 19 feet from a basket. A regulation handball court is 20 feet by 45 feet with a front wall area 20 feet by 20 feet high. Therefore, each recreation area should have a basketball net with backboard, a twenty foot square area of the institution's wall painted with handball court lines, and 110 feet of fencing to complete each enclosure (one side being the institution's wall) plus four corner posts and probably a gate.

Our costs of sports equipment and fencing were solicited from Philadelphia sporting goods and institutional fencing companies respectively. Fencing costs are figured by foot and decrease with larger purchases. We did not figure in delivery or labor costs, as we assumed inmate and regular maintenance labor would be used for installation, and delivery costs would be minimal.

Estimated costs are as follows:

3 basketball nets, backboards and mounting equipment	@ $70.	=$ 210.
Handball court paint		minimal
3 units of 110 feet x 10 feet high fence with 3 strands of barbed wire on top	@ $6.00 a foot	= 1,980
12 fence posts	@ $62 each	744
3 feet gates	@ $125 each	375.
	TOTAL	$3,309

To check this figure we solicited other estimates. The National Clearinghouse, drawing from former plans and costs, suggested a figure of $12.30 per foot per 12 foot high, galvanized steel fence including posts, gates, and installation. This base figure, for 330 feet, would total up to $4059 or $4269 with basketball equipment. The Clearinghouse also suggested that $8-$10 per foot be used as a base figure to estimate cost of fencing materials, anticipate use of inmate labor, but allow for spoilage and installation materials. On this basis, the total figure would be $2850 ($8 base) or $3510 ($10 base) including basketball equipment. All of these figures come closer to the aforementioned $3309 than the University's or Board's $15,000 per each recreational unit.

We also received a figure of $35 per foot of ten feet high fence topped with a V of barbed wire, posts, gates, and installation. This figure was from the Deputy Director of Adult Corrections in Delaware. Using this figure, the total cost would be $11,760. When asked to comment on this figure, the National Clearinghouse staff person called it excessive. Consequently and after all consideration, we would recommend $3310 as the best figure for the cost of meeting recreational needs of segregated/isolated inmates, assuming the use of inmate labor for installation.

G. Food Service Area and Equipment

The principal requirement for meeting food service requirements is the renovation or reconstruction of a kitchen at Draper and kitchen plus dining area at Fountain.

With the use of staff and inmate labor, the Draper kitchen has been renovated at a cost of about $150,000.

There seems to be some uncertainty about the potential cost of a kitchen and

dining area at Fountain. The University of Alabama cited $330,000 to do the job but gave no references for, or breakdown of, that figure. In the proposed 1977 budget, the Board of Corrections requested $325,000 to build a new kitchen and convert the old kitchen into a recreation hall. The architect with the Alabama Department of Public Health estimates the cost as follows:

Kitchen	2640 square feet at $45 a foot with fixed equipment	$118,800	
	additional equipment	44,687	
			$163,487
Dining Area	4500 square feet, at $30 a foot (for 300 capacity)	$135,000	
	furniture	6,000	
			141,000
		TOTAL--	$304,487

The head of Alabama's Public Buildings Commission expects the cost of a kitchen including dry, cold and freezer storage space to run $100,000, assuming inmate labor. He agreed with the $141,000 cost of a dining area as projected by the architect with the Department of Public Health.

To further substantiate these figures, we solicited the experienced advice of The National Clearinghouse for Correctional Architecture. The Clearinghouse estimates that a kitchen to service 400 inmates should be 8,000 square feet (20 square feet/inmate) to accommodate all food preparation, storage, cleaning and staff needs. This area is probably larger than most prison kitchens because once again the Clearinghouse believes that if one needs to build, the building should not be deficient. Their figures, therefore, include areas for serving line, lockers and toilets for hired and inmate staff, janitorial needs, cart

washing and storage as well as the more usual dishwashing, baking, refrigeration, utensil storage, etc. Cost per square foot is estimated at $45 which for 8,000 square feet comes to $360,000. Some portion of that square footage area must be costed again at $43 a square foot to cover heavy equipment. We and the Clearinghouse arrived at 2460 square feet (31%) as adequate, for a cost value of $105,780. Therefore a kitchen for 400 would cost $674,580 to build.

To adjust this kitchen size and cost to the Fountain situation is a matter of good guessing. If Fountain followed Clearinghouse plans to make single cells out of dormitories and therefore have a capacity of 342, the kitchen costs could be considered equivalent to the one quoted above. Following this plan, Alabama could well circumvent the need for a dining area, a decision the Clearinghouse would encourage by using the new dayrooms (i.e., the old dorms). The Clearinghouse kitchen plans include the cost of purchasing and storing carts to be used in transporting food to dayrooms for eating. (As experienced correctional personnel know well, institutional tensions tend to be exacerbated by and displayed in large dining areas. The Clearinghouse's resistance to constructing dining areas stems from a desire to avoid destructive but needless confrontations.) Clearinghouse plans do not assume inmate labor which we feel should be assumed. To account for this saving, we will subtract $200,000 from Clearinghouse estimates to arrive at $474,580.

If the plans were for Fountain to continue accommodating 632 inmates, the kitchen space would probably have to be expanded some but not the exact 20 square feet per additional inmate. For instance, dishwasher space for 600 inmates would probably be the same as for 400 only the machine would have to be run more often. Also food storage space may well depend more on the buying schedule and practice than the amount of inmates. Food preparation areas could be used

for longer hours to preclude some additional areas. Therefore, a rational guess might add 1,000 square feet or $45,000 plus $21,500 ($43 x 500 square feet) for equipment. A kitchen for 632 might then cost approximately $741,080. In addition to these costs, Alabama would have to include a dining area cost because the dayroom space from the converted dormitories would not be available. The Clearinghouse accepts the Department of Public Health's dining area size and cost of $141,000 for 4500 square feet and furniture. Thus to adequately provide for food preparation, storage, serving, eating and cleaning for 632 inmates would cost $882,080. Assuming a savings of $200,000 from inmate labor, the figure would be $682,080.

We further tested out the Clearinghouse's estimates of space allotments and costs by consulting the Delaware Department of Corrections. Delaware recently constructed a kitchen to serve 200 for $240,000 with $90-100,000 additional for equipment. The space cost divides out, using Clearinghouse estimates, to accommodating 266. Considering some loss from economies of scale in a smaller institution, this figure adds credibility to the National Clearinghouse's estimates.

To resolve the confusion of all these divergent figures, we will summarize as follows. Alabama will most probably spend $454,487--$150,000 at Draper and $304,487 at Fountain both using inmate labor. A fully adequate kitchen for 400 should cost $674,580 without inmate labor or $474,580 with inmate labor. To do a complete job at Fountain should cost $474,580 assuming inmate labor, renovation of dorms into single cells, and use of former dorm areas for dining-dayrooms. However, assuming inmate labor but no dormitory changes, the cost would run to $682,080 because an additional dining space and larger kitchen would be necessary.

The court order also called for proper eating and drinking utensils. To

meet this requirement, the Board has already spent the following:

4,000 trays	$ 5,600
9,000 bowls	3,233
9,000 cups	3,300
	$12,133

Although some money has been spent on plastic spoons, we were unable to ascertain the exact amount. Therefore, we solicited a bulk cost from a local supply store and calculated the cost as follows:
one spoon per meal each day for each prisoner divided by the bulk amount of 2500 spoons per case times $16 per case.
1 x 3 x 365 x 3884 ÷ 2500 x 16 = $27,219 for plastic spoons per year. This cost may well be high considering lower costs of living prices in Alabama compared to Pennsylvania and lower costs available by buying even larger quantities at once. However, the three spoons per day may well be a meager allotment which might mitigate for some difference in total cost.

A total of $39,352 should be considered into the initial capital investment costs to cover eating utensils. To figure the annual replacement costs, we suggest approximately 50% of the trays, bowls, and cups cost, or $6,067, plus the total spoons cost of $27,219 should estimate a reliable annual cost of $33,286.

The Board of Corrections in its 1977 budget request asked for $175,858.70 to equip the kitchens of all its institutions including work release centers, cattle ranches, etc. We believe these would be Board costs regardless of the court order, except for one item. To meet health standards and citations observed by Mr. Ted Gordon, public health specialist, Kilby should install the heavy duty garbage disposal worth $689 as requested. We will include this figure as a required capital cost.

Adequate maintenance of existing cooking, storage and cleaning equipment would in large measure cover the other inadequacies noted in the health standards

of the food service areas. Maintenance is severely lacking throughout the system and could in the long run cause needless, larger expenditures.

TABLE 5: TOTAL FOOD SERVICE COSTS NECESSITATED BY THE COURT ORDER

CAPITAL INVESTMENTS

	PROBABLE ALABAMA EXPENDITURE EXACT	OUR PREFERRED POINT ESTIMATE	
Draper kitchen	150,000	150,000	
Fountain Kitchen and Dining Areas	304,487	474,580 -	682,080*
Trays, bowls, cups	12,133	12,133	
Plastic spoons	27,219	27,219	
Kilby garbage disposal	689	689	
Capital total	$494,528	$664,621	872,121

ANNUAL COSTS

Trays, bowls, cups, spoons	$33,286	$33,286

* Fountain kitchen/dining cost depends on construction of single cells. The higher figure is based on no reconstruction, the least desirable option.

CAPITAL COSTS

	OUR PREFERRED POINT ESTIMATE
Single Cell/adequate living space	$18,493,065
Public Health Standard Improvements	1,343,000
Office space and equipment	119,900
Recreational Equipment	12,500
Outdoor recreation for segregated/isolated inmate	3,310
Food Service/area and equipment	664,621.
TOTAL--	$20,636,396

PROGRAM COSTS

(includes salaries, one year operating and initial capital costs)

A. PRISON INDUSTRIES

Status of Existing Prison Industries and Supporting Vocational Programs

Though industrial space is scarce, there is a need, and opportunity, to expand prison industry operations at the four large institutions for males and the women's prison. Table 6 following provides an overview of the existing vocational training and prison industry programs and their inter-relationships in Alabama's institutions.

It is apparent from Table 6 that vocational training (and education) programs are presently viewed as being totally independent of the available prison industry programs. In addition, prison industry workers receive no monetary wage; all prisoners except those in punitive isolation receive 25¢ a week. Several of the vocational training programs listed in Table 6 provide the inmates with an income of $10.00 per week from CETA funds ($3/ week to the inmate and $7/week to his bank account) These training programs include carpentry, furniture refinishing, furniture upholstery and shoe repair. The differential wages available to inmates through some vocational education programs, as contrasted with prison industry, presents one potential problem which must be carefully considered in order to achieve successful prison industry operations in Alabama.

Strict eligibility requirements for vocational education programs constitute another characteristic of Alabama's vocational training programs.

In sharp contrast, the only requirement for prison industry at present is that an inmate be assigned to regular duty status and not be in segregation.

TABLE 6: SUMMARY DESCRIPTION OF VOCATIONAL TRAINING/ PRISON INDUSTRIES OPERATIONS

	VOCATIONAL TRAINING			EXISTING INDUSTRIES
INSTITUTION	COURSE	CAPACITY	COURSE LENGTH	
FOUNTAIN Capacity=632	Shoe repair *	16	6 months	Farm work only;number of workers varies from 200- 450.
	Welding	16	6 months	
	Carpentry	16	6 months	
	Trowell Trade	16	at least 1 yr.	
	Auto Mechanics	12	1 year	
	Front-end Alignment	8	1 year	
		84		
HOLMAN Capacity=540	Furniture refinishing*	16	6 months	Tag plant only ;number of workers varies from 120-150.
	Furniture upholstering*	16	1 year	
	Cabinetmaking*	16	$1\frac{1}{2}$ yr.	
		48		
KILBY Capacity=503	None	NA	NA	Print shop only; number of workers= 5
DRAPER Capacity =632 New facility for 350 is under construction	Barbering	20	7 months	Farm work; number of workers varies 60-200. Also, matress renovation work,periodically.
	Heavy equipment	15	6 months	
	House Building	15	6 months	
	Auto-front end	15	3 months	
	Bricklaying	15	3 months	
		80**		
FRANK LEE YOUTH Capacity=	Welding	30	6 months	None
	Upholstering	15	1 yr.	
	Cabinetmaking	15	1 yr.	
	Radio-TV Repair	15	1 yr.	
	VW Repair	15	1 yr/	
	Auto mechanics	15	1 yr.	
	Body and fender repair	15	1 yr.	
	Masonry	30	6 months	
	Barbering	20	7 months	
	Furniture Refurbishment	15	6 months	
		185 of which 80-90 slots are Draper inmates		
TUTWILER Capacity=350 women	Commercial sewing	15	90 days	Garment factory ; number of workers 40-50.
	Cosmetology	10	1 yr.	Canning plant;40 workers.
	Floral Arrangements	22	6 months	Contract work to outsiders
	Typing	10	6 months	
		57		

*CETA Program paying each Inmate $10 per week.
**See also vocational courses under Frank Lee Youth.

Requirements of the Court Order Relevant to Prison Industries

The Court has ordered the Board of Corrections to undertake several specific actions relevant to vocational and work opportunities within the Alabama correctional system:

1. Each inmate shall be assigned a meaningful job on the basis of the inmate's abilities and interests, and according to institutional needs. Inmates shall not be required or allowed to perform household or personal tasks for any person. (The court order has subsequently been modified to allow inmates to perform household labor, maintenance work, and other personal services at state owned and operated facilities and for state governmental officials who may be physically disabled and need personal services in order to perform their official functions.)

2. Each inmate shall have the opportunity to participate in a vocational training program designed to teach a marketable skill.

3. The defendants may establish reasonable entrance requirements and rational objective criteria for selecting inmates to participate in particular programs. However, no inmate shall be denied educational, vocational and work opportunities except while in isolation for disciplinary reasons or when the participation of an inmate in a particular program presents a clear threat to institutional security.

To accomplish the above, the Board of Corrections should develop a time-sequenced, integrated plan for providing general education, vocational training and work opportunities for all inmates. In other words, programs should be organized and operated (i.e. entrance requirements restricted to only necessary prerequisite programs and/or skills) so as to feed people logically from one program to the next .

In addition to the need for careful program management design studies, the Board of Corrections must expand the industrial opportunities presently available to Alabama's inmates. We had some difficulty in determining the exact number of inmates needing a meaningful job through prison industries as the number currently employed is unclear. To figure the numbers of workers to be accomodated, we considered the following:

1)National experience shows a maximum of 25% of a prison's population can be accomodated in industries without detracting from other programs or institutional maintenance.

2)Certain prison industries can accomodate certain numbers of workers.

The numbers of workers projected for in Table 7 reflect these parameters.

Specific recommendations for industrial expansion are also shown in Table 7. These recommendations were formulated with a view toward making every effort to economize in the industrial expansion program.Thus, industrial candidates were explored which could make productive use of the existing vocational education programs and which require relatively low capital investment costs. In addition, the recommended industries are considered to have stable and substantial sales markets(within the constraints of the state use law, recently enacted) and provide in-prison work/training experience

TABLE 7: RECOMMENDED ADDITIONAL PRISON INDUSTRIES
(Assumes continuation of farm work at Fountain, Tag Plant at Holman, Garment Facotry and Canning Plant at Tutwiler)

LOCATION	TYPE OF INDUSTRY	NO. OF WORKERS*	REQUIRED SPACE
FOUNTAIN	Auto-refurbishment State Cars	20-30	Transport to Holman
	New Furniture Manufacture for schools & State Agencies	15	Eransport to Holman
HOLMAN	New furniture Manufacture for School & State Agencies	15	Approximately 10,000 sq.ft. available in existing building --needs floor and exhaust system
	Furniture Repair for Schools & State Agencies	30	
KILBY	Expand Print Shop	15	Remove and replace wall
DRAPER	School Bus Repair/Refurbishing	50-75	New industry building needed
TUTWILER	Data Processing Entry (Keypunch)	20	Assume adequate space available

*For one year after implementation; could be increased in future.

relevant to employment opportunities that are available upon release from prison.

The cost of implementing these recommendations comes to approximately $584,000 and is delineated in Table 8. Our estimate includes only capital costs -- building construction/renovation and purchased equipment -- as each of the industries we recommend has potential to be self supporting. Therefore, given proper management, sales (operating revenues) should cover operating costs. A detailed breakdown of the shop equipment costs are provided in Appendix C.

TABLE 8: CAPITAL COSTS OF IMPLEMENTING PRISON INDUSTRY RECOMMENDATIONS

	Costs	Subtotals
Industries Located at Holman		
Equipment		
Auto Refurbishment Shop	$54,000	
Cabinetmaking & Millwork	40,000	
Furniture Refinishing	30,000	
Upholstery Repair	6,000	
Completion of Industries Building		
4" Concrete Floor	8,000	
Power,heat,water,exhaust system	15,000	$153,000
Industries Located at Kilby		
Equipment		
Print Shop	13,850	
Remove and Replace Wall	2,500	16,350
Industries Located at Draper		
Equipment		
School Bus Repair	145,000	
Construction of School Bus Repair Facility (Brick Building 40-45,000sq.ft) using inmate labor	240,000 - 270,000	385,000- 415,000

Costs Subtotals

Industries Located at Tutwiler

Keypunch -- No capital investment is required.

Office furniture and keypunch stations can be leased.

TOTAL CAPITAL INVESTMENT FOR INDUSTRIES:

Equipment	$288,850
Facilities	295,500
TOTAL	$ 584,350

B. BASIC EDUCATION AND VOCATIONAL TRAINING PROGRAMS

The court order stipulates that "each inmate have the opportunity to participate in basic educational programs" and "in a vocational training program designed to teach a marketable skill".

To estimate basic educational and vocational training needs, we used several sources of information: the classification figures (expected distribution of inmates by custody category and services needed) based on a selection of those classified to date provided in the Supplementary Order of 12/26/76, an update of these figures provided by the University of Alabama (1/17/77), the Alabama Department of Education, and an article by Neil Singer titled "Economic Implications of Standards for Correctional Institutions" in Crime & Delinquency (January 1977).

In his article Singer states that, on national average 75% of institutional populations could benefit from basic education but in practice, at most 35% are motivated to participate. We would concur on the basis of our experience, knowing that other opportunities and concerns of the potential participants take precedence and that attendance reflects the quality of the programs. Singer also cited 15% as the current enrollment rate for vocational training. We feel this figure may be presently correct but is too low considering the demand and need for job skills. Therefore, we have assumed the level of demand for basic education programs would not exceed 35% of the population, here defined as capacity, and for vocational training, we anticipate no greater than 50% demand. Our estimates are broken out by institution in Tables 9 and 10 on the following page.

TABLE 9: PROGRAM PARTICIPATION ESTIMATES FOR CURRENT CAPACITY POPULATIONS

		EDUCATION			VOCATIONAL TRAINING		
INSTITUTION	CURRENT CAPACITY POPULATION	EXISTING PROGRAM CAPACITY	NO. OF PEOPLE TO PARTICIPATE (35% prison capacity)	NO. OF OPENINGS NEEDED	EXISTING PROGRAM CAPACITY	NO. OF PEOPLE TO PARTICIPATE (50% of prison capacity)	NO. OF OPENINGS NEEDED
HOLMAN	540	40	189	149	48	270	222
KILBY	503	--	176	176	--	251	251
DRAPER	632	48	221	173	80	316	236
FOUNTAIN	632	40	221	181	84	316	232
TUTWILER	200	30	70	40	52	100	48

TABLE 10: PROGRAM PARTICIPATION ESTIMATES FOR SINGLE CELL CAPACITY POPULATIONS

		EDUCATION			VOCATIONAL TRAINING		
INSTITUTION	SINGLE CELL CAPACITY POPULATION	EXISTING PROGRAM CAPACITY	NO. OF PEOPLE TO PARTICIPATE (35% of prison capacity)	NO. OF OPENINGS NEEDED	EXISTING PROGRAM CAPACITY	NO. OF PEOPLE TO PARTICIPATE (50% of prison cap.)	NO. OF OPENINGS NEEDED
HOLMAN	396	40	139	99	48	198	150
KILBY	442	--	155	155	--	221	221
DRAPER	336	48	118	70	80	168	88
FOUNTAIN	342	40	120	80	84	171	87
TUTWILER	175	30	61	31	52	88	36

Teachers Needed -- Additional Salaries & Benefits

We determined the number of basic education teachers needed by establishing a ratio of 1 teacher per class of 15 students and expecting each teacher to handle two classes a day. For calculation purposes, this means 1 basic education teacher per 30 participants. We have subtracted the number of teachers working at the time of the court order to arrive at the total number of basic education teachers needed for court order compliance. By institution , the numbers are as follows.

BASIC EDUCATION TEACHERS NEEDED FOR

	CURRENT CAPACITY	SINGLE CELL CAPACITY
Holman	5	3
Kilby	6	5
Draper	6	2
Fountain	6	3
Tutwiler	1	1
Subtotal	24	14
Number Employed Pre-Court Order	- 9	- 9
TOTAL NEEDED	15	5

To calculate the number of vocational training teachers, we followed a similar process but used an average ratio of 1 vocational training teacher per 25 participants a day (assuming different hours for and capacities of different programs). The numbers of vocational teachers required at each institution are as follows

VOCATIONAL TRAINING TEACHERS NEEDED FOR

	CURRENT CAPACITY	SINGLE CELL CAPACITY
Holman	8	6
Kilby	10	8
Draper	10	4
Fountain	10	4
Tutwiler	1	1
Subtotal	39	23
Number Employed Pre court Order	-29	-29
TOTAL NEEDED	10	NONE

Salaries are based on average salaries in comparable teaching positions throughout Alabama. Basic Education teachers receive ,on average, $11,000 plus 19% fringe benefits ($13090); vocational training teachers receive $12,588 plus 19% fringe benefits ($14,980). Additional salaries and benefits, then, would cost a total of $346,147 with current population capacities or $65,450 with recommended single cell construction.

with current population capacities	
15 Basic Education Teachers @ $11,000 plus 19% benefits	$196,350
10 Vocational Training Teachers @ $12,588 plus 19% benefits	149,797
TOTAL	$346,147
with single cell capacities	
5 Basic Education Teachers @ $11,000 plus 19% benefits	$ 65,450
No Vocational Training Teachers needed	
TOTAL	$ 65,450

Other Operating Costs

For current capacity populations, we predict a need for educational materials costing $5000 per institution and general supplies costing $1000 per institution. This total comes to $30,000. Furthermore, we will approximate half that sum as necessary for institutions renovated to hold single cell capacities (total then, $15,000).

General supplies for vocational training programs to be provided to current capacity numbers would cost approximately $300,000. None of this figure would be needed for single cell capacities as no vocational program would then be added.

Capital Costs

Readers should note here that our following estimates for capital costs of classrooms and equipment are quite unsubstantiated and probably the weakest link of our cost analysis. The State Department of Education cited some cost estimates for classrooms and shops, but gave no indications of the numbers or sizes involved. Thus, we had no means of adjusting their figures to our assessment of needs. Also, as we have not suggested specific vocational training programs, we can not be definite about space and equipment requirements. Our capital estimates to follow then, are admittedly rough.

The Board of Corrections currently uses approximately 30-35 classrooms, a major portion of which are located at separate trade schools for vocational training. We applaud, and would encourage, the use of outside-the-system resources. However, we recognize that most of the major institutional population, especially once the classification system is operant, will need classrooms provided internally.

Reflective of the lack of basic education teachers is a lack of basic ed classrooms. We estimate about two classrooms plus an audio-visual lab-room should be provided for each group of three additional teachers per institution. On that basis, approximately 10 classrooms, if current capacity, or 4, if single cell capacity, would be needed as well as 4 learning labs (Draper excluded).

The least costly way to provide this space would be to use self-contained, mobile classroom units. We could not locate an exact unit cost, but we did ascertain that a trailer currently used by the Board for housing costs $7800, unfurnished (except for bathroom) but installed. Fourteen (capacity currently) would add up to $109,200; eight (single cell capacity)

would cost $62,400. Installed equipment would run approximately $3000 per class or lab room. Therefore, total capital costs for educational programs could come to $151,200 for current capacity needs or $86,400 for single cell capacity needs.

To provide space and equipment for the ten additional vocational training programs needed for current capacity populations, we suggest the following allowances and costs:

3 large size areas (10,000 square foot) @ $25/sq.feet	$750,000
2 smaller areas (5,000 square foot) @ $25/sq. feet	250,000
5 Equipment sets @ $10,000/ program	50,000
TOTAL	$1,050,000

The $25/square foot cost was quoted to us informally by the University of Alabama, Department of Correctional Psychology as the average construction costs of Alabama office-type buildings.

To summarize this section on costs of educational and vocational training programs, we offer the following.

COSTS OF EDUCATIONAL AND VOCATIONAL TRAINING PROGRAMS

	For Current Capacity Populations	For Single Cell Capacity Populations
Salaries & Benefits	$346,147	$65,450
Educational Operating Costs	30,000	15,000
Vocational Operating Costs	300,000	----
Educational Capital Costs	151,200	86,400
Vocational Capital Costs	1,050,000	---
	1,877,347	166,850
TOTALS ROUNDED OFF -	$ 1,900,000	$170,000

(As the reader can easily see, program costs are highly dependent on the construction of single cells. For the final total estimate, we have quoted the larger figure as we feel programs can not wait for implementation. However, savings could be incurred through single cell construction.)

C. TRANSITIONAL PROGRAM

The court order states that prior to release, each inmate should participate in a transitional program designed to aid his/her re-entry into society.

We interpret this to mean:

1) some information given about the community to which one is returning and strategies for dealing with reentry stresses and problems
2) opportunity to participate in work release or other community-based programs (accounted for in the following section)
3) assistance in special problems of re-entry such as finding housing and employment.

This last point is really the most crucial. In Alabama, as in most states, the existing process is fractured. No linkage exists for many inmates seeking employment prior to release. Therefore, we suggest hiring four job developers who will interface with the classification staff and social workers to identify inmates due to leave within three months . Job developers will aid these inmates in obtaining employment in the community to which they plan to return.

Staff from the staff training center,parole agents, and vocational training staff could be utilized to provide the re-entry training. Existing personnel within the Board of Corrections and State Department of Education can develop this curriculum. No additional costs are anticipated.

For the job developers, we estimate the costs as follows:

One Year Operating

4 Job Developers @ $13,000 plus 19% benefits ($15,470)	$61,880
Operating Costs	8,000
Subsistance	4,080
Subtotal --	$73,960

Capital Costs

4 Automobiles @ $5,000	20,000
(No space needed) TOTAL FOR TRANSITIONAL PROGRAM	$ 93,960

D. WORK RELEASE, PRE-RELEASE CENTERS AND ROAD CAMPS

To provide sufficient work release centers to house those classified as appropriate, the Board of Corrections opened two combination work and pre-release centers as well as four road camps subsequent to the court order. The initial costs to be included in the estimate of the court order costs include capital costs, salaries and benefits, and overhead and food costs incurred during the period of operation. These categories are cost out as follows

Capital Costs

Trailers and hook-up at two work release - prerelease centers	$237,989	
Lease of four road camps from Highway Dept. ($1/camp/yr)	4	
Renovation/refurbish of road camps	300,000	
Equipment	36,000	
		573,993

Salaries & Benefits

Montgomery Pre-and Work release -27 staff all year @ $10,000 plus 19% benefits	321,300	
Atmore Pre- and Work Release -- same as above	321,300	
Camden Road Camp -15 Staff for 10 mo. @$10,000 average yearly plus 19% benefits	148,750	
Elbe Road Camp -- 15 Staff for 7 mo. @ $10,000 average yearly plus 19% benefits	104,125	
Hamilton Road Camp -- 15 Staff for 5 mo. @ $10,000 average yearly plus 19% benefits	74,375	
Grove Hill Road Camp -- 15 Staff for 4 mo. @ $10,000 average yearly plus 19% benefits	59,500	
		1,029,350

Overhead and Food Costs minus Wage Rebate

The average overhead and food cost per prisoner per year in Alabama's work release centers is $1900 (1974 dollars). To figure overhead and food costs,we gathered population counts in the new facilities on 1/12/77 and assumed the counts averaged half of these figures over the start-up period.

	1/12/77 Count	Half of 1/12/77 Count	Time Open
Atmore	50	25	12 mo.
Montgomery	97	48	12 mo.
Camden	26	13	10 mo.
Elbe	38	19	7 mo.
Grove Hill	29	15	4 mo.
Hamilton	49	25	5 mo.

Using these figures, total overhead and food costs are $209,000 for the initial year.

Offsetting these costs are inmate contributions from wages. Alabama inmates are required to pay 25% of their salary to the state. Past Alabama experience has shown that the average inmate contribution is $1200 per year (1974 dollars). For the new centers in 1976, discounting approximately 37% of the Montgomery center's population and 50% of Atmore's as unpaid pre-release people, this total rebate comes to $96,000.

Since both wage rebate and overhead/food costs were calculated using 1974 dollars these figures must be multipied by 24% as an inflationary factor to reach 1977 dollars. Considering this, the net start-up and one year operating costs of the work release, pre-release and road camp centers begun as a result of the order are:

Capital Costs	$ 573,993
Salaries & Benefits	1,029,350
Overhead and Food (inflated)	259,160
Subtotal	$1,862,503
Inmate Wages Rebate(inflated)	- 119,040
TOTAL	$1,743,463

PROGRAM COSTS
Point Estimates of Capital and One-Year Operating Costs

	Current Capacity	Single Cell Capacity
Prison Industries	$584,000	$584,000
Education/Vocational Training	1,900,000	170,000
Transitional Program	94,000	94,000
Work Release, Pre-release Centers and Road Camps	1,744,000	1,744,000
TOTAL ESTIMATE	$ 4,322,000	$ 2,592,000

FUTURE SCENARIOS

Cost of accommodating 1980 and 1985 Inmate Population Projections in additional Institutions, Community Facilities, and/or Non Residential Sentence Alternatives

Future Scenarios

Demand for and Supply of Future Spaces

A determination of the numbers of people to be provided for is the first condiseration in assessing and budgeting for future needs. To make this determination, we began with the projected population estimates derived from our calculations described at the beginning of this report. The population figures are as follows:

Present Population (includes county jail inmates awaiting transfer)	5,330
1980 Projected Population	6,000
1985 Projected Population	6,700

To break out these figures into the five classification categories established jointly by the Alabama Board of Corrections and Department of Correctional Psychology, University of Alabama, we multiplied these population projections by the emerging percentage distribution of prisoners in each custody category. We recognize these percentages to be rough and temporary but the best available to date (2/11/77):

Classification:
22% Community
51% Minimum
25% Medium
2% Close or maximum

About four percent of the population consists of elderly or infirm prisoners who may be found in the various classifications.

The multiplication rounded off to whole numbers provides the following breakdown of projected populations by the custody classifications.

Table No. 11

Classification	Present	1980	1985
Maximum	105	120	130
Medium	1330	1500	1670
Mimimum	2720	3060	3420
Community	1170	1320	1470
Elderly		240	270

In comparing the present supply of beds with the future demand for such, it is necessary to take into consideration that there are now, and will be, special institutions for youth (200 beds) for minimum classification and that by 1980, there is planned to be a special institution for the elderly and infirmed (300 beds via Tutwiler renovation). To account for these institutions in the analysis, it is necessary to have a classification breakdown for youth, women, and the elderly. Assuming the classification percentages given above will hold for youth, women, and the elderly; and assuming that women and youth populations will increase by the same percentages as the general inmate population, the populations of youth and women would be projected as follows.

Table No. 12

Classification	Youth			Women			Elderly	
	Present	1980	1985	Present	1980	1985	1980	1985
Maximum				4	5	6	5	6
Medium				53	60	66	60	66
Mimimum	125	140	158	108	122	135	122	135
Community	53	60	67	47	53	58	53	58
Totals	178	200	225	212	240	265	240	265

By substracting these figures from comparable figures in Table No. 12, we have the number of males other than youthful offenders and elderly who will need future accommodations.

Table No. 13

Classification	Present *	1980	1985
Maximum	101	110	123
Medium	1277	1380	1538
Mimimum	2487	2676	2992
Community	1070	1154	1287

*Includes Elderly

If reconstruction as proposed by the National Clearinghouse for the provision of single cells is accomplished, these would be 1691 cells (including women's) which could be used for maximum or medium categories. This would be enough to handle maximum and medium populations through 1980, and is close to being enough to handle them through 1985 (limits of accuracy of this analysis do not permit a more specific statement). Mimimum and community categories are left on which to focus the remainder of this analysis.

To ascertain the number of spaces short for minimum and community custody categories presently ,in 1980 and 1985, we subtracted from the total demand, ie. the number of people needing placement, the amount of currently available bed space including the new 360 bed minimum custody facility at Draper by excluding female and youth space. We did not calculate to include any other proposed institution. Our calculations are described more fully in Appendix D. The following table summarizes the space shortages in minimum and community custody categories.

Table 14 Number of Spaces Short in Minimum and Community Custody Categories

	Present		1980		1985	
	Min.	Comm.	Min.	Comm.	Min.	Comm.
Regular	747	368	1,048	452	1,535	585
Youth		53		60		67
Women		23		29	7	34
Elderly(incl.under regular)				53		58

The various scenarios discussed below provide alternative ways for dealing with these shortages.

Analysis of Scenarios

We have defined and costed out several ways of providing for the shortages enumerated above. Each option or scenario is described and outlined according to its impact, i.e. how offenders would be accommodated. Subsequently, we have assigned cost estimates to each scenario. As institutions, community facilities, or non-residential programs take some time to construct, rent, or initiate, we have assumed that for the present in each scenario, the status quo is the only realistic option and impact. Therefore, all present options would cost the same as Scenario 1. The scenarios and their impact are as follows.

Scenario 1) Status Quo: The Board would expand and renovate as currently planned, including a new 360 bed institution in northern Alabama, but house all overflow in county jails.

Impact: Present - 1,115 people in jails
1980 - 1,156 people in jails
1985 - 1,826 people in jails

Scenario 2) Community Facilities plus Jail: The Board would expand and renovate as currently planned, including a new 360 bed institution in northern Alabama; obtain enough community facilities to house community classified people, continue to house the overflow minimum category in county jails.

Impact: 1980-- 505 (including 100 work release) people in new community facilities. 60 youths in new community facilities. 29 women in new community facilities. 688 inmates in county jails.

Impact 1985: 643 (including 200 work release) in new community facilities. 67 youths in new community facilities, 34 women in new community facilities. 1182 inmates in county jails.

Scenario 3) Community Facilities plus new Minimum Facilities: The Board would expand and renovate as planned except for not building the 360 bed institution in northerm Alabama ; obtain enough community facilities for community classified people; and put the overflow minimum custody people in special new facilities . These facilities might be A) small community-based or B) more institutional albeit more centrally located. In further analysis, both these possibilities will be costed out.

Impact 1980: 500 (100 work release) in new community facilities. 60 youths in new community facilities . 29 women in new community facilities. 1,048 in special new facilities for minimum custody.

Impact 1985: 643 (200 work release) in new community facilities. 67 youths in new community facilities. 34 women in new community facilities. 1,542 in special new facilities for minimum custody.

Scenario 4) Alternative Sentencing: People who would have been classified in community or minimum categories receive a non-residential, non-prison sentence instead. In further analysis, this scenario will be split into three possibilities:

A) Alternative sentence is probation.

B) Alternative sentence is restitution.

C) Alternative sentence is work support.

Once again, this scenario assumes the 360 bed institution in northern Alabama would not be built.

Impact 1980: 1642 in community programs

Impact 1985: 2286 in community programs

These figures could be higher but were limited to permit meaningful comparisons in cost with other scenarios. It is possible that some of the present institutions could be emptied if these options were used more fully.

Scenario 5) Combination of Scenarios 3A and 4:

The Board would expand and renovate as currently planned except the new 360 bed institution in northern Alabama would not be built. Overflow minimum custody persons would be put in special new community - based facilities. People who would have received a prison sentence and been classified in the community category would receive an alternative (non-prison) sentence instead. We have a distribution of these people as follows one-third probation, one-third restitution, one-third work support).

Impact:

1980 - 198* on probation, 198* in restitution programs, 198* in work support programs 1048 in special new community facilities.

1985 - 248* on probation, 248* in restitution programs, 248* in work support programs. 1542 in special new community facilities.

*Could be higher. Limited to this figure to permit meaningful comparison with other scenarios.

Cost Projections for Scenarios

Available in Appendix D is a list of typical capital and operating costs (1977 dollars) for a halfway house, community house (more in-house services than at a halfway house), community-based institution, work release facility, probation supported work (training and publicly funded jobs), and jail. Each is cited on a per client per year basis. References are also given.

We used these figures, multiplied by the numbers of people to be appropriately accommodated in each scenario, to determine rough cost estimate for each scenario. Our calculations are demonstrated in Appendix D; our results are shown in the following table.

TABLE 15: Cost Estimates for all Scenarios of Future Accommodations (1977 dollars)

Scenario	Present Operating	Capital	1980 Operating	Capital	1985 Operating	Capital
1 (Jail, new 360)	$5.35M	0	$7.75M	$5M	$11M	0
2 (Jail, new 360, new comm.fac.)	5.3M	0	9.65M	7.95M	12.8M	0.74M
3A (New comm.fac., new comm. fac. for min.	5.35M	0	14M	8.15M	19.4M	3.19M
B (New comm.fac. new min inst.)	5.35M	0	10.6M	17.5M	14.3M	7.6M
A (Probation)	5.35M	0	1.32M	0	1.84M	0
B (Restitution)	5.35M	0	0.497M	0	0.686M	0
4C (Supported work)	5.35M	0	2.02M	0	2.81M	0
5 (Combination 3A & 4)	5.35M	0	10.3M	5.2M	15.1M	2.45M

Future Scenarios

Discussion of Results

Before presenting conclusions and recommendations from our analysis of future scenarios, some comments should be made about the analysis itself.

It is evident that we had to make a number of critical assumptions in doing this analysis, including assumptions about future inmate populations, unit operating and capital costs, percentages of the population in various security categories etc. Obviously the results of the analysis - the scenario costs - are dependant on these assumptions. It is useful to note, though, that scenario cost differences (i.e. the difference between the cost of one scenario and another) are usually less sensitive to the assumptions than are absolute costs. The reason is that assumption errors common to two absolute costs tend to cancel out when the two costs are subtracted to produce a difference. Thus, attention should be focussed on cost differences.

In the future, if more accurate population projections and other data are available, it should be relatively straightforward to use the study's methodology to recompute costs. In a sense, the methodology is a formula that can be used to make more refined cost estimates as better base data becomes available.

Finally, one should note that we have computed only direct or primary costs; for fully informed decision-making, one should also compute indirect or secondary costs, such as costs of future crime, loss of wages due to incarceration, etc. For example, one might well find that although putting a state inmate in a county jail is cheaper (in terms of direct costs) than putting him in a halfway house, it is possible that if indirect costs such as the costs of recidivism were considered, the jail alternatives might not be cheaper at all. Unfortunately, we had neither the time nor data needed to compute indirect costs for this study.

With these comments kept in mind, we can make the following conclusions and recommendations from the future scenario analysis:

1) In the future, Alabama's problem of insufficient prison space will be much less severe for maximum, close, and medium categories than for persons classified for minimum custody. This finding has many implications for future actions. One in particular is that if the proposed 360 man institution in northern Alabama is to be built at all, it should be a minimum security institution.

2) The capacity of existing and/or planned institutions for women and low security youth will be sufficient provided alternative facilities or sentencing alternatives are created for women and youth classified in the community category. The planned capacity of the institution for elderly and infirmed inmates will be sufficient regardless of whether community alternatives are developed for them.

3) We considered adding an additional scenario based on having inmates eligible for parole after serving one-quarter of their sentence rather than the present one-third. This possible scenario was not developed further because its effect would be to free up institutional beds, with the likely result that the beds would quickly be filled with persons who might otherwise be in community facilities or programs. We do not believe such a result would be consistent with the court order.

4) Except for Scenario 4, the least expensive action that can be taken is to continue to do what is being done now (Scenario 1) i.e., to put excess state prisoners in county jails. This would be an unacceptable "solution" in view of the court-ordered requirement to place community-classified persons in community settings. Also, county jails have become unacceptably overcrowded as a result

of the imposed limits on state prison populations and may be unable to operate as such indefinitely. However, we included Scenario 1 because, being about the cheapest and certainly the easiest thing to do, it is always a likely fall-back position for the state to take. The cost data provides an advance warning of this possibility.

5) Scenario 2 is also relatively inexpensive and, furthermore, might meet the requirements, if not the spirit, of the court order. Scenario 2 means the state would acquire community facilities for community-classified persons but would handle excess minimum classified persons by putting them in the county jails. This would be a minimally acceptable response by the state. Again, the cost data provide an advance warning.

6) Scenario 3 indicates a tradeoff that can be made in the treatment of overflow minimum category inmates. On the one hand, they can be placed in institutions (Scenario 3B) at a high capital cost per bed, but at relatively low operating costs. Alternatively, they can be placed in community facilities (Scenario 3A) at a considerably lower cost per bed but at higher operating costs reflecting the provision of more intensive counseling and other human services. We believe money is more effectively invested in people and human services than in buildings. Therefore, we would opt for the 3A option over 3B.

7) Scenario 4 recommends sentencing to probation or non-residential community programs all people who would have received a community or minimum classification. This option involves no capital expenditures, with the possible exception of facilities to house expanded community service staff (an estimate of which is beyond

the scope of this study). This scenario's operating costs are considerably less than that of all other scenarios. Computed costs do not show the full possible impact of this scenario because the costs were not estimated to include those community and minimum classification persons filling existing institutions and camps who might not be there were this scenario to receive extensive application. The reason we excluded them from the computation is that they aren't affected by the other scenarios and thus weren't included in the computations for those scenarios.

The main difficulty with scenario 4 is its inclusion of minimum category persons, many of whom might well be considered ineligible for probation or non-residential community programs. For this reason Scenario 5, incorporating the best parts of Scenarios 3 and 4, has been created.

8) Scenario 5 eliminates the main weakness of Scenario 4 (see above) by stating that only community custody people be given probation or non-residential community program sentences; the overflow minimum category inmates would be placed in special community facilities. As seen, the costs are comparable to those of Scenario 3 but generally higher than for Scenario 1 and 2, both of which we discourage as unacceptable. It's our belief that Scenario 5, while not the least expensive, combines the best features of the other scenarios and concurs with the letter as well as the spirit of the court order. Thus, we would recommend scenario 5 as the future direction of the Alabama Board of Corrections.

TOTAL COSTS

COSTS INCURRED BY THE ORDER -- IN THE FORMAT OF OUR REPORT

ADDITIONAL ANNUAL COSTS	$3,490,818
CAPITAL COSTS	20,636,396
PROGRAM COSTS	4,322,000
	$ 28,449,214

GRAND TOTAL ESTIMATE OF COSTS INCURRED BY ORDER OF THE COURT ROUNDED TO NEAREST HUNDRED THOUSANDTH (excluding costs of extra accomodations for 1980 & '85)	$28,500,000
including costs of extra accomodations for 1980	$44,000,000
including costs of extra accomodations for 1985	$46,100,000

COSTS INCURRED BY THE ORDER -- IN THE FORMAT OF THE ORDER

ISSUE	Alabama Spent by 2/77	Alabama's Cost Projection (when available)	Our Point Estimate
I. OVERCROWDING			
-only cost is for additional facilities cited under Section X.			
II. SEGREGATION and ISOLATION			
-cost of physical improvements to cells cited under Section V			
-outdoor exercise areas	$5,000?	$15,000	$3,310
-due process procedures require no additional costs			
III. CLASSIFICATION			
-Initial Classification job done by the University of Alabama, Dept. of Correctional Psychology			159,000
-Additional Salaries & Benefits			218,770*
-Office Space		34,000	40,000
-Office furnishings, equipment, and operating costs (for one year)			57,900*
IV. MENTAL HEALTH CARE			
-Additional Salaries & Benefits			110,520*
-Office furnishings (Space and operating costs included in classification figures)			2,000*
V. PROTECTION FROM VIOLENCE			
-Construction to convert dorms into single cells			18,493,065
-Other directives require policy changes, no cost			
-Staff needs covered under Section XI			
VI. LIVING CONDITIONS			
-Provision of toilet articles			16,376
-Padlocks for lockers	3,000		3,000
-Clean clothing			317,950
-Clean bed linen and towels (weekly)			52,123
-Capital repairs for heat, lighting, ventilation and plumbing		1,343,000	1,343,000
-Maintenance Salaries & Benefits			142,800

*Figure presumes our adjustments in required numbers are followed as described in the text.

ISSUE	Alabama Spent by 2/77	Alabama's Cost Projection (when available)	Our Point Estimate
VII. FOOD SERVICE			
-Three wholesome meals a day (assumes current population)			$1,162,481
-Proper Utensils (Alabama's figure excludes plastic spoons)	$12,133		39,352
-Additional Salaries		$13,328	13,328
-Equipment/Facilities to meet health standards			
Kitchen -Draper	150,000		150,000
Kitchen & Dining -Fountain		304,487	474,580
Garbage Disposal -Kilby		689	689
VIII. CORRESPONDENCE AND VISITATION			
-Postage and Stationery - two/person/week			61,924
-Additional Visiting Space		50,000 for Kilby	OPTIONAL
IX. EDUCATIONAL, VOCATIONAL, AND RECREATIONAL OPPORTUNITIES			
-Prison Industries for meaningful job		250,000	
Equipment			288,850
Facilities			295,500
-Educational Programs (assumes current population)			
Salaries &Benefits			196,350
Operating Costs			30,000
Capital Costs			151,200
-Vocational Training (assumes current population)			
Salaries & Benefits			149,797
Operating Costs			300,000
Capital Costs			1,050,000
-Transitional Program			
Salaries & Benefits			73,960
Capital Costs			20,000

ISSUE	Alabama Spent by 2/77	Alabama's Cost Projection (When available)	Our Point Estimate
-Recreational Opportunities			
Salaries & Benefits			56,857
Equipment			12,500
X. PHYSICAL FACILITIES			
-Costs of meeting minimum standards for current institutions covered in Sections VI and VII.			
-Work Release, Pre-release Centers and Road Camps Initiated to meet order			
Salaries & Benefits	1,029,350		1,029,350
Capital Costs	573,993		573,993
Overhead and Food			259,160
Inmate Wages Rebate	-119,040		-119,040
-Most Preferred Projected Cost of Accomodations for 1980 prison population above that already accomodated			
Operating Costs			(10,300,000)
Capital Costs			(5,200,000)
-Most Preferred Projected Cost of Accomodations for 1985 prison population above that already accomodated			
Operating Costs			x (15,100,000)
Capital Costs			(2,500,000)
XI. STAFFING			
-Salaries and Benefits			1,019,800[4]
-Training			
Salaries and Benefits			126,615
Equipment			20,000
-Affirmative Action Hiring Program -- Salaries & Benefits			29,274
GRAND TOTAL ESTIMATE OF COSTS INCURRED BY ORDER OF THE COURT ROUNDED TO NEAREST HUNDRED THOUSANDTH (excluding costs of extra accomodation for 1980 &'85)			$28,500,000
including costs of extra accomodations for 1980			$44,000,000
including costs of extra accomodations for 1985			$46,100,000

ADDITIONAL COMMENTS AND APPENDICES

ADDITIONAL COMMENTS

A variety of suggestions and issues came to our attention in the process of making cost estimates. Some are more important and have greater ramification than others. Below are a few that we feel specifically need to be passed on for your attention:

Several serious problems were noted in our site visits. Most important was the beleagured and crisis state of the Alabama Board of Corrections. Not only have they assumed a defensive posture regarding the court order and its implementation, they lack nearly total imagination for seeing opportunities in the situation. The management capability is extremely limited in many top administrative and accounting positions. Consequently, the implementation of the court order is generally mismanaged, lacking in planning or prioritizing, and fraught with confusion and controversy each step of the way. The Board sees only one solution to their problems--build more institutions-and this will be their primary thrust.

These dynamics have in turn led to an erosion of confidence between the Alabama Board of Corrections and the Lt. Governor, the Legislature and the court-ordered Citizens' supervising committee. This deterioration of communication is likely to lead to greater constraints on the willingness of these arms of government to adequately fund the budget requests of the Department and to further requirements for court monitoring and litigation. We fear even, that the current state of Alabama Corrections' management may well mitigate against the achievement of the court's orders or our recommendations, regardless of budget allotments.

Also, since the Board of Corrections is oriented towards new construction,

no strong emphasis is being placed on a "system's redesign", i.e., utilization of less restrictive custody alternatives or non-institutional, community options. We suggest much of the prison population rise is attributable to high unemployment levels, recent increases in the male population at risk, and racial practices. We recommend that (a) alternatives to the tremendous costs of prison expansion and (b) major rehabilitation of existing institutions be emphasized wherever possible. We have costed out several scenarios to facilitate your strategy planning and actions.

In addition, we would not limit the projected numbers eligible for these alternatives to the people projected as falling under the community release classification. Minimum custody is now for those with drug involvement, those who would not meet the responsibilities of community placement, or those who would probably commit an offense if immediately released to the community. We feel these qualities are in large measure another description for unemployed, black youths with energy and without a future. These people could definitely benefit from, or at least not be as harmed by, a sentence alternative to imprisonment or probation. To this end, we advise taking a critical stance toward the classification categories.

Furthermore, we are concerned about staff/inmate ratios in work and pre-release facilities or what are known as community corrections centers. "Community Alternatives" can very easily become mini-prisons with no change in orientation or operation. Although we recognize the need for personnel sufficient to provide twenty-four hour coverage, we warn that staff/inmate ratios must be monitored to detect "empire building" or continuation of the old regime under the rubric of modern, correctional terminology.

Finally, you will find that we have, where applicable, indicated costs for current and single cell capacities. Predominately, but alas not consistently, we have used the single cell figure for our estimated totals as we feel the order mandates single cells and the contingent changes.

If the Board of Corrections continues to balk at the suggestion/order of providing single cells, our figures could be used to demonstrate that some savings in other areas -- e.g. fewer programs, smaller kitchen, or dining area -- will be possible subsequent to single cell construction. The relevant figures are readily available in the text.

APPENDIX A

Information and Suggestions for Further Population Projections

As we established earlier in this report, our involvement with population projections has been cursory and pragmatic. We reget that time limitations prevented us from making more reliable projections, especially since this issue is all important in corrections planning and policy decisions. For someone who might have time, energy, and data to do a full scale population projection, we pass on the following suggestions and information.

States have used differing techniques to derive their projections of offender populations. In a section of the forthcoming Colorado State Plan, it was noted that of the 27 states responding to Colorado's request for information, 14 sent population projections and the methodologies used. Six states used straight line linear regression, 2 used figures derived from age group "at risk", 2 used curve fitting techniques, 4 used multivariate. Illinois also incorporated a diversion alternative. Methodologies from Illinois and Colorado would be useful to anyone developing detailed projections for Alabama.

One methodology which might be employed to predict the future size and composition of the offender population in Alabama over the next 5 to 10 years is multiple linear regression. Several variables that seem necessary to include are:

- Alabama's present and projected unemployment rate
- Rate of Parole revocation
- Rate of Diversion to Community programs
- Rate of Increase of statewide "at risk" population of males between 18 and 34
- Lengths of mandatory minimums

During our site visit to Alabama we received a variety of data items which may be useful in forming and evaluating prison population projections.

1. Net Changes since 1968 in Prison Populations

Year	Net Increase on Decrease
1968-69	123
1969-70	-350
-71	114
-72	62
-73	111
-74	313
-75	911
-76	586

There has been a general upward trend of net gains in the prison population starting about 1972. It would be helpful to look at changes in the unemployment rate in relation to the rise in prison admissions.

2. Present Prison Population December 31, 1976 = 5,334

3. Prison Population Detained in Jail Presently Awaiting Transfer to State Prisons January 10, 1977

1,611	New conviction already sentenced (542 waiting sentencing)
128	parole violators
27	escapees
1,766	TOTAL TO BE TRANSFERRED

4. Probation and Parole Statistics for Alabama -1974-76

DATA BIT - PAROLE	9/1/74 to 8/30/75	9/1/75 8/30/76	1970	TOTAL 8/15/39 to 8/30/76
No. cases Considered	2,483	2,693		88,180
No. Parole Granted	1,346	1,562		30,790
Percent Paroled	54.2%	58%		34.9%
No. of Parole Revocations	495	545		
Total Parole Caseload	3,034	2,501	2,512	
Percent Revoked	16.3%	21.8%		28.1%

PROBATION	9/1/74 to 8/30/75	9/1/75 8/30/76	1970
No. Cases Considered			
No. Probations granted	4317	4615	
No. Probations revoked	494	576	
Total Probation Caseload	9229	9940	4833
Percent Revoked	5.3%	5.8%	

There are 67 counties in Alabama. Six counties generate roughly half the probations and paroles. Breakdowns are shown below:

Probations	Granted	(No. cases Revoked)	Paroles given/ Parolees	From	(No. of cases Revoked)
Jefferson	1,028	162	Jefferson	246	100
Tuscaloosa	459	22	Mobile	200	80
Mobile	408	35	Montgomery	105	60
Montgomery	180	37	Houston	70	17
Etowah	153	6	Madison	64	19
Morgan	150	17	Tuscaloosa	64	22
(51.5% of Total)	2,378	279 (48.4%)	(48% of Total	749	298 (52%)

Assumed Variables	1975	1976	1977	1980
Probation Revocations (by %)	5.3	5.8		
Parole Revocations (by %)	16.3	21.8		
Diversion to Community (12/1/75) Programs	346		%	
At Risk Population Growth Rates				+13% (1975-80)
Base Incarceration Projections	4748	5300		
Net Changes in Population	+911	+586		
Paroles (year = 9/1 to 8/30)	1346	1562		

APPENDIX B

Available Cost Estimates for Standard Facility (400 Capacity)

Court Order Requirement	Project N = 400
I. Immediate/Short Term	
Outdoor Exercise Area	1,103
Clothing (76.24)	30,496
Bed Linen & Towels (13.42)	5,368
Toilet Articles (4.22)	1,688
Food (1.80 per day)	262,800
Utensils (10.20)	4,080
Postage and Stationary	6,240
DOES NOT INCLUDE STAFFING AND ON-GOING OPERATIONAL COSTS SUCH AS UTILITIES	$311,775.
II. Long Term/Capital Construction	
New Construction (approximately $39,000 per unit)[1]	15,600,000
Would Include:	
Kitchen	674,580
Gymnasium	285,600
Visiting space (contact & non-contact - excluding some additional furniture)	23,482.40

[1] Neil Singer, "Economic Implications of Standards for Correctional Institutions", Crime and Delinquency, National Council on Crime and Delinquency, Vol. 23, No. 1, January, 1977, p. 16.

APPENDIX C

Recommended New/Expanded Industrial

Programs and Anticipated Equipment Costs

Automotive Service Shop at Holman

The State of Alabama maintains a motor pool of some 150 state cars to provide transportation for officials in state agencies. In addition, approximately 100 state cars, mostly public safety cars, are auctioned off/traded-in every three to six months.

An automotive repair shop located at Holman could provide two separate services for the state vehicles (1) routine maintenance, including tune-ups, tire changing, and winterizing of vehicles as well as (2) auto refurbishment including painting, engine cleaning, upholstery repair, body and fender work, engine overhaul, etc. prior to auction/trade-in of the vehicles.

The total volume of business which can reasonably be anticipated by the prison automotive shop, given the existing practices for performing routine auto maintenance work for both state and county agencies, needs to be carefully researched in order to properly size the automotive repair facility. Capital equipment costs listed below correspond to a facility which can perform routine maintenance on 200 vehicles per month and major overhauls on 10 cars a month

EQUIPMENT LIST

Equipto:

10 benches	2422-5	62.52 ea.	625.20
5 drawers	222	22.50 ea.	112.50
stock truck	152		46.12
2 stock shalving	565B	49.40 ea.	98.80
6 addition	565B2	46.40 ea.	278.40
lockers	121278		30.58
5 addition	121278A	29.27 ea.	146.35

Ammco:

Brake shop	1-40E	2562.30
Brakedrum grinder	4050	249.50
HD arbor	3481	103.50
Outboard support	7725	198.70
Bleeder	7400	83.50
Bearing packer	7150	23.80
Brake handtools	2650	69.80
Disc tool kit	9542	128.30
Bubble balancer	9580	156.00
Disc. caliper Hone	9575	11.80
Adj. shoe gauge	8650	9.80
Drum micrometer	8500	50.30
Ridgereamer	2100	12.50
Cylinder hone	500	79.80

Graysmills:

Cleanomatic parts cleaning tank	500		439.00
2 2A Brushes		3.85 ea.	7.70
2 5D "		2.90 ea.	5.80

Lincoln Greasing Equipment

Chassis lub. reel	2991		242.00
Gear lub. reel	2995		269.50
Motor oil reel	2994		279.50
ATF reel	2997		288.50
Air reel	2993		158.20
End panels (pair)	83434		48.00
Mounting rails	82168		13.00
Air regulator	81194		15.00
Air control assembly	82414		52.70
Chasis lubgun	923		268.50
Oil pump	499		243.00
2 lubrigun	434	247.00 ea.	494.00
2 lever guns	1142	5.25 ea.	10.50
greasing fitting asst.	5469		11.95
12 couplers	815	2.95 ea.	35.40
12 "	11659	.65 ea.	7.80
4 blow guns	840	4.25 ea.	17.00

Equipment List (Continued)

Dorman

RP-981	cap screw asst.	27.60
RP-984	metric cap screw asst.	46.50
AD-1	drain plug asst.	12.00
AD-8	fuel fittings asst.	19.50
AD-9	cup expansion	9.00
AD-10	expansion asst.	8.65
AD-43	wheel bolt & nut asst.	16.50
760	spool hose dispenser	81.00
75	copper tube tispenser	69.38

Sioux

4026	1/2" impac tool	165.00
313S	3/8" " "	150.85
4027	1/2" " " extended spindle	169.50
272M	muffler kit	89.55
1250	HD grinder	115.00
503	air sander disc	84.50
2017	7" bench grinder	151.25
2012	eye shield	5.15
2065	6" bench grinder	92.95
2011	eye shield	5.80
1200	polisher elect.	99.50
1510	HD 1/2" electric drill	78.50
1495S	1/4" all angle drill kit	89.15
645C	valve grinding machine	636.00
677	valve service cabinet	145.55
1725BB	Valve seat set	299.65
3600	socket sets	5.85
4601	" "	7.50
2751	3/8" universal socket drive	4.70
2752	1/2" " " "	5.05
275	hole saw set	21.60
1850	electric sander	55.50

Weaver

EC 403-5	hoist		1294.35
EC 202	"		1539.65
EC 105	twinpost truck hoist		2452.75
WA 90	transmission jack		436.00
2 WA 72A	2 ton service jack	258.75 ea.	517.50
WA 73A	4 ton " "		340.00
2 W1 20	jack stands (pair)	39.75 ea.	79.50
2 W1 21	" " "	30.60 ea.	61.20
WA65	high stands		63.00
WC101	hydra motor crane		310.00
WD 15	press		230.00
WD 102	arbor plates		17.85
WD 10[illegible]	safety shields		4.50

Equipment List (Continued)

Weaver (Cont.)

WD 106	axle bearing adapter	56.41
WD 109	extra press bed	36.20
WA 120	12 ton jack	44.25
WH 4-1	4 ton hydra power	193.00
WH 10	10 " " "	229.00
WX 51	headlite aimer	352.00

Peerless

960 Console Tune-up Center: consists of:

903 base with 955 pulsar performance pack, 902 cabinet, 500 pulsar diagnostic scope, 625 gas analyzer, 550 diagnostic analyzer and 816 universal connecting harness and sidepanel 1298.00

2	160 selfpowered timing lite	43.50 ea.	87.00
3	702 compression tester	19.50 ea.	58.00
2	713 remote starter switch	5.95 ea.	11.90

Pullman

JB 90-AV vacuum cleaner 190.00

Marquette:

	42-148	alternator, regulator, battery tester		399.50
	42-135	scopeless engine analyzer		895.00
	42-127	distributer tester		735.00
		Welding-Gas-Electric		
2	20-002	torch sets	179.50 ea.	359.00
2	26-373	karts for tanks	39.50 ea.	79.00
	15-951	welding bench		289.00
	10-118	electric arc with wheel kit		272.90

Bear

630-3823 alignment service 4273.00
pit cost extra
(width 13' length 12' depth 12'
allow. 15' access to pit)

Goodall

708	start all 8 hp 4 cycle engine	645.00
738	caddy cart	48.00
739	canvas cover	18.00

Equipment List (Continued)

Detroit Auto Body Equipment

B100	power shear		84.50
SWB	spotweld breaker		6.95

Proto Tools

5	9905	hand tool sets	972.08 ea.	4860.40

Robinair

Package 6 kit — 472.33

10570H	charging kit
10561	service manual
10538	leak detector
12008	goggles
10559	wrench
10569	dial thermometer
10522	compressor tool kit with a board

Schrader

Qty	No.	Item	Unit	Total
3	7750T	pressure gauge	2.50 ea.	7.50
3	8100	" "	2.50 ea.	7.50
	599B	tread depth guage		.90
	365D	chuck guage		17.80
	992	tire valve tool		2.65
2	3522	valve tool		.98
2	2688	screw driver tool		1.38

Hunter

3D Group balancer:
Includes 1/2 & 3/4 ton trucks and passenger car balancing.

300B Spinner
107A Tune In
127-13, 14,15 and 16 adapters
108 Truck Adapter — 655.00
200-13 Electronic Balancer with dual pick-up — 466.00

Kellogg American

B452BO Air Compressor
10 HP-120 gallon tank and belt guard — 1870.00

Equipment List (Continued)

Jenny

1560 OMP Steam Cleaner		1233.00
Thermostatic control		48.25
Nozzle control		55.10

Tru-Cut

AK-1 Alternator Kit		22.25

Ideal

MO-5 Tilt-a-bar positioning tool		20.85

Vulcan

FJ-31 Frame Jack		345.00

Tempo

FM-1009 Gas-tank pump		298.00

Kennedy Tool

165 Truck ring tool		6.39
166B HD Impac Bar		30.37
145A Truck tire iron		7.10
190A Truck tire spreader		18.59
164 Lock ring remover		3.64
188 Tire tool		3.14
T121 Portable Air Tank		52.00
2 191E Sledge hammers	15.90 ea.	31.80
5R Tire Mounting hammer		8.84
95 Portable lock ring guard		42.88
175 Truck tool board set		117.71
T606 Tap and Die set		77.55
S19 Stud remover		8.80
6 B104 Battery post tool		39.54

Fairmount Tool

G92K Body and Fender Tool Kit		197.46
MB12 File		2.16
MS 12 "		2.66
FB 12 "		2.88
FS 12 "		3.62
RB 12 "		2.20
RS 12 "		2.80
Hrb12 "		3.50
Hrs12 "		4.18

Equipment List (Continued)

Edlemann:

2	45 Battery hydrometer	5.90 ea.	11.80
	92A Cooling System Tester		6.85
2	909 Freeze Detector	9.80 ea.	19.60
	116VP Tube cutter		6.25
	90A Flairing Tool Kit		6.85

Associated:

2	R100 110 amp. battery charger	234.00 ea.	468.00

Bishman:

	2100 tire changer		775.00
	3000 tire truer balancer		1545.00
	9717 weight tray		19.95
	855BT tire leak tester		59.60
2	129 battery filler	5.90 ea.	11.80
	861 tire spreader		25.20
	9821 mag wheel adapter		52.55

Blackhawk:

2	ES100 1000 lb. engine stands	159.50 ea.	319.00
	ES200 2000 " " "		249.00

AC:

	Model A spark plug cleaner		70.75
	ST-1 Stand		10.95

Wilton:

5	746 vises	70.22 ea.	351.10
	2780 1/2" drill press		279.50

Lisle:

	55500 cluth align. tool		6.95
	24000 ring groove cleaner		4.95
	20500 ring compressor		3.75
6	46000 snap ring pliers	6.95 ea.	41.70
6	11000 battery post cleaners	2.75 ea.	16.50

Equipment List (Continued)

Lisle (Cont.)

Qty	No.	Item	Unit Price	Amount
	31500	tailpipe tool		9.95
	32500	expander		8.50
	32000	shaper		6.95
6	44000	tubing bender	7.50 ea.	45.00
6	31000	magnets (pick-up tools)	2.95 ea.	17.70
	18000	camshaft tool		87.50
	25000	hydraulic lifter tool		13.95
6	39600	screw starters	1.85 ea.	11.10
6	39200	scres starters	2.20 ea.	13.20
6	24500	gasket striper	1.45 ea.	8.70
6	97502	creepers	10.50 ea.	63.00

Ammerman Exhaust System

Suggest underground with blowers on roof or wall mounted. Estimated cost installed	7500.00
Estimated Hoist Installation	2000.00
	$53,962.59

Wood Furniture Manufacture and Repair at Holman

The State of Connecticut and its political subdivisions (municipal government) expend 4 to 5 million dollars annually on the purchase of new furniture and the repair and refurbishment of existing furniture. A major sector of this market is provided by the school system.

Similarly, a substantial market (at least $2-3 million annually) can be anticipated to exist in the State of Alabama. This market would easily support a cabinetmaking and millwork factory, a furniture refinishing and upholstery shop as new prison industries.

Estimates of the capital investment required to equip these facilities are provided below. As in the case of the automotive service shop, a more detailed study of the size (annual sales potential) of the State use market should be undertaken before firm decisions are made concerning these three furniture shops.

EQUIPMENT LIST

Cabinet Making and Millwork Facility

Equipment	1975-1976 Prices
1. Large Belt Sander	1,000.00
2. Power Sander/Surfacer	2,000.00
3. Belt and Disc Sander	700.00
4. Spindle Shaper	1,000.00
5. Mortiser	1,750.00
6. 20" Band Saw	1,500.00
7. 24" Scroll Saw	600.00
8. 10"-12" Long Bed Jointer	1,500.00
9. 12" Table Saw	2,300.00
10. 15" Drill Press	1,500.00
11. Tool Grinder (Pedestal)	300.00
12. 12" Wood Lathe (2)	2,000.00
13. 24" Planer/Surfacer	6,000.00
14. Spray Booth and Exhaust System	2,000.00
15. Dust/Chip Collecting System	2,800.00
16. Air Compressor System	1,000.00
17. Misc. Hand Tools	3,500.00
18. Portable Power Tools	
Belt Sander (2)	400.00
Finishing Sander (10)	1,500.00
Hand Drill (2)	200.00
Power Saw (1)	200.00
Sabre Saw (1)	100.00
Router (1)	200.00
19. Drafting Table (2)	600.00
20. Clamping Table	1,000.00
21. Asst. Lumber/Material Racks	1,000.00
	36,650.00

Furniture Refinishing Shop

Equipment	Price
1. Large Belt Sander	1,000.00
2. Power Sander/Surfacer	2,000.00
3. Belt and Disc Sander	700.00
4. Band Saw (20")	1,500.00
5. Tool Grinder	300.00
6. Drill Press (15")	1,500.00
7. Double Spray Booth and Exhaust System	5,000.00
8. Dust/Chip Collecting System	2,800.00
9. Air Compressor System	1,000.00
10. Stripping Vat	1,000.00
11. Misc. Hand Tools	3,500.00
12. Portable Power Tools	
Belt Sander (2)	400.00
Finishing Sander (10)	1,500.00

2.

12. Continued

	Hand Drills (2)	200.00
	Power Saw	200.00
	Sabre Saw	100.00
	Router (2)	400.00
13.	Clamping Tables (2-3)	2,000.00 (@2)
14.	Asst. Material Racks	1,000.00
15.	Veneer/Formica (Plastic Laminate) Press with accessories	1,500.00
		27,600.00

Upholstery Shop

- 5-6 Sewing Machines
- Power Material Cutters
- Assorted Hand Tools
- Portable Air Compressor

(5,000 - 6,000.00)

Total capital investment required for equipment (1977 dollars) is approximately $76,000. This figure allows for a five percent increase in the above cited 1975-1976 prices.

CONTINUED

8 OF 12

EXPANDED PRINTING OPERATION AT KILBY

An in-depth market research study in the State of Connecticut, which is roughly comparable to Alabama in population size, revealed that state agencies expend $3.8 million on printed matter, and political subdivisions (municipal government) expend $4.3 million on printing. The print shop at Kilby which now services the printing requirements of the Board of Corrections and provides silk-screening services (decals) to other state agencies could confidently be expanded to increase the size of the state use market it currently services.

Investment Cost

1722 Chief Offset Press	$10,000
Paper Shredder	850
Envelope Feeder, light table and sundry items already requisitioned by Shop Foreman	3,000
	$13,850
Replace Wall/Access Door	2,500
	$16,350

SCHOOL BUS REPAIR AT DRAPER

The State of Alabama[1] utilizes some 6,400 buses to transport students. Of this number, approximately 90% are owned by the counties, and only 170 are contracted through private companies or parties. The average cost of purchasing a new bus is $13,000.00, and the bus has an expected life of eight years.

Presently, the state has considerable difficulties acquiring necessary replacement parts such as wheel bearings, wheel cylinders, gears which are needed typically when the school bus has aged 4 or 5 years. One private firm in Alabama has offered school bus refurbishment service for several years at approximately $5,500/bus but has had little success in penetrating the state's county market.

The Department of Corrections in Texas operates a complete school bus repair program which renews approximately 1,000 buses per year at an average cost of $1,000.00 per unit. Their research indicates that the average age of buses worked on is six years and that $1,000.00 renewal cost buys five additional years of service for the unit.

School bus repair affords potentially substantial savings to the county school system and opportunities to substantially increase the prison industry labor force in Alabama. Marketing problems can be anticipated but a solid program based on the Texas operation should be attractive.

[1] Information provided by Mr. Norman Loper, State Coordinator of Pupil Transportation, State Office Building, Montgomery (205) 832-3984

EQUIPMENT FOR SCHOOL BUS REPAIR INDUSTRY

4	Impact Wrenches	$ 324.00
2	Blast Machines	2,100.00
5	Air Drills	520.00
1	Chair Hoist	275.00
1	Transmission Jack	300.00
1	Rachet Hoist	120.00
1	Air Dryer	9,150.00
2	50 hp Air Compressors	13,600.00
1	Battery Charger	150.00
1	Hydraulic Crane	315.00
1	Metal Band Saw	1,300.00
1	Arc Welder	329.00
1	High Frequency Welder	375.00
3	Grinders	276.00
1	Drill Press	925.00
1	50 Ton Hydraulic Press	715.00
1	Arbor Press	150.00
6	Air Screw Drivers	510.00
1	Portable Lift	425.00
2	Pneumatic Cutters	150.00
1	Spot Welder	265.00
5	Air Sanders	650.00
3	Air Polishers	360.00
1	Air Sander Edger	525.00
2	Air Sanders MOD	195.00
1	40 DVA Spot Welder	1,300.00
1	Abrasive Belt Machine	625.00
3	Sander Filers	225.00
1	Saw (Portable Circular)	75.00
1	Twin Saddle Jack	162.00
1	Squaring Shear Machine	1,750.00
1	Wheel Balancer	1,100.00
1	Huck Installation Tool	450.00
1	Rivet Press-Grinder	570.00
2	4 ton Jacks	390.00
1	Reliner Grinder	510.00

1	Power Washer	300.00
1	Headlight Tester	250.00
1	Alternator - Gen.-Reg. Tester	560.00
1	Distributor Tester	520.00
1	Tune up Machine	345.00
1	Huck Bolt Fastener	710.00
2	Steam Cleaning Machines	1,170.00
1	Valve Grinding Machine	850.00
1	Brake Drum Service Unit	2,200.00
1	Engine Tester	2,250.00
1	Water Wash Spray Booth	27,500.00
1	Bostitch Air Tack Stapler	90.00
1	Metal Shear	265.00
1	Alignment Machine	5,100.00
4	Impact Cutters	300.00
1	Circuit Tester	70.00
1	Twin Post Lift	2,300.00
2	Sewing Machines	1,400.00
	Work Benches and Tables	3,000.00
	Storage Cabinets	3,200.00
1	Frame Straightening Machine	30,159.00
1	Tire Changer	2,500.00
3	Air Grinders	500.00
1	Electro Static Spray Unit	2,200.00
	Central Paint Storage and Pumping Unit	4,500.00
1	Steam Cleaning Unit	2,600.00
1	Bus Transporting Wrecker	9,000.00
		$145,000.00

Initial supplies including paint, sheetmetal abrasives, lubricants, floor covering materials, solvents, detergents, body filler, etc. - $20,000

APPENDIX D

Calculations and Costs

Related to Future Scenarios

Demonstration of how we arrived at the

Shortages of Minimum and Community Custody Space

Total capacity now, excluding Tutwiler, Frank Lee Youth Center and Wetumpka Work Release (women), but including the new 360 bed minimum facility at Draper, is 3,820. Subtracting the needed 1,378 maximum and/medium cells from that figure leaves 2,442 available capacity of which 702 beds are strictly community (work and pre-release). Total demand is for 2,487 minimum and 1,070 community beds. Thus, there is a shortage of 747 minimum beds and 368 community beds. Also, there is a need for 53 community youth beds and 23 community women's beds.

Total capacity in 1980, assuming no additions except what is now planned and excluding the womens' facility (200 beds), Wetumpka Work Release, the 300 bed facility for the elderly, Frank Lee Youth Center, and a possible new 360 unit institution in northern Alabama, will be 3,280. Subtracting the needed 1,490 maximum and medium cells from that figure leaves 2,330 available capacity, of which 702 beds will be strictly community (work release). Total demand will be 2,676 minimum and 1,154 community. Thus, there will be a shortage of 1,048 minimum beds and 452 community beds. Also, there will be a shortage of 60 community youth beds, 29 community women's beds, and 53 community elderly beds.

Total capacity in 1985, under the same assumptions and with the same exceptions as for 1980, will be 3,820. Subtracting the needed 1,661 medium and maximum cells from that figure leaves 2,159 beds, of which 702 beds are strictly community(work release). Total demand will be for 2,992 minimum and 1,287 community beds. Thus, there will be a shortage of 1,535 minimum beds and 585 community beds. Also, there will be a shortage of 67 community youth beds, 34 community womens' beds, and 58 community elderly beds.

Unit Costs (and References) of Community Facilities

Community Institutions and Non-Residential Options

The following are taken as typical capital and operating costs (1977 dollars).

Jail

Operating cost/estimate/year	=	$4,800

Community-Based Institution (Minimum)

Operating cost/client/year	6,120
Capital costs/bed	13,895

Community House (providing comprehensive in-house services; capacity 15-25)

Operating cost/client/year	9,395
Capital cost/bed	4,960

Halfway House (providing basic in-house services and community resource referral using volunteers; capacity 15-25)

Operating cost/client/year	7,660
Capital cost/bed	4,960

Work Release Facility (capacity about 50)

Operating cost/client/year	3,720
Capital cost/bed	4,960

Probation

Average cost/case/year	806

Supported Work

Cost/placement/year	1,230

Restitution - by payment or community volunteer work

Cost/client/year	300

References

1. See Reference (3), p.30

2. "Cost Analysis of Correctional Standards: Institutional-Based Program and Parole", Correctional Economics Center, January 1976, p. 47. Cost inflated to 1977 dollars.

3. Ibid, p.19. Cost inflated to 1977 dollars.

4. "Cost Analysis of Correctional Standards: Halfway Houses", Vol. 1, p.10, Correctional Economics Center, November 1975. Costs inflated to 1977 dollars.

5. Unpublished paper by ACLU in Tuscaloosa, Alabama

6. State of Alabama, Board of Corrections, Annual Report - Work Release, October 1,1974 September 30, 1975. Figure includes income of $1200/inmate/year to offset operating costs. Costs inflated to 1977 dollars.

7. Unpublished paper by ACLU in Tuscaloosa, Alabama

8. "Pre-and Post-Trial Alternatives to Jail", Vol. 5, p.73, American Justice Institute, September 1976. Cost includes supervision and service purchases.

9. Private communication from Ms. Barbara Taylor, Acting Director, Private Concern, Inc., New York City. Cost includes job development counseling and placement.

10. "Cost Analysis of Correctional Standards Relative to Community-Based Supervision: Probation, Community Service and Restitution", Correctional Economic Center, Working Paper - Spril 1976, p. 103. Cost inflated to 1977 dollars.

Calculations Shown for Each Scenario

(1977 dollars)

- Scenario I

Operating Cost

Present - 1115 x $4800 = $5.35M

1980 - 1156 x $4800 = $5.55M, 360 x $6120 = $2.2M

1985 - 1826 x $4800 = $8.76M, 360 x $6120 = $2.2M

Capital Cost

Present - 0

1980 - 360 x $13895 = $5 M

1985 - 0

- Scenario 2

Operating Cost

Present - $5.35 M

1980 - 688 x $4800 = $3.3 M

494 x $7660= $3.78 M

100 x $3720 = $0.37 M

360 x $6120 = $2,2 M

94-420 O - 77 - 49

1985 - 1182 x $4800 = $5.67 M

544 x $7660 = $4.17 M

200 x $3720 = $0.74 M

360 x $6120 = $2.2 M

Capital Costs

Present - 0

1980 - 360 x $13895 = $5 M

594 x $4960 = $2.95 M

1985 - 150 x $4960 = $0.74 M

- Scenario 3

Operating Costs

Present - $5.53 M

1980 - 494 x $7660 = $3.78 M

100 x $3720 = $0.37 M

A 1048 x $9395 = $9.85 M

B 1048 x $6120 = $6.41 M

1985 544 x $7660 = $4.17 M

200 x $3720 = $0.74 M

A 1542 x $9395 = $14.5 M

B 1542 x $6120 = $9.44 M

Capital Costs

Present - 0

1980 594 x $4960 = $2.95 M

A 1048 x $4960 = $5.2 M

B 1048 x $13895 = $14.6 M

1985 150 x $4960 = $0.74M

A 494 x $4960 = $2.45 M

B 494 x $13895 = $6.86 M

- Scenario 4

Operating Costs

Present - $5.53 M

1980

A 1642 x $806 = $1.32 M

B 1642 x $300= $0.493 M

C 1642 x $1230 = $2.02 M

1985

A 2286 x $806 = $1.84 M

B 2286 x $300 = $0.686 M

C 2286 x $1230 = $2.81 M

Capital Costs

Present - 0

1980 - 0

1985 - 0

- Scenario 5

Operating Costs

Present - $5.53 M

1980 - 198 x $806 = $0.16 M

198 x $1230 = $0.244

198 x $300 = $0.059

1048 x $9395 = $9.85 M

1985 - 248 x $806 = $0.2 M

248 x $1230 = $0.305 M

248 x $300 = $0.074 M

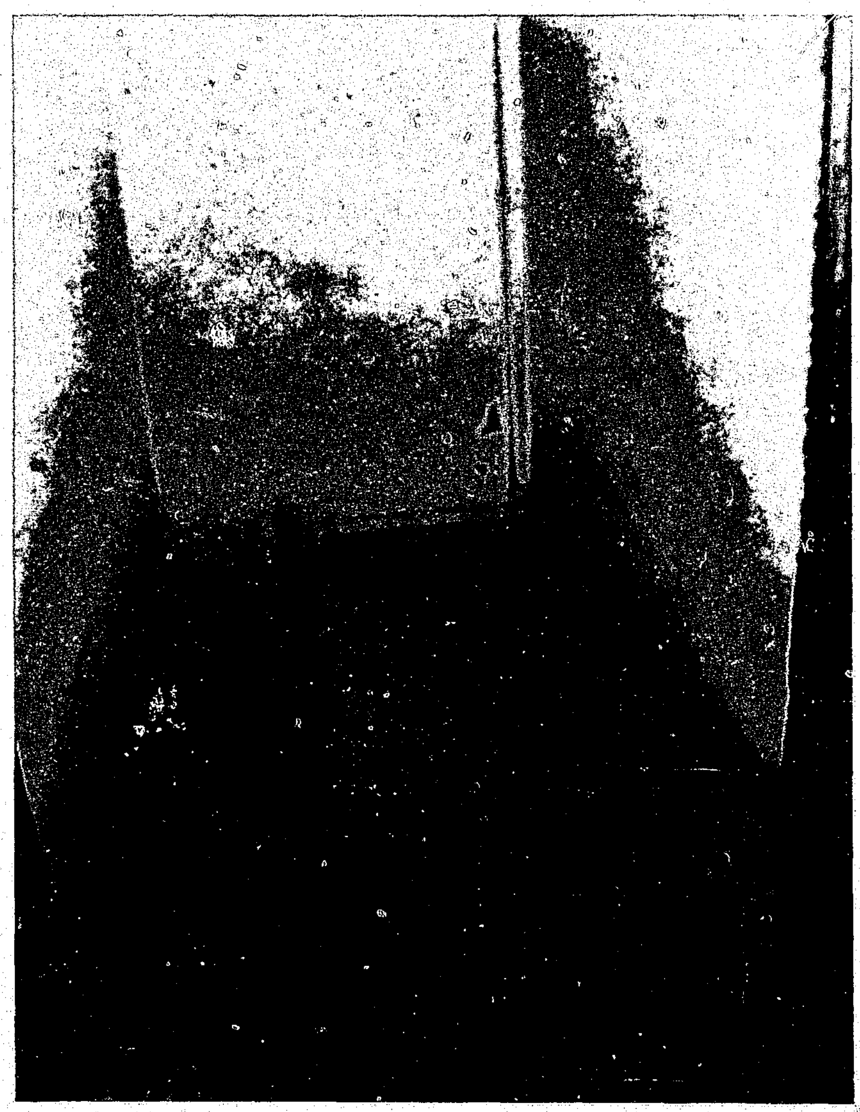
1542 x $9395 = $14.5 M

Capital Costs

Present - 0
1980 - 1048 x $4960 = $5.2 M
1985 - 494 x $4960 = $2.45 M

[The eight photographs taken of substandard conditions in the Alabama State prison system were marked "Exhibit No. 31" and are as follows:]

[EXHIBIT No. 31]

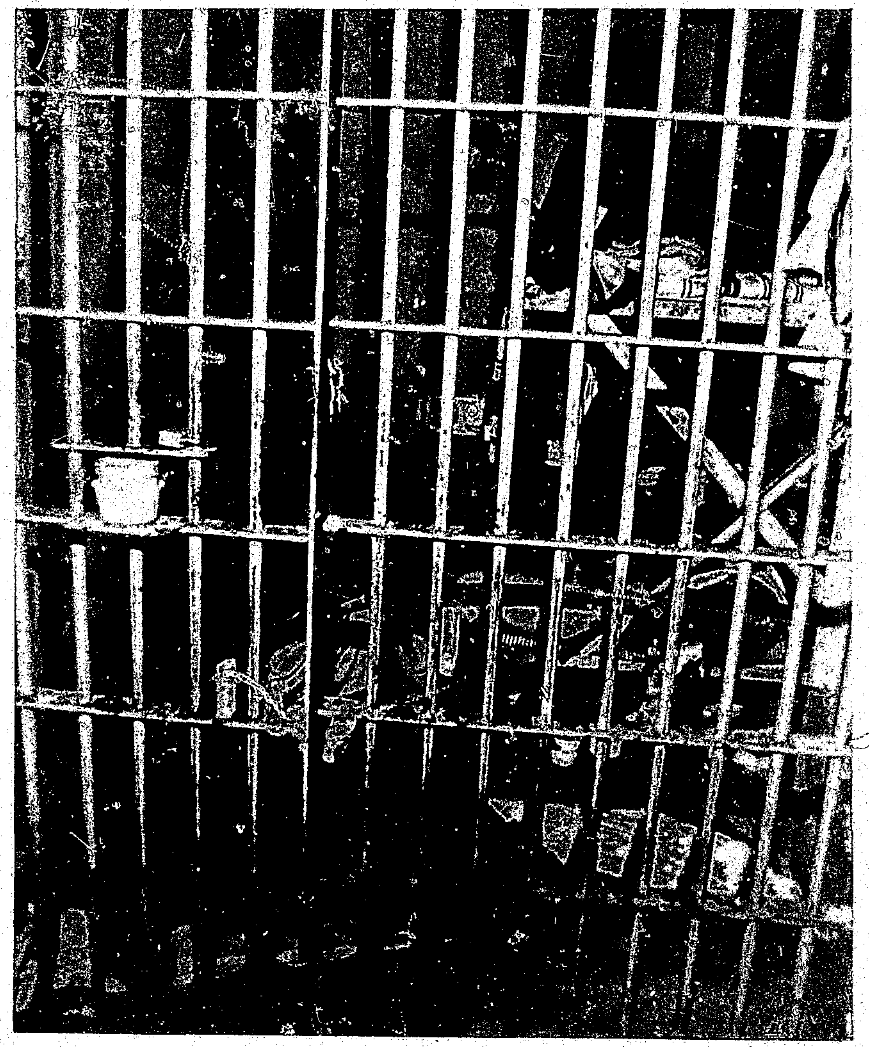


4 foot by 8 foot cell in the Draper "Doghouse" which housed six prisoners in almost total darkness.

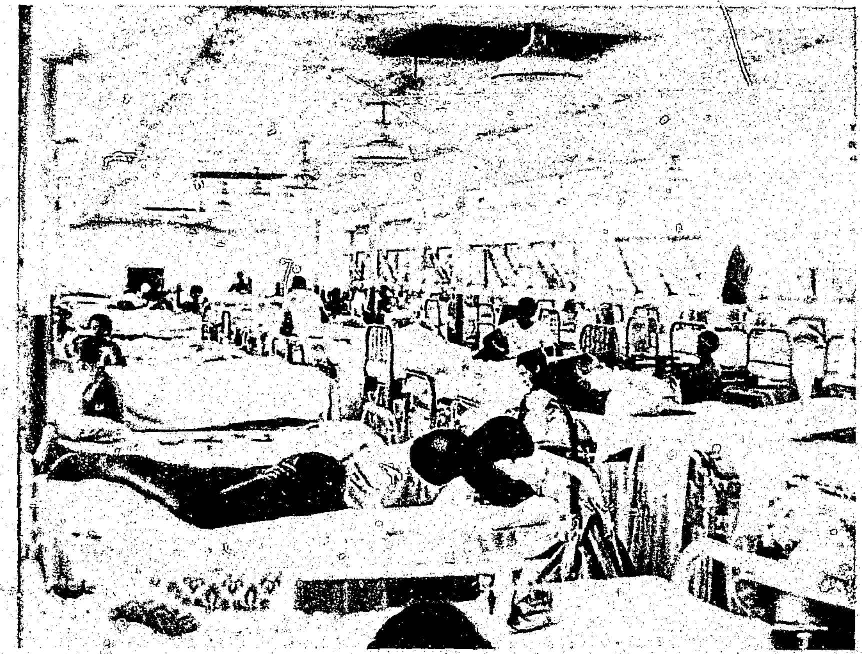
"Chinese toilet," or hole in the floor in a Draper "Doghouse" cell which housed six prisoners.

The "Doghouse" building at Draper prison, Alabama. This building, ordered closed by the Court, had no windows and no staff stationed inside the building.

One of 350 geriatric prisoners, this elderly man was confined to a wheelchair and housed in a second story dorm at Draper with only one stairway for egress. Many like him had not been out of the dorm for months and even years.

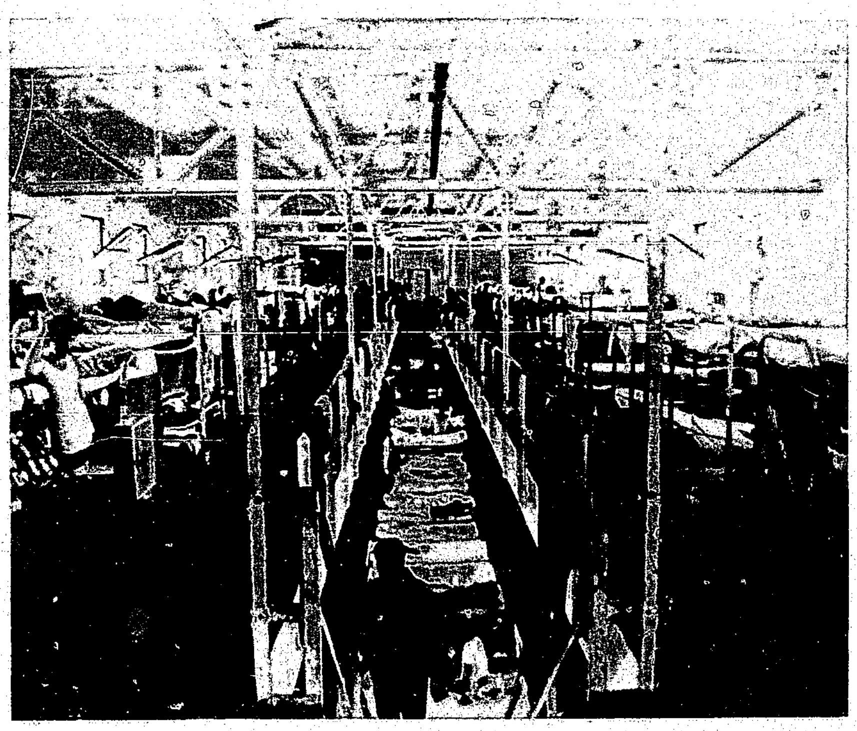


Four men can be seen in this 5 foot by 8 foot cell at Fountain Prison, Ala. Two are on the double bunks, two are on the floor.



One side of a dorm at Fountain. Bunks are double tiered and some are so close together that they touch. Most of the men are sitting or lying on their bunks because there was nothing else to do.

Another dorm at Fountain.



One level of dorm housing on top of another level at Draper.

Senator BAYH. Mr. Nagel?

TESTIMONY OF WILLIAM G. NAGEL, EXECUTIVE VICE PRESIDENT, THE AMERICAN FOUNDATION, INC., INSTITUTE OF CORRECTIONS, PHILADELPHIA, PA.

Mr. NAGEL. I submitted a prepared statement. I will not read any of it nor will I refer to any of it.

Senator BAYH. Without objection your prepared statement will be inserted in the record.

Mr. NAGEL. I would like, however, to make a few observations that perhaps will expand the significance of the written statement I have submitted.

First of all, I should tell you that I come to this spot here today by a circuitous route. When I came out of the U.S. Army as a major after World War II I decided to go into corrections. I spent the next 11 years of my life in corrections as a correction official with the State of New Jersey. Following that I served in the office of two Governors of Pennsylvania as executive secretary for human services. In that regard I had responsibilities in the area of corrections, mental retardation, and mental health and other institutional services as well as community services.

So, I have some appreciation of how the correction official looks at this problem. I have some appreciation of how the State executive looks at this problem.

Senator BAYH. When were you serving in Pennsylvania?

Mr. NAGEL. From 1964 to 1969, during the administrations of Governors Scranton and Shaeffer. I was in their office as executive secretary for human services.

Since then I have had another responsibility. I have been vice chairman of the Governor's Justice Commission which is the agency which does the overall planning for criminal justice in the Commonwealth of Pennsylvania and, as Vice Chairman I have served under five consecutive attorneys general who in our State serve as chairman of that commission.

So, I have three points of view that bring me to my concern about this bit of legislation.

I do not think I was ever terribly concerned in all my years as a prison official or all my years as an administration official with constitutional issues. We were concerned with the practical matters of getting the job done. Like the county preacher who carries the Bible under his arm, none of us carried the Constitution under our arm. We went about our business doing what we had to do to get through the day. Many of the things we had to do I look back upon with a great deal of shame.

However, in 1971, I was asked by the U.S. Department of Justice to take a look at all the new prisons in the United States. The Parkie Amendment and the Safe Street Act had been passed some while earlier. The Congress wanted to know and the Justice Department wanted to know how money should be spent as far as institutions were concerned. I was asked to look at all the new institutions. In that process I went to visit two new prisons, brand new prisons that had only been open for 3 months prior to visit in Alabama. The conditions I saw there were unbelievable.

Senator BAYH. In the new institutions?

Mr. NAGEL. Yes; in the brand new institutions. They were only open a relatively few months. I saw the conditions that Mr. Bronstein has commented about. I went back to the Board of American Foundation. I have not told you about that foundation but we are a privately endowed foundation. We are a foundation that was endowed by the American Publisher Edward Bok. One of our responsibilities is to try to make the criminal justice system more responsive. I went back to my board and told them what I saw in Alabama. As citizens of our country they were appalled and I was appalled. They said that they wanted me to use part of my energies, in whatever way I thought I could spend those energies, to eliminate those conditions which they viewed as intolerable and unconstitutional.

As a result of that I have been involved in 17 court suits in the country. I am about to be involved in two more.

I am involved generally as an expert witness. My involvement has taken me lately to Utah. It has taken me as recently as Tuesday to Attorney General Burch's State of Maryland. After listening to those two gentlemen today affirm their concerns and feelings if only they had 3 months to know about it or 6 months to know about it then I wonder if I, indeed, was in the same world they were in when I was in Utah last week and in Maryland this week.

In Utah, I was brought in as a part of the process of discovery. The attorney general spoke only that the prison was overcrowded. That was the cause of the suit. That, indeed, is a very small part of the cause of the suit. There were six or seven other major issues of a constitutional nature that the chief judge wanted us to get information on.

When I arrived, we could not get in the place. Attorney general Hansen said that we were not to be allowed in until he had talked to Attorney General Bell himself.

Senator BAYH. Did he know you were coming?

Mr. NAGEL. He knew we were coming. The judge had indicated that we had to give 24 hours notice before coming. My coming was determined by the fact that on Tuesday of the week before I went, I was notified that I was to be the recipient of an award, the Roscoe Pound award for distinguished service to criminal justice and corrections. That was going to be given in Salt Lake City on the following Tuesday. And because that was going to be given and because I had been asked weeks and weeks in advance by the Federal Department of Justice if I would be willing to participate in the process of discovery, I phoned them on Tuesday a week in advance. I said to them "I will be in Utah next Tuesday. I will be glad to look at the prison while I am there."

The judge had required that there be 42 hours of notice before we were to be allowed in. Actually they were given 72 hours of notice but nevertheless when I arrived on Monday morning, I was faced with newspaper headlines saying "Federal Expert to Close Prison, Throw Criminals on Street." That's the last thing I'm interested in, This had been released from the attorney general's office.

There were photographers there to take a picture of me. All I was interested in at that moment was the process of discovery. I was not even sure I would be willing to be a witness. Because of my own view I am unwilling to be a witness unless there are substantial constitutional issues as I perceive them.

Anyhow, the cooperation that seemed to have been suggested here in attorney general Hansen's remarks, I certainly was not aware of.

After I spent a day there I must admit the people seemed to be less frightened of me. There developed a kind of rapport between myself and the warden and with the deputy attorney general who was assigned to follow me around everywhere I went. But generally speaking I got no sense that there was any overwhelming desire on the part of the attorney general of Utah to look rationally and dispassionately at the issues that were alleged.

Similarly, I listened to attorney general Burch this morning speaking about the Maryland situation. It so happens coincidentally that I was in Baltimore yesterday because the University of Maryland Law School Clinic is initiating a suit against the Baltimore City Jail. The Baltimore City Jail has the capacity of 920 and presently has a prison population of just under 2,000. Conditions there are absolutely horrible.

But I do not know how I can say this, but I must say it. The warden is a good man. The warden does not want those circumstances. But why do those circumstances exist? Because there has been accom-

modation between the administration of the State of Maryland and the administration of the city of Baltimore to keep 760 convicted men sentenced to the State penetentiary in the county jail rather than cause an overcrowded situation in the prisons.

Therefore, 900 other people who are presumed to be innocent are being held in the city jail under conditions that are absolutely unbelievable to me.

Senator BAYH. Was the attorney general involved in that agreement?

Mr. NAGEL. I do not know. All I know is that when I asked why this existed they said, "It is an accommodation between the city and the State." No small man waiting trial is big enough to upset that accommodation, they said.

I looked with a certain amount of jaundice, I suppose, on the statements of those two honorable gentlemen this morning indicating how willing they were or would be if only they had a little bit of time.

Now, my feelings on all of this matter are supported by a lifetime of public service. In addition to the Alabama thing, which I happened to fall upon, I have been a public official for a good part of my long life.

I remember, as long ago as 1964, when I was in the Governor's office and when I had a lot of responsibility, mentioning to the attorney general of Pennsylvania—talking to him seriously about the conditions in a mental hospital for the criminally insane in Pennsylvania called Waymart. Some people call it Farview. Every time that matter was brought up in my private conversations they would say, "You don't understand the complications." We found the complications were with the unions. They didn't want to face the issue. The complications were also with the city fathers. This is the biggest industry in the town so "don't upset the apple cart."

From 1964 until the present time conditions are so horrible that a civilized person can hardly utter them and they have existed in those institutions. Today a commission of which I was appointed a member is looking into the conditions at Waymart. Perhaps something will help them but it has taken, to my knowledge, 13 years to move up from darkness to darkness. When I was in the Governor's office we had a prison for children called Camp Hill. I went to the deputy attorney general of our State when I was in the Governor's office and said "that this condition at Camp Hill in which you have 600 juveniles and 400 adults confined together is an unconstitutional situation. You must know it is unconstitutional because they have not had due process. The adults have had due process. They are thrown into the same jungle together."

He had written the law and he said he was sure that that law could sustain any challenge and he would be willing to fight it in any court in the country.

From 1964–65 when I first discussed that with the deputy attorney general, those conditions there until 1974 when a new commissioner of children and youth and a new deputy attorney general, who happened to be my son, got together and looked at the law and looked at the issues and the constitutional decisions and went to the attorney

general and the Governor of the State and said, "This is indeed unconstitutional." They closed that institution.

Senator BAYH. Was that in Pennsylvania?

Mr. NAGEL. Yes, in Camp Hill.

It took 13 years, of my knowledge, to move a State from an intransient position about that unconstitutional system.

In 1970, I was appointed to a commission to look into some serious riots in the Philadelphia County Prison. These were horrible riots. People were cutting up each other. These were racial riots.

Following that riot, a lawsuit was instituted against the city of Philadelphia about conditions there. That lawsuit started in February of 1971. Conditions were indescribable.

In the process of the trial, which took by the way—in February they started and in April the preliminary objections were heard and in September a court opinion dismissing preliminary objections was determined. In December of that year testimony was heard. In January of the next year the arguments for the city were then heard and in April, just 1 year and 2 months after the initiation, an opinion was filed by the court of common plea saying that the conditions of the Philadelphia County Prison constituted a cruel and unusual punishment and had violated three of the Bill of Rights. It violated I don't know how many articles of the State constitution and about 69 matters of State law.

The opinion was filed. Exceptions were heard in June. The city filed an appeal immediately. In August the appeal went to the commonwealth court which is the first court of appeals in the State of Pennsylvania.

In July it went to the State Supreme Court. And in October of the following year finally a decision came down from the Supreme Court. In 1976, 5 years later it all started, a master was appointed and today this very day that we are here, the city is back in court on contempt.

I point this out to show the systematic way that governments work to impede the fulfillment of constitutionality within our institutions. This is not uncommon. It has been a part of almost every one of the 17 court suits that I have been involved in. I, therefore, testify today strongly on behalf of this bill, Senate bill 1393. I would argue very strongly also that the matter of exhaustion be considered, in my view, as frivolous and not valid.

I have only one objection, frankly, to the bill as I read it. I am not a lawyer. I'm not that terribly good at reading such things, but I'm rather disappointed that within the bill authority has not been given to the Attorney General to initiate suits against Federal bureaucracies that are involved in institutionalization. The Federal Bureau of Prisons is not above reproach.

Thank you very much.

Senator BAYH. Talking to my staff about your last suggestion, it seems that the Attorney General is in the same kind of conflict with Federal penetentiaries as the States' attorneys general are in with regard to State prisons.

Mr. NAGEL. Two divisions of the same department. The Bureau of Prisons is in many ways viewed by the States as the standard setter.

If they are above the kind of pressure that is involved in this, then if indeed the inmates in the Federal prison have to depend upon the good officers of poverty-stricken law firms such as Mr. Bronstein's are sometimes, then their problems are difficult. It is a strong bureaucracy. It's an extremely powerful bureaucracy. It is the fastest growing bureaucracy that I know of in the Federal Government.

I think a few restraints on it would be a desirable thing.

Senator BAYH. In the Federal system do you have the clear pattern of abuse that we have had documented in the State system?

Mr. NAGEL. Generally the Federal system is not as terribly overcrowded. Generally it is cleaner. Generally it is, I think, more responsive to reason when people sit down with it. Not always, however.

I am involved in a court suit right now with the Federal Government. It has to do with the Metropolitan Correction Center in New York City which is the new pride and joy of the Federal system. It's a brand new institution with rugs on the floor and all outside rooms and fairly large rooms and all the rest.

The reason that I am involved as a witness is because in designing this institution they determined that there was only one value and that is to prohibit escapes. That was the absolute value of that institution.

So they built an institution—a high-rise institution—that is escape proof. That is a value, of course. I don't have any problem with that.

But because the people who are in there, by and large, are presumed to be innocent, they are denied what I would call the least restrictive principle, the Blackstonian concept that a person presumed to be innocent should be held under the least restrictive circumstances necessary to ensure his appearance at trial. The people in the Metropolitan Correction Center all have the most restrictive conditions.

So, we are in the process of challenging that, not because of unsanitary conditions, because they are much better financed and staffed and so on. There are many things about the Federal Bureau of Prisons that States should emulate; but there are many things because of their strength and power which frighten me.

Mr. BRONSTEIN. May I add something since my office has probably had the most experience with negotiating and litigating against the Federal Bureau of Prisons?

Senator BAYH. Certainly, go ahead.

Mr. BRONSTEIN. I share Mr. Nagel's view that in certain areas like sanitation and the numbers of staff and the quality of staff generally that those kinds of things like overcrowding, you do not see the gross violations that you see in the State systems.

But there are patterns and practices of constitutional violations. We have successfully litigated against some of them. One or two have been as gross as anything in the State system when we successfully challenged the Federal Bureau of Prisons behavior modification program called START which was their acronym at their medical center in Springfield for prisoners. The conditions there were as gross as anything we have seen in State institutions.

Senator Ervin held some hearings on that when he chaired the subcommittee or its predecessor and the Bureau closed that down as a result of the lawsuit.

There are other kinds of patterns. But I would also say and I think this has something to do with Attorney General Bell that in the past 4 or 5 months the Bureau and the top staff at the Bureau indicated a much greater willingness to discuss, to hear about issues. For example, after I testified on this very bill before Congressman Kastenmeier's committee. I had commented in a negative fashion about the Bureau's administrative remedy procedure. The very next day Mr. Carlson, the Director's assistant, called me and asked me if I would detail the complaints for them because they wanted to look at them.

So there is some movement, but there still are problems and we're still litigating patterns and practices of violations in the Federal system.

Mr. NAGEL. Senator, may I just mention this? This is a concern to me.

One of the things that I became aware of, as we traveled the country looking at most of the new institutions in the country, is that so many of them are in rural areas. Finding attorneys in the rural parts of Texas or any other State, who are able to give the time, the energy, and everything else, and even have the inclination to take on the State system, is very difficult.

We have some 4,000 jails in this country. I have been in 400 or 500 of them, most of which have awful conditions. But, I find that attorneys in the county seats where those jails are are most reluctant to serve as attorneys for prisoners in class action suits because much of their life depends upon an accommodation with the judge, an accommodation with the warden of the jail to allow them in to interview and so on. They have indicated to me around the dinner table that there is too much at stake to get them involved and because the people in the institution are not likable and powerful and are pretty damn unlikable. So why should you risk one's professional reputation and enter into a suit? So the result is a likelihood of these issues ever being brought to a head in the 4,000 counties and the hundreds and hundreds of rural counties. It seems to be pretty unlikely.

Senator BAYH. Let me ask you gentlemen to look at three problems regarding areas of disagreement that have been mentioned by previous witnesses. I don't need to spend a lot of time on them but there was, at least with attorney general Hansen, and I think generally among the attorneys general, a suggestion that there had been a new awakening or a new breed of attorneys general. They conceded that terrible problems had existed in the past that were documented in court suits and this kind of thing, but that today no State official would tolerate such abuses. In other words, these were problems of the past.

Are we talking about something that exists now or something that has already been litigated and resolved?

Mr. BRONSTEIN. We're absolutely talking about a problem that exists now. I have seen no evidence of this renaissance. I would say that I think there is a new breed of State corrections officials in a number of States in this country who will not tolerate the kinds of conditions that we have talked about. That number is growing.

But these conditions exist today. They exist in most of the States in their penal institutions, in their State mental hospitals, and in their juvenile institutions. The horrors that we have talked about—we deliberately selected Rhode Island as our next case after Alabama, a Northern State, merely to point out that Alabama was not a phenomenon and could not be labeled as a Southern State and that they have no humanity.

The conditions in Rhode Island, Mr. Nagel toured those facilities as an expert and testified. In some respects they were just as bad as anything that we saw in Alabama. That was 2 months ago.

The same exists in Tennessee today. The same kinds of things existed in the segregation unit in the Wyoming prison which Mr. Nagel accompanied me on just last year. These things exist today. There is no great movement, except under the pressure of a new kind of corrections commissioner in a few places and where you have the pressure of "court action," both Federal and State.

Mr. NAGEL. I must repeat that the Utah experience that I had was last Tuesday. The Maryland experience I had was this Tuesday. This is pretty current.

Senator BAYH. The horse, then, is still in the barn.

I asked that question with no desire to embarrass or to impugn the integrity of the present attorneys general. There is a recognition of the fact that we still have the institutional structure and competing pressures in society today that we had 20 years ago. Although there may be a little more light shed on these problems, we are still going to have that same kind of conflict of interest and competition for limited resources. There is the personal human desire of citizens to let somebody else handle the social problems so that they are not bothered with them.

I think your comparison to garbage is probably a good one, tragic as it may be.

Let me deal with a couple of procedural points. Mr. Nagel, although you directed your attention to the "time to react" plea and you were a bit cynical as to whether that would make any difference or not, is there anything wrong with our putting in our bill a requirement that the Justice Department make a good faith effort to try to get action and to try to get those people who are closest to the scene to react, and, failing that, then get involved?

Mr. NAGEL. My own district is exactly that. When I went out to Utah last week, it was not to engage the State of Utah in litigation. It was, in effect, to put the State of Utah on record that the conditions are known and to work from a good faith situation. People who are decent human beings will respond to intolerable conditions when it is brought to their attention.

There were some good people in Utah. I think that a lot of things can be negotiated out of court. A lot of the problems can be solved.

When that situation comes, by the way, as Mr. Bronstein knows, I usually back out as a witness. I think that should be done that way.

I have no objection to that kind of an arrangement in which you sort of do work in a time frame in which people work it out.

However, I would say also that Judge Lasker said when he responded to an experienced correctional witness who said that the

conditions for 4 or 5 months, and he was talking about people waiting for trial, was not intolerable. Judge Lasker responded, "When you are in violation of the Constitution, 4 or 5 minutes is intolerable." A lot of us do not look at it in that way. We just say that we will work it out next year or some other time.

Senator BAYH. I tend to concur with your assessment of the constitutional violations, but I think we must also face hard facts. There are limits to our ability to solve the problems immediately. The question is: How do we get the best results in the shortest period of time and spend the least amount of resources? It is that kind of contest. I wonder, Mr. Bronstein, do you have problems with a notice and presuit negotiation requirement?

Mr. BRONSTEIN. I have no problems with the bill containing language about the Department being required to make a good faith effort. But I think it is imperative to put a fairly short time limit on that because it has been my experience, for example, in Wyoming—now let me say something good about the Wyoming attorney general's office—they immediately, after the lawsuit was filed on the State prison, made a good faith effort to negotiate and did negotiate. I think they came up with some rather excellent settlement proposals which were then incorporated in this court decree.

But they would not have done that without the pressure of the lawsuit. Very often the attorneys general office cannot control the situation but the legislature controls the situation. If the legislature feels they can get away with it for another year or two they will. So I think the negotiations with the good faith effort can be incorporated in the bill as long as there is a fairly short time limit so that you can have the litigation then commence. Then I think you will see a lot more good faith in the negotiations.

Senator BAYH. How short and how long?

Mr. BRONSTEIN. Something like 90 days, I would say.

That would be perfectly appropriate. In most of these cases the people running these institutions know exactly what is wrong with them. The attorney general need only meet with his clients. It did not take them very long to see what was wrong in Wyoming in that penitentiary, in spite of the fact that they did not have the most progressive warden in the country running that institution. The two young assistant attorneys general accompanied us on our tour and they saw immediately what we were pointing out to them which had to be remedied in that situation.

So, I would say that 90 days would be perfectly adequate.

Senator BAYH. Let me ask you another question. This is another problem area.

Should we try to put in the legislation goals or standards which we expect the States to meet? Of course, constitutional standards are nebulous. We are not talking about Utopia in these institutions. In fact, we are probably not even talking about "average" conditions, although I wish we were.

Should we try to put in standards? If so, what standards?

Mr. BRONSTEIN. I would say not for two reasons. One, that would delay the legislation about 12 years. [Laughter.]

We would have this distinguished body arguing over things as to whether the standards ought to include square foot requirements for

housing and what have you. And if so, whether it should be 60 or 75 square feet because one agency like the Bureau of Prisons recommends 75 square feet. The Department of the Army in their penal institutions recommends 85 square feet as a minimum. So I don't think you need that. The standards that we're talking about are constitutional minimums. There are plenty of standards around. The recent draft of the American Bar Association's recommended standards are superb. The National Advisory Commission, and I think Mr. Nagel wrote a part of that report of Governor Peterson's commission, contains adequate standards. They can only be very general because things change.

The American Corrections Association is coming out with their new standards for adult correctional institutions this August. There are plenty of standards, but standards vary and should vary for institutions. You would have, for example, standards that say that in a maximum security institution you should never house prisoners in a dormitory. Whereas, in a minimum security institution or a trustee situation dormitories are perfectly agreeable.

So how could you talk about precise standards without having a bill that would be as big as old S. 1 about which you will never get agreements?

What we are talking about are our constitutional generalities, and that is up to the individual States and their officials, their attorneys general, their courts to work out precise standards.

Mr. NAGEL. I agree with that. In the jail situations there are about 15 to 16 sets of standards which have a great variety. You have the ratio of staff to inmates and so on. If you were ever to try to determine out of that one set of standards and write it into a law, you might be debating it forever.

Senator BAYH. I wasn't thinking so much about statistical standards in specifics as I was general kinds of minimal constitutional requirements.

Mr. BRONSTEIN. It seems that we have a Constitution to work from which says what a State may and may not do in general terms. The patterns of practices of those violations—due process, eighth amendment—which are things that this law would deal with and prescribe. Then it is up to the parties in the particular lawsuit with the assistance of experts and the court to develop those standards that are necessary in a factual sense in a particular situation.

Senator BAYH. Regardless of what we wrote in this bill, the court would ultimately determine whether that met constitutional minimums or not. But it seems to me right now that we would have a number of different standards depending on what a given Federal judge thinks in a given situation in a given community.

Mr. BRONSTEIN. There has been an evolution. It has been necessarily so. The first court to even deal with this—and I attached to my statement the major prison cases dealing with patterns of practices—but it was almost 10 years ago in Arkansas where the court was really cutting new ground and left things rather vague.

Judge Johnson issued a decision a year ago and by that time there had been a number of pronouncements on these issues. You will find that Judge Bohannon in the *Battle* case in Oklahoma is looking very

carefully at Judge Johnson's standards. Judge Scott in Florida is looking very carefully at Judge Johnson's standards. The State court judge before whom we are proceeding in Tennessee is looking at Judge Johnson's standards. State correctional commissioners, for example, the commissioner in Minnesota who testified before you, Mr. Schoen, is using Judge Johnson's Alabama standards as model for his planning there. So I think it is not as disparate as one would gather. I also understand that Judge Bell is putting together a task force to attempt to at least promulgate some recommended national guidelines or standards for correctional institutions which will again be a useful source. But there do have to be variations depending on the nature of the operation that are maximum or minimum security and the physical nature of the institution and other kinds of factors.

Mr. NAGEL. Recently we were asked to make a study of a large county in New Jersey with regard to its jail and county workhouse. What we did was that we listed 14 issues down one side of a page like size of cells, ratio of inmates to staff, and a whole lot of things. Then across the top we put 5 sets of standards like the United Nations, the Federal Bureau of Prisons, and so forth.

But the interesting thing was that they varied and this county was in violation of almost all 14 according to any one of the 5 standards that were chosen.

So there are sufficient standards even to disagree on the quantitative aspects of them. There are sufficient standards right now so that if you take any of these hideous States that we're talking about or hideous counties that we're talking about, any movement toward any of those standards would be an enormous improvement.

Senator BAYH. You have been kind and patient. You have made a significant contribution. I appreciate not only the contribution you made to our search for "truth and wisdom and ultimate justice" but the kind of contribution that you're making out there on your own every day.

We thank you very much.

[The prepared statement and exhibit submitted by William G. Nagel follow:]

PREPARED STATEMENT OF WILLIAM G. NAGEL

I am pleased to have the opportunity to appear before this subcommittee today. From my eleven years of experience as an assistant superintendent of a prison plus years more of responsibilities in the Governor's Office of my state of Pennsylvania and more recently as an expert witness in many prisoners' rights cases, I wish to testify in favor of Senate Bill 1393. I will be brief to allow time for your questions.

First, I want to emphasize that we are here concerned with significant Constitutional rights of institutionalized people. As you know, the bill stipulates that the U.S. Justice Department would be authorized to initiate or intervene in cases "to redress deprivations of constitutional and other federally protected rights" where such deprivation if pursuant to a pattern or practice of resistance to the full enjoyment of such rights, privileges, or immunities".

During the past four years, I have testified as an expert witness in seventeen prisoners' rights cases—against federal, state, and local authorities. I recently agreed to be involved in two more. All of these cases have involved major questions of cruel and unusual punishment, racial discrimination, equal protection of rights of persons presumed to be innocent during detention prior to trial. The suits challenged operational practices—e.g., the overuse of disciplinary confine-

ment, routine subjection of people to rectal searches following visits—and physical conditions—e.g., six people housed in an 8 by 6 foot cell for twenty-four hours a day; others housed in hallways on unclean, uncovered mattresses; inadequate heat, ventilation and lighting. Furthermore, in all the cases I have participated and a decision has been submitted, the court has affirmed the rights of those confined. Decisions have stipulated the end of penal practices which had become callously routine, set required standards on physical conditions, and rejected the inability to pay as a substantial reason for noncompliance. The rights at stake are too consequential to be denied on basis of cost. It follows too, that the rights at issue are too consequential to be denied full protection through access to administrative and/or judicial remedies.

I understand opponents to this bill contend that administrative remedies are themselves sufficient to insure observance of institutionalized people's rights. I contend that this is not true. As a former prison official, I am sensitive to my profession's insensitivity to the Constitution. Moreover I wonder, how can a prisoner expect to get a fair hearing within prison when he or she is challenging that for which the prison officials are responsible? Furthermore, how can a prisoner expect to be heard impartially by the state when state officials are defendants in the suit? I have learned through experience that most states resist correcting their unconstitutional conditions or operations until pressed to do so by threat of a suit or by directive from the judiciary. The right of access to the federal judiciary is integral to the protection of the constitutional rights of people institutionalized.

Just as *Gideon* v. *Wainwright* (1963) assured access to the judicial system through the guarantee of attorneys, so would Senate Bill 1393 assure institutionalized people of access to judicial remedies. Private attorneys, including the American Civil Liberties Union, can not afford the costs nor can they cover all the potential suits of constitutional importance. Public defenders or appointed counsel are rarely drawn into these cases. The Justice Department could fill a present gap in the availability and participation of counsel for these types of cases.

Furthermore, the involvement of the Justice Department would lend sufficient credibility to the plaintiffs' claims that the issues might be more often resolved through stipulations and consent judgments. Also, the Justice Department could cover the high costs incurred in comprehensive, system-wide or state-wide cases. Justice Department involvement might also decrease the amount of tactical delays used by officials to undermine the plaintiffs. Thus, passage of Bill 1393 could well reduce the number of prisoners' rights cases presently pressed on the federal judiciary.

I have one objection with this bill and that is its restricted application to cases in which the State or subdivision thereof is joined as a party defendant. The federal government too runs institutions in which the same costitutional rights apply and for which the same access to redress of grievances should be assured. A government or institution can not be counted on to monitor itself, but it should not be excluded from doing so. There might be some technical difficulties having one part of the Justice Department, the Attorney General, challenging another, the Federal Bureau of Prisons; but because of the import of the rights at stake, I suggest that this possibility be allowed within the prospective law.

Our country was formed on the basis of justice for all and equal protection of our individual liberties regardless of status—economic, racial, sexual, and most recently, confined status. The authorization of the United States Department of Justice to participate in the assurance of these rights is integral to their preservation. Prisoners, be they in local, state, or federal institutions, should be assured legal representation in those cases which are concerned with substantial constitutional deprivations through a pattern or practice of resistance by the authorities responsible. Senate Bill 1393 covers this situation with respect to states and their subdivisions and should be amended to so cover the federal government.

As part of this testimony I submit the attached paper, "Quest or Question? The Presumption of Innocence and the American Jail" which speaks to the issue.

[EXHIBIT No. 32]

Quest or Question?

The Presumption of Innocence and the American Jail

by
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presented
at the Fourth National
Symposium, April 8, 1977
New Orleans, Louisiana

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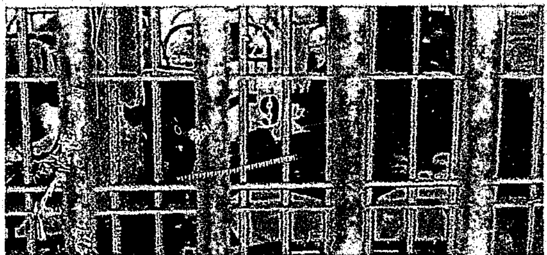


Certainly there can be few more glaring dichotomies than that dividing pretrial justice in the United States. I refer, on one hand, to the "presumption of innocence" and, on the other, to the American jail.

Because that dichotomy has such fundamental significance to you who finance, plan, build, or run our jails, I will speak about it.

First, I needn't tell you that lawyers, and I am not a lawyer, do not agree as to the significance of presumption of innocence. Ex-Attorney General Mitchell, for example, arguing for preventive detention said:[1]

> The presumption of innocence is not a presumption in the strict sense of the term. It is simply a rule of evidence... there is no basis for thinking that the presumption of innocence has any application to proceedings prior to trial.

One of Mitchell's predecessors as Attorney General, Ramsey Clark, arguing against preventive detention, wrote:[2]

> The presumption of innocence should not be lightly discarded. It has elemental force. Its spirit is embodied in the Eighth Amendment. It establishes the relationship between the individual and the state, implying that every person is worth something, may have dignity and be deserving of trust. In questions between citizen and state, the presumption is — and must remain — that the individual will prevail until society proves him a criminal beyond a reasonable doubt.

Legal scholars have lined up on both sides of this issue, one calling it the "bedrock, axiomatic, and elementary principle...of our criminal law",[2] while another termed it an "indulgence in self-deception... pretense and fiction."[3]

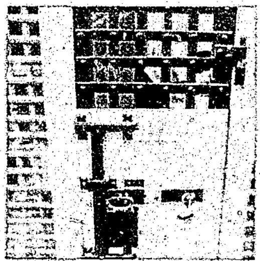
There is no reference to "presumption of innocence" in our Federal Constitution. Jeff Thaler of the Yale Law School recently has done some research on the subject and traced the concept back to Deuteronomy and through the Greek and Roman law to the English and then to the American colonies. In 1657, the Massachusetts Codes held that "in the law every man is honest and innocent unless it be proved to the contrary."

The Judiciary Act of 1789 which translated the Judicial Articles of the Constitution into practice, equated the right to bail provision of the Eighth Amendment to the presumption of innocence.

Since then there has been a long line of court opinions and rules of procedure which uphold the concept and its corollary, the right to bail. For example, in *Stack v. Boyle* (1951), the Supreme Court held that "the traditional right to freedom before conviction permits the unhampered preparation of a defense, and serves to prevent the infliction of punishment prior to conviction...unless this right is preserved, the presumption of innocence, secured only after centuries of struggle, would lose its meaning."[4]

Whatever the doubts in the minds of legal scholars may be, there appear to have been no such doubts until very recently in the minds of the people who planned, built, and operated our jails.

Just one example. Between 1940 and 1970 Roy Casey was undoubtedly the most influential force in jail construction and operations in the United States. He prided himself in the title "Certified Jail Consultant." For many years he was Chief of the Jail Inspection Services to the Federal Bureau of Prisons and after his retirement in 1957, he crisscrossed this country helping counties to design their jails. He was much sought after by the steel companies who fabricated jail equipment. In 1958 he wrote a book called *The Modern Jail — Design, Equipment, Operations.* Until the creation of the National Clearinghouse for Criminal Justice Planning and Architecture in



"...only one purpose, that of detaining criminals..."

1971, this little book served as the Bible of Sheriffs and jail wardens, of steel companies, and of architects. For some it still does.

Page 1, Chapter 1 of Casey's book sets the tone. The "jail is a highly specialized institution and is built *for only one purpose, that of detaining criminals..."*[5]

"Only one purpose – that of detaining criminals." There is no indulgence in self-deception, no pretense or fiction, in that statement. It is straight to the point and in the eighty-nine pages which followed Casey spelled out how to build and operate jails that would indeed hold "criminals." He designed hard, hard jails with inside cells, multiple iron grilles, small "bull-pen" types of day rooms, closed visiting, and limited movements. Most of these jails were inoffensive – even pretty – on the outside but all boiler plate and cages on the inside.

In my 1973 book I described the result as follows:[6]

> Our first impression of almost all the new jails we inspected was that they were designed in hypocrisy. Often built as part of a criminal justice complex or civic center, they are frequently, on the exterior, inoffensive and even attractive structures. The approaches are attractively landscaped, sometimes even including fountains and reflection pools. One warden proudly noted that no bars are visible to outsiders – a now frequent ploy.
>
> The overwhelming impression, once inside, is that the modern American jail, like its predecessor of the last century, is a cage and has changed only superficially. The concepts of repression and human degradation are remarkably intact.

And there is nothing about them that would suggest the possibility of innocence, that would permit the untampered preparation of a defense, or would not add up to the infliction of punishment prior to conviction.

I have visited literally hundreds of American jails – one built as early as 1817 and another scheduled to be opened this month. Almost all of them, the architecture and the operations, speak loud and clear to Casey's single purpose, "that of detaining criminals." They are mute on the subject of "presumption of innocence." In fact, they are in general the most restrictive, most regressive, most inhumane, most punitive segment of our entire penal-correctional system.

We who work in correctional and especially in jail operations have not been in the vanguard of those demanding that our jails be basically transformed. There are many reasons for this. From our experience we know that among those who are presumed to be innocent are men and women who are, in fact, notorious, vicious, hardened, and dangerous criminals. They would go to any length to escape.

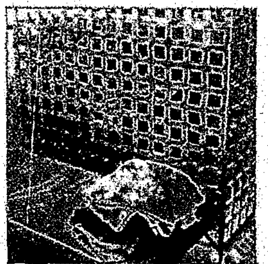
We know, too, that apparently harmless and tractable inmates become violent. Even worse, trusted prisoners who are granted movement rights, ever so often aid the dangerous person to escape.

The "loving kiss" during the contact visit can introduce heroin or other drugs.

As I heard a guard say, just last week, "Those bastards have twenty-four hours a day to figure out how to beat us and they will if we don't beat them first."

All the grilles, prison locks, restrictions, electronic devices, rectal searches, telephonic visiting stalls, remote controlled doors and sally ports are the ways we have devised to "beat them first."

In short, we *question* the applicability of the "presumption" principle to the design and operation of the American jail. Our *quest* is for security and control. In the last few years, however, courts around the country have been demanding that



"They are mute on the subject of 'presumptive innocence.' "

presumption should indeed become part of the design and operation of the American jail. Borrowing from Blackstone, Federal judges are increasingly demanding that:

> In this dubious interval between commitment and trial a person ought to be used with the utmost humanity and neither be loaded with needless fetters nor be subjected to other hardships except such as are absolutely requisite for the purpose of confinement only."[7]

Court decision after court decision had affirmed Blackstone's principle. In *Jones v. Sharkey*, for example, the judge held that "detainees retain all rights of bailees except for the curtailment of mobility deemed necessary to secure attendance at trial."[8]

Compare the "retain all rights of bailees" with Casey's basic principles for jail administration. "All visiting must be through visiting panels. Visiting periods should not exceed twenty minutes and be restricted . . one per week. All mail written and received by prisoners must be censored and carefully examined."[9] Etc., etc., etc.

And in *Hamilton v. Love*, another landmark decision, the opinion stated that "it is manifestly obvious that the conditions of incarceration for detainees must, cumulatively, add up to the least restrictive of liberty."[10]

In establishing "least restrictive" as a principle of jail design and operation, courts have insisted upon differentiation in cell design, availability of both inside and outside recreation, elimination of rectal searches, greater freedom of movement, single occupancy rooms, extensive contact visits, uncensored mail, access to telephones, right to privacy, restriction on search and seizure, and many other requirements that are anathemas to jailers.

It has been a disappointment to me, as a corrections man, to hear and feel the arguments of other corrections persons defending buildings and policies that are diametrically opposed to the "least restrictive" principle required by our Constitution as interpreted by the courts.

Because they are prison people, they argue so often for controls, against movement, against normalcy in visits, against all the things that add up to "least restrictive" and in behalf of all those gadgets and practices that add up to "most restrictive."

I will present one example. Jails, as you know, historically have inside windowless cells with open grilles. Groups of cells are surrounded by a wall of bars. Together this design creates the "cage" syndrome. In addition, the open grilles deprive the detainees of privacy while the windowless inside cells prevent the prisoner from getting so much as a glimpse of the outside world, which has been denied to him only because of his inability to make bail.

Recently a Federal Judge (Lasker) closed such a huge, case-like jail — the Tombs — because its conditions added up to a situation far in excess of any "least restrictive" facility that could be tolerated under the Constitution. New York City, anxious to reopen it, hired an architect who proposed some cosmetic changes. The City then went back before Judge Lasker requesting permission to reopen the place. The petitioners, after careful analysis of the proposed changes, held that the Tombs, under the suggested alterations, would still violate the "least restrictive" provisions. The City engaged some of correction's brightest luminaries who argued, as expert witnesses, that the proposed changes would make the Tombs, Constitutionally, just fine.

In regard to the cage-like inside cells, one correctional leader testified that cells with an exterior view would merely provide "an invitation to attempt at escapes." With complete callousness to the importance of a person's retaining some connection with his outside world; with complete insensitivity to what a person might feel as he toileted behind the open grille required by inside cells; with total disregard for the importance of the privacy provided by outside rooms with their solid, rather than barred doors, he

"We must make the pretrial jail constitutional or we must abolish it."

testified, "From the standpoint of being in the cell itself, I see very little difference whether it is inside or whether it is outside."

The petitioners had argued that the untried had a right to exercise in the open air — to be able to experience the sensory stimulation of the cold wind, the bright sun, or even the gentle rain. To that the correctional expert testified: "I think if a person is confined two, three, four months...that an actual outdoor, physically out of doors facility is not necessarily that important."[11]

Why do we have to defend the past, or the status quo? Why do we always have to defend the rectal search? Oppose the contact or even conjugal visit? Deny freedom of movement from the cell to the law library? Argue against the introduction of work, or play, or school into the lives of detainees? Deny the wearing of personal clothing? Defend the absurd but enforced wearing of red or yellow monkey suits? Invent and support "modular functional units" that would ensure the denial of "least restrictive conditions" for generations to come?

We defend all these because our horizon — at least in regard to those who are untried, presumed to be innocent — is limited by our total absorption with control. Preoccupied with that purpose, we have been oblivious to the basic law of the land.

I paraphrase Orwell's *1984*. Left to ourselves, we would continue, century after century, working and dying not only without any impulse to change but without the power of grasping that the jail could be other than it is.

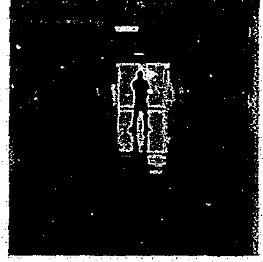
We have not, however, been left to ourselves. First, there have been the courts, already mentioned. Then, in 1971, the Clearinghouse was created with its unfetered, untraditional staff of bright young people questioning the old — questing for the new. Then came the National Advisory Commission and the resulting impetus toward new state standards and goals for jails, followed by the volumes of the National Sheriff's Association and soon the revised Standards of the American Correctional Association.

Sometimes the movement has been slow, causing the courts to prick us again. For example, a member of the National Advisory Commission on Criminal Justice Standards and Goals, testifying in the Tombs case, said that standards were really goals to be obtained one future day, but in the meanwhile the very restrictive conditions of the Tombs were quite acceptable. The Court retorted, "With regards to the presumption of innocence and the least restrictive conditions looking to the future is altogether absurd."[12]

I agree with Judge Lasker's impatience. What is a Constitutional right, he suggests, is today's right. It cannot be delayed until tomorrow. But we know, as he knows, that the meaning and impact of the American Constitution evolved and both are still evolving. In 1789 the Constitution affected, essentially, only white male landowners. In the ensuing 188 years it has spread its protections to the merchant, the craftsman, the laborer, the slave, the freedman, the woman, the child, and now to the prisoner. It has become the twentieth century's secular expression of a twenty century old enjoinder, "As you do it unto the least of these, my brethren, you do it unto me."

Court decisions which impel us, and standards and goals that guide us, are and should be visions. By their very nature they are something to be attained. Born of the present, they are the future which so soon will be the present. Our responsibility is to both generate and actualize those visions. In this, the twenty-first decade of the American experiment, our task no longer is to question the applicability of the presumption of innocence to the pretrial experience. We must make the pretrial jail constitutional or we must abolish it.

That may sound like the impossible dream, the unreachable star, but that must be our quest.



Foot Notes

1. Quoted from Jeff Thaler's unpublished paper, "The Presumption of Innocence and its Application *Prior* to Trial," Yale Law School, July, 1976.

   Mr. Thaler participated with me in a workshop on the Judiciary and the Jail at the Yale Law School. The workshop was financed by the Guggenheim Foundation, and conducted by Professor Dan Freed. I very much appreciate Mr. Thaler's sharing this important paper with me. I am indebted to him for widening my understanding of the subject.

2. *In Re Winship*, 90 S.Ct. 1068,1072 (1970). (Quoted in Thaler)

3. George P. Fletcher, "The Presumption of Innocence and the Soviet Union", 1968 UCLA Law Review. (Quoted in Thaler)

4. *Stack v. Boyle*, 342 U.S. 1 (1951).

5. Casey, Roy, *The Modern Jail*, Continental Press, 1958, p. 1.

6. Nagel, William G., *The New Red Barn*, Walker & Co., 1973, p. 20.

7. *4 Blackstone's Commentaries 300.*

8. *Jones v. Sharkey*, Civ. No. 4948, (D.R.I. June 7, 1972).

9. Casey, *Op. Cit.*, pp. 84-88.

10. *Hamilton v. Love*, 328 F.Supp. at 1194 (E.D. Ark. W.D. 1971).

11. Transcript of testimony, *Rhem v. Malcolm*, 507 F.2d 333, 1974.

12. *Ibid.*

Senator BAYH. Our hearing will come to a close at this point.
[Whereupon, at 1:30 p.m., the subcommittee adjourned.]

CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS

FRIDAY, JULY 1, 1977

U.S. SENATE,
SUBCOMMITTEE ON THE CONSTITUTION
OF THE COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met pursuant to recess, at 10:10 a.m., in room 2228, Dirksen Senate Office Building, Senator Birch Bayh [chairman of the subcommittee] presiding.

Staff present: Nora Manella, counsel; Nels Ackerson, chief counsel and executive director; Mary K. Jolly, staff director; and Linda Rogers-Kingsbury, chief clerk.

Senator BAYH. We will reconvene our hearings this morning.

Our first witness is Mr. Stephen Berzon, Legal Director of the Children's Defense Fund here in Washington. He successfully brought the *Gary W.* case, a suit challenging Louisiana's practice of sending hundreds of children out of State to foster care facilities in which conditions were often atrocious.

Mr. Berzon, we appreciate your taking the time to be with us.

TESTIMONY OF STEPHEN P. BERZON, LEGAL DIRECTOR, CHILDREN'S DEFENSE FUND

Mr. BERZON. Thank you, Senator Bayh. I'd like to thank you for inviting me to testify here today.

Not only have we been involved in the *Gary W.* case and in other cases challenging institutional conditions and the overinstitutionalization and inappropriate institutionalization of children but we have also recently completed a study of children out of their homes in seven States. I would like to report briefly today on some of the findings in that study.

I will not repeat at any length the written testimony. I would ask that it be introduced into the record and I would like to highlight that testimony.

Senator BAYH. We will place it in the record.

Mr. BERZON. In view of our experience with regard to children out of their homes in residential facilities of various sorts, we would like to express our strong support for the enactment of S. 1393.

In introducing this bill the chairman of this subcommittee stated that it is intended to encompass all facilities in which prisoners, pretrial detainees, juveniles, the mentally ill, the mentally retarded, and the physically handicapped, and the aged reside. We agree with Senator Bayh's purpose. This bill is urgently needed and in no area

is it more necessary than in the case of our Nation's most vulnerable children.

I would like at this point, Senator Bayh, to commend you not just in introducing S. 1393 but also for the work you have done over the years in the Senate for the deinstitutionalization of children.

Taking children out of facilities that they do not need to be in and having them placed in the least restrictive alternative within reasonable proximity to their families is something that we need. We believe this bill will work in that direction as well and we very much appreciate the work that you have done in this field over the years.

Senator BAYH. Thank you. Both of us have been missionaries in the same struggle for quite a while.

Mr. BERZON. I would like to share some of the experiences and findings that have led us to make our recommendation that S. 1393 be enacted.

As you described in introducing me, the *Gary W.* case involved the sending of hundreds of children away from their homes to institutions in Texas. This case involved virtually the entire spectrum of children who need the protective coverage of this bill. It involved handicapped children, mentally retarded children, children who were emotionally disturbed, children who were status offenders and children who were delinquents. Some were just hard-to-place children. They were preadolescents or adolescents, or were minority children. The State claimed that it could not find homes for them.

Senator BAYH. Were most of these young people low-level offenders and nonoffenders, or were there a large number of young people who had committed violent crimes?

Mr. BERZON. There were no violent offenders in this category.

Senator BAYH. Is it fair to say that most of them were children whose offenses would not have been considered criminal acts had they been adults?

Mr. BERZON. That is correct. The overwhelming majority of the children were either dependent or neglected which meant that their parents had neglected them or abandoned them or their parents had homes that were deemed inappropriate. Or they suffered from handicaps and their parents needed assistance. The assistance that the State offered was these institutions in Texas.

Some of the children were status offenders. They had committed offenses that would not have been unlawful if they were adults.

In a very small minority of some instances there were delinquents. There were no violent delinquents at all. Those children were put into the Louisiana Training Institute in Louisiana.

While the children suffered from different conditions, what they shared in common was that they were all placed with State funds, they were all cut off from their families and loved ones, and none of them received treatment.

Many of the children were placed by the State in the most atrocious conditions. Judge Rubin found that in certain facilities children were physically abused, handcuffed, beaten, tied up, kept in cages, and overdrugged with psychotropic medication.

I would like to point out that these atrocities did not occur in the giant warehousing institutions about which this committee has heard much testimony these past weeks. They occurred in relatively small,

privately owned residential treatment centers or large group homes.

One such home, Peaceful Valley, was reported to keep children in cages.

One woman who testified at the trial indicated that her son lost the use of his legs while he was placed there by the State.

For this group of vulnerable children who have been separated from the families that would ordinarily act to protect them it is clear that abuse is not confined to the boundaries of our large public institutions. It is essential that the bill reported by this committee cover all of the types of facilities in which children reside under State auspices, whether they are large or small or public or privately owned.

The *Gary W.* case is especially relevant to this committee's proceedings, not only because it illustrates the need for Federal judicial intervention to protect a wide group of vulnerable children but because the Justice Department intervened in the case and played an indispensable role. There were over 40 private institutions named as defendants in the case. We had very little idea what was going on behind those closed fences and institutional walls. The Justice Department was able to hire panels of experts and through the discovery process to have those experts visit the institutions.

In addition, we were able to take some 25 to 30 despositions, and the Justice Department was able to commit the resources necessary to do this job.

As a result of this case, these children are currently being brought home. There is a Lousiana State University Medical School team that is evaluating every single one of these children in Texas and proposing individualized treatment programs for them in accordance with the principle of placement either with their families with services, or in the least restrictive setting within reasonable proximity to their families.

I am getting, on a weekly basis, a series of individualized reports. They come in two forms. We get the LSU placement recommendation, and then shortly thereafter, we get the report from the State describing the placement they have found for the child. I can assure the subcommittee that these children are being placed in foster homes, in group homes, or with their families near their homes and it can be done. It is because of the Justice Department's involvement in this case that we were able to accomplish this result.

The situation in Louisiana is not unique to that State. Our study of seven States revealed that in those seven States as well—and they were Arizona, California, South Carolina, South Dakota, Massachusetts, New Jersey, and Ohio, we tried to pick a broad spectrum—repeatedly children are removed from their homes unnecessarily. If their parents were provided preventive services, they would not have to go into care.

The children are often placed in inappropriate facilities, often in institutions when they do not have to be institutionalized, and then they are left to linger in foster care indefinitely. A great deal of this takes place at Federal expense under the AFDC foster care program.

The General Accounting Office recently did a study of the AFDC foster care program and found that 25 percent of the foster children under the program are in institutions and almost 50 percent of the

institutions they studied had serious deficiencies. We're not talking about nit-picking violations here. We are talking about children sleeping against gas heaters operating at full power on a hot summer day, dirty, unsanitary conditions, children sleeping in living and kitchen areas, and total inadequate control over prescription and psychotropic medications. In some places such drugs were left in shoe boxes for children to take.

GAO also found that many children are over-institutionalized. Our study revealed that as well. We were told by numerous State officials, in fact we were told in the *Gary W.* case in certain instances, that many children are in institutions who could be placed back in foster homes or in group homes.

In the *Gary W.* case we had one plaintiff named Joey G. Joey G.'s case really puts the issue well. Joey G. was a child who in 1965 was a perfectly normal child. He was 2 years old. His mother had been married. Her husband deserted her. She had four other children. She applied for welfare and was unable to obtain welfare because at that time the husband had to be out of the home for 6 months. That law was subsequently declared unconstitutional.

The welfare department told her that if she placed the children in foster care they would be eligible for AFDC support immediately. So she placed the children in foster care. She was told she could get the children back. A number of months later she tried to get the children back and they told her, no.

She visited the children on a regular basis. In Joey's case she visited him as often as two or three times a week. The case record is full of descriptions of Joey crying when his mother would leave him. Joey was in three foster homes over a 3-year period and finally his mother remarried and the welfare department allowed her to take back four of the children but didn't allow her to take back Joey. They claimed Joey was disturbed. No wonder he was disturbed. He wanted his mother.

They sent him to an institution in New York. He stayed in that institution for 8 years. His mother never saw him during the 8-year period. She could not afford to go up to New York.

She called the welfare department. This is all in the official case record. She called the welfare department on numerous occasions to have Joey returned and brought home for visits. Each time they said that it would be inappropriate.

The record shows that the institution said on a number of occasions that Joey should either be sent home if the home was a good home, or placed in a foster home in New Orleans. All he needed was special education which could be provided in public school.

The home must have been a decent home because the State was not taking away Joey's mother's other four children, his brothers and sisters. They were allowed to stay in the home.

Finally the institution raised its rates. The State did not want to pay the higher rates so it sent Joey to an institution in Texas, the East Texas Guidance and Achievement Center, one of the defendants in our case.

To make a long story short, the State still would not return Joey even for a visit. His mother obtained a special education placement in New Orleans for him and they still would not return him. As a

result of the work of CDF and the Justice Department, he was returned.

Not only is he now doing fine back with his family but he is not even in special education. He is in a regular academic 10th grade program and is doing extremely well. The first few months were very difficult. He had been away for 10 years. But it is now working out.

The Justice Department's involvement in the case helped to make that possible and there are lots of kids in this country who are in Joey's position.

Some may say that the States can protect these children, but the facts are that the State is too often, for bureaucratic reasons or otherwise, a neglectful parent. At times it has even been an abusive parent in terms of ignoring or losing track of children, or placing them in harmful surroundings.

Others have said that this act may burden the States. This act cannot possibly burden the States. First of all, the track record of the Justice Department in picking pattern and practice cases has been extremely good. There have been few situations, if any, where the Justice Department over these recent years when they have been bringing cases for children in institutions, has litigated cases that were not crying out to be litigated.

But even if the Justice Department were to make a mistake and were to institute litigation that should not be brought, the worst thing that would happen to the State is that they would have to defend the case. The judge would then say, "yes; the State is correct. The Justice Department is wrong."

So the State has very little to lose. But the children have an enormous amount to lose because if the Justice Department is right and if the children are suffering in unconstitutional conditions and are being abused it is essential that they be protected.

We have some minor technical recommendations to make about the language of the statute, but I will not repeat those here. They are in the written testimony. We think that S. 1393 has been drafted very well. It is a very sound piece of legislation. Many of the difficulties that we testified about on the House side are simply not present here. It does by and large cover virtually all children out of their homes where there has been State action. We think it is an excellent piece of legislation.

Finally, I want to close by commending the author of S. 1393 for not including an exhausiton of State administrative remedies provision. The Supreme Court has consistently declined to read such a requirement into section 1983 of the Civil Rights Act. We think if there were ever a context in which exhaustion should not be required it would be the context of institutionalized persons whose constitutional rights are being denied.

We are not dealing here with a fixed body of rules where the State simply made a mistake that a hearing officer can correct. We are dealing with the basic questions of liberty and sometimes even life. We are dealing with highly politicized cases. We are dealing with a situation where much of the information is behind closed walls and the discovery process is necessary. We are dealing with a situation where time is critical and a preliminary injunction may make all the differences in terms of the development of a child or in terms of

whether the institutionalized person is going to continue to suffer in unconstitutional confinement.

So, we would hope that in reporting a bill—and we hope this committee does report a bill—that the committee will not insert an exhaustion requirement.

Thank you very much.

Senator BAYH. Thank you.

In the *Gary W.* case, were the authorities approached before the suit was initiated? Was an effort made to get the State, by its own volition, to change the practices which the court ultimately mandated be changed?

Mr. BERZON. The welfare department was approached on behalf of the named plaintiffs, yes. We requested that the named plaintiffs be allowed to be returned home. In fact, our local counsel in New Orleans I believe was approached by a parent when a child was home on vacation. She explained to him that she wanted her child placed near home, not far away in Texas. He contacted the welfare department and received no satisfaction. We felt we had to resort to litigation. We really had no other alternative.

Senator BAYH. I certainly appreciate your assessment of this bill. We are talking about a pattern and practice of abuse. Would you conclude that that would require involvement by State authorities at a number of foster homes in which the kind of conditions you describe here exist?

Mr. BERZON. Yes; I think that is appropriate. I think the resources of the United States ought to be used for pattern and practice cases. I think it's not easy to define a pattern and practice but it may involve a number of homes or it may involve a number of children. That would depend upon the circumstances of a particular case but it would clearly involve more than an isolated incident or an aberration or mistake on the part of a State official. Anybody can obviously make a mistake in an individual context or an individual case. It would have to be more than an aberration. It would have to be something the State is doing relatively consistently either with regard to a number of children or a number of facilities.

Senator BAYH. I appreciate your suggestions on how to improve the bill. I appreciate the contribution you have made to the committee. I am even more appreciative of the effort that you and your organization have made to try to help defend children who do not have the capacity to defend themselves.

Thank you very much.

[The prepared statement of Stephen P. Berzon follows:]

PREPARED STATEMENT OF STEPHEN P. BERZON

Mr. Chairman and Members of this distinguished Committee: Thank you for inviting me to testify here today on S. 1393, which authorizes civil actions by the Attorney General in cases involving violations of the constitutional and federal statutory rights of institutionalized persons, both children and adults.

I am testifying on behalf of the Children's Defense Fund, a national, nonprofit, public interest child advocacy organization created in 1973 to gather evidence about, and address systematically, the conditions and needs of children in this country. CDF has issued a number of reports on specific problems faced by large numbers of these children, and will issue several more in 1977. We seek to correct problems uncovered by our research through the monitoring of federal and state administrative policies and practices, litigation, the dissemina-

tion of public information and the provision of support to parents and local community groups representing children's interests.

In the course of our litigation efforts, we have in several cases successfully challenged the placement of large numbers of children in inadequate or otherwise inappropriate institutions or other residential facilities. We have also had underway for two years a study of public responsibility for children out of their homes and in child care systems. The study involved an examination of the relevant policies and practices in seven states, and an analysis of the federal role in relation to children at risk of removal from their homes or in or out of home care. In view of our experience with regard to children in residential facilities, we would like to express our strong support for the enactment of S. 1393.

In introducing this bill, Senator Bayh stated that it "is intended to encompass *all facilities* in which prisoners, pre-trial detainees, *juveniles*, the mentally ill, the mentally retarded, the physically handicapped, and the aged *reside.*" 123 Cong. Rec. S. 6411 (April 26, 1977). (Emphasis added.) We agree with this purpose. This Bill is urgently needed. And in no area is it more necessary than in the case of our Nation's most vulnerable children.

Let me share with you some of the experiences and findings that have led us to make this recommendation. In *Gary W., et al.* v. *William Stewart, et al.*, No. 74-2412 (E.D. La.), CDF successfully challenged the state of Louisiana's used of the federally-financed AFDC foster care program to send hundreds of childrn away from their families and home communities to distant out of state residential placements.

This case involved virtually the entire spectrum of children who need the protective coverage of this Bill. Some suffered from handicaps, either mental retardation, emotional disturbances or physical disabilities; some were status offenders or delinquents; still others were just hard to place foster children (e.g., too old or considered the wrong color); some entered residential care on the application of their families, who, in many cases, had no other choice; others were placed through court action. What they shared in common was that, while they resided in a variety of different types of facilities, all of them were placed with state funds, all of them were completely cut off from their families and loved ones, and none of them had had individualized case plans as required by federal law.

Many of the children were placed by the state in the most atrocious conditions. The court found that, in certain facilities, children were physically abused, handcuffed, beaten, chained and tied up, kept in cages, and overdrugged with psychotropic medication.

I should point out that these particular atrocities did not occur in giant public warehousing institutions, about which this Committee has heard much testimony these past few weeks. They occurred in relatively small, privately owned residential treatment centers and group homes, some of which had fewer than 25 children. One such home, Peaceful Valley, was visited by a state official following the filing of the case. He reported to the director of the state agency:

"I had an eerie feeling. The room where most of the children were kept was rather dark and though most of them were awake I was not allowed in the room . . . Evidently most of the children are confined to their rooms and care and management is designed to cause as little work for the operator as possible."

A mother testified at trial that her son, who could walk when he was placed in this home by the state, lost the use of his legs while there.

Clearly, for this group of vulnerable children who have been separated from the families that ordinarily would act to protect them, abuse is not confined to the boundaries of our large public institutions. It is therefore essential that the Bill reported by this Committee cover all of the various types of facilities in which children reside under state auspices, whether they are large or small or publicly or privately owned.

The *Gary W.* case is particularly relevant not only because it illustrates the need for federal judicial intervention to protect a wide group of children, but because the United States intervened in the case and played an indispensable role. The case involved a number of state agencies and over 40 private institutions. In order to learn why and how the children came to be placed by the state in these facilities and what was occurring inside their closed fences and doors, extensive discovery was required. Fortunately, the Justice Department was able to marshall the resources necessary to take a large number of depositions and have a series of expert panels visit the majority of the institutions.

Under the court's decision, the children are now being returned home, either to their families or community placements near their families. Without the evidence put on by the United States, it is likely that the conditions existing in these institutions never would have been brought to light.

The situation that we encountered in the *Gary W.* case is not restricted to Louisiana and Texas. Our study of children without homes in seven states[1] revealed repeatedly that children were removed from their homes unnecessarily, placed in inappropriate facilities, often at great distances from their families, and left there to linger indefinitely, often at federal expense. Overall we estimate that there are between one half and three-quarters of a million children in out of home placements, and that at least 10,000 of these children are in placements in states other than the ones which have responsibility for them. In a stratified random sample survey we conducted of 140 counties, child welfare officials reported that over 20 percent of the children in their care had been in foster care six years or more; over 50 percent had been in care two years or more. Our study and many others, including studies by the General Accounting Office and the HEW Audit Agency, have documented the terrible conditions in which many of these children are placed and left to linger. These children desperately need the protection afforded by this Bill.

Abuse and neglect of children in residential facilities takes many forms. The GAO, in a recent review of 18 facilities housing 13 or more children placed under the foster care provisions of the AFDC program, observed serious deficiencies at seven of the 18 facilities they studied. The deficiencies included children sleeping on mattresses on the floor in cramped and dingy rooms; children's beds pushed up against gas heaters that were operating at full power even though it was a hot summer day; dirty and unsanitary sleeping, living and kitchen areas; and inadequate control over prescription drugs, which in two institutions were left in shoe boxes on desk tops.[2] In our study states, CDF found evidence of punitive and unmonitored seclusion and severe behavioral restrictions.

Many children are over-institutionalized. In each of CDF's seven study states, public officials openly acknowledged that children who did not belong in institutions were placed in them. Similarly, children with special needs were placed in facilities which had no appropriate programs for them.

But there are more subtle forms of abuse as well. Children are abused when they are cut off from visits with their families, when they are placed in care and left indefinitely without any attempt to develop an individual case plan or treatment plan for them, and when no attempts are made to reunite them with their families or provide other permanent homes for them. Our study revealed that the further away a child in care is placed from a family setting, the less caseworker-child contact takes place. For example, 64 of the 140 counties in our survey reported written policies requiring caseworker-child contact. But while 46 percent of the counties reporting require such contact if a child is in a foster home, only 30 percent require contact if a child is in a group home, 25 percent if the child is in an institution and only 12 percent if the child is in an out of state placement. Of the 50 states we surveyed concerning out of state practices, only one-third reported any efforts to visit or specifically review out of state facilities in which they place children, beyond requiring that the facilities be licensed. Two-thirds of the states do not even require case reviews of children in out of state care as a matter of state policy.

In our study we looked not only at children in the child welfare system, but also at the children who have become the responsibility of other public child care systems. All of the child care systems—the child welfare system, the juvenile justice system, the mental health system, the mental retardation system, and the special education system—place children in residential out of home care, pay for them and make crucial decisions about what happens and does not happen to them. And increasingly, all of these public child care systems place children in the same kinds of facilities: foster family homes, group homes, and various sorts of child-care institutions. Thus, it is not unusual to find in a single residence, children who have entered care in a variety of ways. For example, a moderately retarded youth who has been returned to the community after a number of years in an institution for the mentally retarded;

[1] Arizona, California, South Carolina, South Dakota, Massachusetts, New Jersey and Ohio.

[2] "Children In Foster Care Institutions: Steps Government Can Take To Improve Their Care" (Washington, D.C., General Accounting Office, February 1977), pp. 22–26.

a youth who has been determined by the court to be a status offender and assessed by the court psychiatrist to have some emotional difficulties; a ten-year old youth whose mother voluntarily placed him in state care because she had to be hospitalized temporarily and could find no one to care for him at home; all may be placed in the same group facility.

In reality, distinctions among group homes, residential treatment centers, special schools, child care institutions and other specialized institutions become blurred. Good, bad, and even abusive programs are found in each type of setting, and it is important that in reporting this much needed Bill, the Committee insure that all children residing in state supported or administered out of home care are protected by its coverage, whatever the size or label of the particular facility in which they reside.

Some may suggest that we do not need the Attorney General to protect these vulnerable children; that the problem should be left to the states to resolve. Unfortunately, the record reveals that in discharging its fiduciary responsibility to serve as custodian for children who have been separated from their families, the state has proven to be an often neglectful, and sometimes abusive parent.

Our study revealed that state and local officials know little about the children in their care or what is happening to them. Licensing, which theoretically constitutes a core component of the states' efforts to protect children, is ineffective. Even in our two study states that have recently modified licensing procedures and regulations, licensing efforts are still beset with enforcement failures, and the licensing process is isolated from other placement activities. The GAO study referred to earlier concluded that licensing and placing agencies did not ensure that facilities were maintained at acceptable levels. In many states, licensing standards do not address the adequacy of treatment or, for that matter, whether an institution is providing any treatment at all.

Compounding the problem, state placing agencies have been found to use unlicensed facilities. And, HEW audits of the AFDC Foster Care Program have revealed that frequently children were placed in facilities and left to remain there for years, without any reevaluations of the qualifications of the facility, although such reappraisals were required by law.

In the *Gary W.* case, CDF obtained through discovery a report prepared by a supervisory official of the Louisiana Department of Family Services following an investigatory trip to a number of out of state institutions in which Louisiana children had been placed. The report acknowledged such state neglect, concluding:

". . . I have tried to convey the feeling of loneliness and abandonment that our children seem to experience . . . [O]ur agency seems to lose essential contact with our children once they are placed out-of-state. Any such contacts as we do have with them seem to be incidental, not on a purposeful and sustained basis . . . Indeed, the children with whom I was acquainted had progressed, some perhaps enough to be considered for alternate type care. Yet, some simply linger indefinitely in these institutions. I realize this implies dereliction on our part." [3]

The children whom I have been discussing are in pressing need of the Attorney General's assistance, for the stark fact is that they have no one else to speak for them. In some instances, their parents no longer care about what happens to them. Often, however, their families do want to challenge the care their children are receiving, but do not have the capability, capacity, or sufficient knowledge of their children's circumstances to do so. Nor are there others who tend to be in a position to act on their behalf. Foster parents have a contractual relationship with the state and frequently feel inhibited from complaining about the failure of the state to provide services to the children. Other caretakers may be employed by the very agency or facility which is harming the children.

In short, we strongly support the enactment of S. 1393. However, we would like to suggest certain improvements which we believe would better enable the Bill to accomplish its intended purpose for children—"encompass[ing] *all* facilities in which . . . juveniles . . . reside." (Remarks of Senator Bayh, 123 Cong. Rec. S. 6411). (Emphasis added.)

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[3] *Gary W., et al.* v. *William Stewart, et al.*, No. 74-2412 (E.D.La.), Plaintiffs' Exhibit 94, p.4.

Section One of S. 1393 authorizes the Attorney General to bring suit only on behalf of persons "confined" in institutions. The term "confined" could be interpreted to exclude children who reside in otherwise covered facilities, but who have not been formally "committed" to them. Many children enter residential care because their parents voluntarily request the state to accept responsibility for them and place them in facilities, sometimes specialized, sometimes not, where they will be cared for and provided adequate services. For some of these children, parents are required to "voluntarily request" placement in order to get special services for them. Other children enter the child welfare system or the various mental health systems pursuant to a court determination of dependency, neglect or abuse. Although this latter group of children may have been involuntarily removed from their homes by a court, the court frequently does not "commit" them to a particular facility, but rather entrusts responsibility for them to a state child care system, which then makes a placement.

Clearly, the potential for abuse in a facility does not turn on how a child got there. Because of their age and dependency, children are often not free to leave a facility of their own choosing, regardless of whether they have been formally committed. Thus, we would recommend that the term "confined" in line 5 of Section One be deleted and replaced by the word "residing."

Paragraph Five of Section Four, the paragraph pertaining to children, defines the term "institutions" as: "Any facility in which juveniles are *held* awaiting trial or in which juveniles have been *placed* for purposes of receiving rehabilitative care or treatment or for any other state purpose." (Emphasis added.)

We are concerned that the term "held" could be interpreted to exclude children placed in non-secure facilities pending trial. In addition, the term "placed" might be interpreted to exclude those children who have been institutionalized through the voluntary action of their parents.

In order to insure that all of the children I have discussed this morning are brought under the protective umbrella of this Bill, we would suggest that Paragraph Five of Section Four be modified to read:

"Any facility in which juveniles are placed awaiting trial or in which juveniles reside for purposes of receiving care, rehabilitation, treatment or for any other state purpose."

This definition is meant to include all residential facilities in which juveniles reside when they are separated from their natural families or guardians, either voluntarily or involuntarily.

Another matter which should be clarified, probably in the legislative history, is that this Bill is not meant to limit or restrict any existing remedies available to institutionalized persons through private civil rights actions. Clearly, an Act which is intended to expand protection for our most vulnerable citizens should not be allowed to be interpreted in a way that would result in a restriction of their remedies.

It should also be made clear that the use of the term "State or its agent" in Section One includes not only the state, but also local units of government (which often operate public institutions) and private institutions caring for persons with state or local funds.

Finally, we would like to express our strong support for the fact that S. 1393 does not contain an exhaustion of state administrative remedies requirement. The Supreme Court has consistently declined to read such a requirement into Section 1983. We believe that it would be a terrible mistake to break with that precedent here.

Exhaustion is particularly inappropriate in cases involving the constitutional and federal statutory rights of institutionalized persons. These rights protect not only the liberty but sometimes even the lives of the most vulnerable persons in our society.

Cases alleging a denial of treatment or institutional abuse tend to be highly politicized. Both potential witnesses and the administrative decision-maker may be subject to great pressure. Effective relief often calls for the development of institutional reforms which may tread on bureaucratic toes and interfere with agency budgets. In situations of this sort, the administrative process can not guarantee the necessary protection for witnesses and impartiality on the part of the decision-maker.

Challenges to institutional conditions also tend to involve factually complex pattern and practice issues. Usually the discovery tools provided by the federal

courts are the only way to obtain a reasonably accurate picture of what is occurring behind institutional walls.

Time is often a crucial factor. Thus, the ability to obtain an immediate court injunction may be key. The administrative process does not provide for an immediate enforceable order of this kind.

In short, whatever its merits in other contexts, the administrative process was not designed for and is not effective in cases of this sort.

In closing, I would like to thank the Committee for granting me this opportunity to present the Children's Defense Fund's views and urge the adoption of S. 1393 with the modifications we have recommended today.

Senator BAYH. Our next witness is Mr. Paul Friedman, managing attorney of the Mental Health Law Project. He is the author of "The Rights of Mentally Retarded Persons." He has a long-term interest in a number of cases which are the subject of our concern and the motivating force behind this legislation.

Mr. Friedman, we are glad to have you with us.

TESTIMONY OF PAUL R. FRIEDMAN, MANAGING ATTORNEY, MENTAL HEALTH LAW PROJECT

Mr. FRIEDMAN. Thank you, Senator.

I too have prepared some fairly extensive written testimony which I do not intend to read today. I would ask that it be made a part of the record.

Senator BAYH. We will put it in the record.

Mr. FRIEDMAN. First, I would like to say that on behalf of the Mental Health Law Project, I am grateful that we have been invited to testify today on S. 1393, which the project views as a vitally needed piece of legislation.

The Mental Health Law Project is a public interest organization that has been engaged for the past 5 years in law-reform advocacy on behalf of mentally ill and mentally retarded persons.

As you nicely recognized, we have been responsible for legal research and litigation which have established a number of constitutional rights for those whom we think of as the "consumers" of mental health and mental retardation services both in institutions and in the community.

In my time this morning, I would like to highlight some of the major points made in my written testimony.

The first point that I would like to stress today is that there is a documentable and universal national emergency involving our country's mental institutions, perhaps even more shocking and disquieting than some of the very harsh conditions we know exist in our country's prisons.

Second, I would like to amplify the point that mentally ill and mentally retarded adults and children in public residential facilities do have a number of what are now clearly defined and accepted constitutional rights and that these rights are, in fact, being violated every day.

Finally, other sources of advocacy—and I think this is a crucial point for S. 1393—are at present completely inadequate to meet the need—the underrepresentation and violation of rights in these institutions. Participation by the U.S. Attorney General with his resources for maintaining complex and protracted litigation of the pattern of practice variety, which you were just discussing with Mr.

Berzon, is indeed indispensable to further what is already a well-established congressional concern for protecting the civil rights of persons institutionalized in mental facilities.

In this connection I would take strong exception to the position of certain State attorneys general whom I gather have testified ahead of me. I want to take exception to their suggestion that there are many other kinds of effective and adequate outlets to protect the rights of mentally handicapped persons and that, therefore, there is no need for participation by the Justice Department. The facts are very much to the contrary.

To begin with the first of these major points the plight of the residents at Rosewood State Hospital in Maryland which gave rise to the *Solomon* case represents a national problem which has resisted solution for decades. The evidence solicited in pretrial discovery documented overcrowding, lack of program staff, and use of behavior modification drugs. And as I am sure you recall, Mental Health Law Project staff had occasion to testify in previous hearings before your Subcommittee to Investigate Juvenile Delinquency about the terrible problem of overmedication and unnecessary polypharmacy in facilities for mentally ill and retarded children.

Senator BAYH. Yes, your testimony was very helpful in those hearings. I think most people would be shocked and unwilling to accept the idea of physical restraint such as tying children to beds. Amazing as it may seem, apparently it is still going on in some places.

But the use of drugs is not as obvious. But, considering what these "mental handcuffs" do to the person, it is just as detrimental.

Mr. FRIEDMAN. The project is appreciative of the concerns that you personally have shown for this issue in the past. We agree completely that chemical restraints are every bit as damaging, perhaps even more so than the physical restraints. Yet they are somewhat more subtle. If an average observer goes into an institution he sees children who are drugged to the extent of being zombies. He assumes this is part of their mental disability rather than a condition superimposed on the problems which caused commitment in the first place. The drugs have been used for control purposes because the staffing is woefully inadequate even to maintain safe custodial conditions, let alone to provide the kinds of services such persons need in order to improve their condition or functioning and then to return to the community.

This condition was documented in the record at Rosewood and is typical in case after case that has been brought on behalf of mentally handicapped persons.

The failure of such institutions even to protect the very basic physical safety of the mentally retarded citizens, predominantly children, confined there: For example the Willowbrook court found deterioration rather than improvement, the loss of an eye, the breaking of teeth, part of a resident's ear bitten off by another resident, frequent bruises and scalp wounds.

Senator BAYH. Unfortunately there are some people who do have extreme mental abnormalities which cause them to engage in violent behavior; these people do need some type of institutionalization. But these people have been comingled with others who could lead a more normal life. That compounds the irresponsibility.

Mr. FRIEDMAN. There is no doubt about that, Senator. In addition, the evidence presented by distinguished experts in psychology, special education and vocational rehabilitation makes it clear that if institutions had active rehabilitation or treatment programs and if they had a stimulating environment, then much of the bizarre or physically dangerous or antisocial behavior of the residents would be eliminated. It is because these people are, in effect, locked in closets with no stimulation, no staff contact, no guidance, no active programs, that they regress further. They lose functioning skills that they had even when they entered the institution. They develop the kinds of antisocial and physically abusive behavior which, again, the average visitor might assume was an inherent part of mental illness or retardation. In the vast majority of cases, of course, it is not.

I would like to stress for the record that except for a small population in the mental-illness area who have been found not guilty by reason of insanity or incompetent to stand trial, the overwhelming majority of persons in these institutions have not even been accused, let alone convicted of any antisocial or criminally proscribed acts. They are some of our very most needy and vulnerable citizens because of the special disabilities from which they suffer.

In common sense terms, the commitment of such persons to State institutions is always premised on the rationalization that they will get services, rehabilitation treatment or training so that they can go back to the community. Instead, they go into these institutional warehouses. They are trapped and often spend 5, 10, 20 years or a lifetime there. Even though there is a trend toward deinstitutionalization in our society, the fact is that, when a mentally retarded person spends more than a year or two in an institution, the chances are that he will live his entire remaining lifetime in the institution.

I can't begin today to fully document the institutional abuse suffered by residents. I have not been able to attend previous days of hearings on this bill. I am sure you have heard a lot of documentation of such conditions. I do not think it is necessary to go on.

In my written comments I have reviewed some of my personal experiences in these areas because I do feel that the rock bottom issue here is what the conditions are like for some of our country's most helpless and vulnerable citizens and how badly they are being discriminated against and how clearly they are treated as second-class citizens. They are suffering very basic violations of their rights as human beings, their rights as citizens under our Constitution.

I think it is very important to keep these facts foremost in mind while we do the other important work of justifying S. 1393 in terms of the inadequate advocacy resources, the cost implications or whatever minor technical comments I might have about the bill as it is presently drafted. Essentially I agree with Mr. Berzon that it is a well-drafted piece of legislation. It is well-suited to meet an important need.

As Federal District Judge Johnson said in Alabama in the *Wyatt* case, "What is at stake in these cases is the very preservation of human life and dignity." Maybe it would help to have a brief view of the numbers of people affected because some people have tried to minimize this problem.

There is a statistical analysis compiled by the National Institute of Mental Health in 1975 which indicates that each year 435,000 persons are admitted to State and county mental institutions.

It was estimated by NIMH in 1972 that about 1,600,000 persons were confined at some time during the year in inpatient psychiatric facilities. The reason for the difference in those figures is that the first one covered only State and county facilities.

Senator BAYH. What was the first figure again?

Mr. FRIEDMAN. The 435,000 persons were persons admitted to State and county public mental institutions in the year 1975. The 1972 figure showed 1,600,000 persons confined at some time during that year in in-patient psychiatric facilities.

I think the major difference is that the larger figure covers the full span of psychiatric institutions in our country, private as well as public, and VA as well as State and county public institutions.

At any one time in our State and county public institutions, it is estimated that there are about 200,000 mentally ill persons confined. Some are—and remain—in chronic back wards and some are in front wards, in the revolving door kind of situation. Therefore, the number of people passing through the system and subject to quite serious harms is much larger than the 200,000 who are there at any one particular moment. And that is just mentally ill people.

It is reported that there are an additional 190,000 persons in public residential facilities for the mentally retarded. Most are defined as having either profound or severe mental retardation.

Mr. Berzon has already eloquently documented the very serious problems affecting children. They may have double impairments. They may have a mental handicap, and because they are not adults, they may be unable to protect themselves to the extent that even mentally ill or retarded adults might be able to. I think it is worth flagging that the National Science Foundation's Advisory Committee on Child Development found a total, depending upon definitions, of from 250.000 to 500,000 children who live in public and private residential institutions and who are, for the most part, members of minority groups in our society.

That is a little bit about the dimensions of the problem in terms of the number of people affected.

I understand that at previous sessions of the subcommittee, some witnesses have questioned whether in fact there is a constitutional right to protection from harm to which these persons are entitled when they are committed to public mental institutions. I would like to state for the record that mentally ill and mentally retarded persons, to my knowledge—and I've been working full time and actively in this field now for 5 years and I believe I have thoroughly researched the issue—have never lost and have usually explicitly prevailed in every single court case that has been brought. Some of these are at the trial levels and others were necessarily on appeal. But they have never lost where they have asserted that the Constitution guarantees a humane and safe environment and a certain minimum level of adequate services either under a constitutional right-to-treatment or constitutional right-to-protection-from-harm theory. The first is based on the due process clause of the Constitution and the latter based on the eighth amendment's guarantee about protection from cruel and unusual punishment.

There can be quite complicated legal theories extrapolating the due process right to treatment because, of course, it is not anywhere expressly provided in our Constitution. Briefs can take up many pages with these legal arguments. But I think it is hard to quarrel with the basic notion that when we take people and involuntarily commit them on the basis that they are suffering from a mental disability, when they have not done any criminal act and when the only legitimate justification that is given in every instance is that we are doing this for the good of these people, then to deprive them of their liberty without giving them any services in these very damaging conditions would violate elemental principles of fairness.

Senator BAYH. Most significantly, as you pointed out, regardless of what legal arguments they make, the defendants have never won any cases. The courts have always ruled in favor of the plaintiff.

Have any of the cases differentiated on the basis of whether a patient was voluntarily or involuntarily committed?

Mr. FRIEDMAN. That distinction comes up most often between cases affecting mentally retarded persons and cases concerning mentally ill persons. In a case like *Wyatt*, which was the first in which the Federal district court reached the issue and found there was a constitutional right to treatment, the evidence was clear that almost all of the persons in the mental institutions were involuntarily committed. There the basis for the right to treatment was the due process clause which, of course, protects deprivation of life, liberty or property without due process of law. So in order to derive the substantive due process right to treatment one needs to find an involuntary deprivation of liberty.

Then there was a lot of discussion in scholarly journals whether that right would extend to persons whose admissions were labelled "voluntary." Presumably there voluntary admissions did not involve any involuntary deprivation of liberty that would have involved due process.

But this has been clarified substantially and most importantly in the *Willowbrook* case in New York which concerned mentally retarded residents, largely children who were "volunteered" in by their parents. At first, on a motion for preliminary relief, the district court showed some skepticism about whether these persons would have a constitutional right to treatment. But the judge said immediately, and stuck to this throughout the case, that at a minimum when a State agrees to take the responsibility for these people, whether on a voluntary or involuntary basis, then it has an obligation to protect them from harm. This is in keeping with the eighth amendment.

It was feared that that would mean a lower standard of protection for these people because when the eighth amendment has been used to protect against extreme abuses in the prison system, it has been interpreted just to protect against shocking and horrendous conditions. The right-to-treatment theory, of course—and the detailed standards ordered by Judge Johnson to implement it in Alabama institutions—went much further. These standards require affirmative services and programing.

But what happened by the time 50 experts had been presented and 3,000 pages of expert testimony had been gathered in the *Willowbrook* case was that the court became convinced that without affirmative program and affirmative efforts to provide services to the

residents of an institution, their functioning would inevitably deteriorate and they would be harmed. Once that fact had been proved to the judge's satisfaction, he ratified in very strong terms a consent agreement arrived at by the parties, providing protection from harm for all the residents, voluntary as well as involuntary. And he concluded that the consent judgment in *Willowbrook* reflects the fact that protection from harm, which applies to all residents, requires extensive relief because harm can result not only from abuse but also from the absence of programs and from custodial conditions that cause regression.

This brings me to the final points which I would make this morning, having to do with the adequacy of resources to protect the rights of this disadvantaged and vulnerable minority group.

In the fuller written testimony I tried to give you a complete listing of the right-to-treatment and protection-from-harm decisions that my colleagues and I have been able to locate. We also list a large number of Federal statutes that Congress has enacted in recent years, including the Developmentally Disabled Assistance Act and Bill of Rights Act, the Rehabilitation Act with its antidiscrimination provision, the Education of All Handicapped Children Act and so forth. There is the Juvenile Justice and Delinquency Prevention Act with which you are well acquainted. This shows a strong commitment which Congress has already expressed in this area.

The United States also has a strong financial interest in protecting its investment of funds in State institutions. For example, in the *Rosewood* case, where the Justice Department was denied standing and which necessitates the legislation we are considering today, that institution for retarded citizens had received $14 million in Federal funding in fiscal year 1974–75. The United States has invested millions and millions of dollars at other institutions and in programs for the mentally handicapped. I think the ability of the Attorney General to file suit in appropriate cases is one of the necessary mechanisms by which Congress can insure that this very substantial investment remains a sound one.

Senator BAYH. Mr. Friedman, are you familiar with the *Rosewood-Solomon* case?

Mr. FRIEDMAN. I've read some of the papers and the decision of the district court.

Senator BAYH. You were not personally involved?

Mr. FRIEDMAN. No, I was not personally involved.

The project did submit an amicus brief supporting the authority of the Justice Department to bring such litigation based upon inherent authority, but that's an issue that the courts have not yet resolved. Of course, it's an issue the resolution of which this proposed legislation would make unnecessary. This bill would clarify the situation, which we believe is very important.

Senator BAYH. I'm trying to find out just what the factual situation is or was. Yesterday the attorney general of the State of Maryland protested very indignantly that the Justice Department had gotten involved in the case without informing him and without any effort to get the State to initiate action and to solve the problem voluntarily.

I will find out what happened. I wondered if you had any personal knowledge.

Mr. FRIEDMAN. I cannot speak to that specific situation.

In my personal experience there was always an attempt to negotiate by the plaintiffs' lawyers and by the Justice Department, when it was involved, and to get administrative reform using litigation as a last resort. I would note, however, that sometimes one comes upon a situation where the abuses are so great and the situation is so precarious that one feels it is urgent to initiate action, perhaps to get a temporary restraining order or a preliminary injunction.

In other cases one hears that there has been a 5- or 6-year history of trying to get reform through the administrative processes. One can in good faith decide that going that route for another year or two will not do any good but that it is better at least to file a complaint and to put the State on notice. Then one can proceed to negotiate when the State knows that somebody means business and that a court will hear this issue if there is no progress.

Personally, that does not seem to me to be an inappropriate approach in certain situations.

Senator BAYH. I will find out the facts, but I thought you might be familiar with them.

Mr. FRIEDMAN. No; I am sorry. I cannot speak specifically about Rosewood. I do know that in hearings on a similar bill introduced by Congressman Kastenmeier in the House a number of attorneys general raised that concern and also expressed the view that participation by the U.S. Attorney General simply is not necessary, that the resources by other organizations such as the Mental Health Law Project are adequate to remedy the situation. I could not disagree more strongly with those assertions.

It is obvious that the people we are talking about have little or no access to lawyers because of their total confinement in institutional warehouses, often deliberately located "out of sight and out of mind," far from population centers. The people in these institutions, the NIMH statistics show, are typically indigent and without resources to pay for counsel. They tend to be from racial minority groups and from lower socioeconomic classes.

The law often considers them incompetent to bring suits in their own names, and many of them, because of their particular mental disabilities, simply cannot know or comprehend what their legal rights are or know how to vindicate them effectively.

These people are also particularly subject to intimidation, harassment, and retaliation from the custodians who have the power to release or keep them confined. Mentally retarded persons are often very suggestible and very afraid to defy authority.

In my experience very rarely if ever will State agencies who are part of the same "executive family" responsible for advising the commissioners and superintendents on a day-to-day basis bring suit on behalf of the residents against their executive family members.

What about resources of groups other than the Justice Department? In my formal testimony I cite the present capacities of legal service and public nonprofit advocates to make it clear how desperately participation by the Justice Department is needed.

The legal services program describes its own capacities as "woefully inadequate to keep pace with the demand." I think that is a fair conclusion.

Even though no figures are available on the number of cases being handled by legal services lawyers for institutionalized persons, I know that the inability of those persons to get to lawyers' offices, as well as the very heavy caseload and small budgets of our legal services attorneys, dedicated as they are, make the kind of protracted expensive institutional litigation, like the pattern in practice litigation which this legislation aims at, almost impossible for legal services to bring. It means that the subclass of poor persons in our institutions now receive even less legal representation than poor people in general.

The resources with the private advocacy groups are even fewer, a mere drop in the bucket. In 1975 the budget of all tax-exempt public interest law centers in the United States was approximately $40 million. That is less than the combined income of just two of the major Wall Street law firms. That budget has to cover environmental actions, health actions, consumer actions, welfare actions and housing actions as well as activities on behalf of mentally retarded and mentally ill persons in our public institutions, prisoners and children confined to a variety of State institutions.

The Council on Public Interest Law did a survey. It found that of the 92 public interest law centers that responded to the survey questionnaire only two of them had a client population consisting principally of mentally handicapped persons.

I heard in the testimony on the Kastenmeier bill in the House that groups like the mental health law project could bring these cases and that the Justice Department was not necessary. I would only mention here, as I did there, that the project has had from 4 to a maximum of 7½ lawyers during the past 5 years. A single major case, like the *Gary W.* case or the *Wyatt* case or the *Willowbrook* case, could entirely exhaust the resources of an office such as ours. Although we are generally regarded as the major public interest organization bringing litigation affecting mentally handicapped persons, we could not possibly have even done one of those cases without a joint efforts with legal services attorneys and without the participation of the U.S. Attorney General.

The *Willowbrook* case has cost over $50,000 simply in expenses. That does not include lawyers' fees or salaries at all. That's over the last 4 years. It will continue in its implementation phase for a long time. We have learned that when you get a good paper decree proclaiming constitutional rights, that that is only the first step in a very long and hard process. In case after case, we have had to go back to ask for subsequent hearings on the implementation phase of a right-to-protection-from-harm, or right-to-treatment decree. Public interest lawyers, because of the very low salaries that we are able to pay relative to private practice and because of the emotional drains of this kind of work, do not stay on indefinitely. There is a changeover. The Justice Department can provide a kind of ongoing presence and stability, as well as a special expertise that is very lacking in the bar at large at this time.

In the end, of course, the court cannot do it all. But all who are knowledgeable in this area agree that these cases have led to meaningful improvements. We need more of the same. Barring some unlikely circumstance, such as a massive infusion of funds into the legal

services programs or into public interest advocacy groups, it is impossible to think that civil rights will be vindicated for mentally handicapped citizens in our public institutions without the continued presence and resources of the Department of Justice.

In the written testimony I made a few, relatively minor suggestions for changes in language, many at the stylistic level, but I do not believe it is necessary to go through those at this time.

We support the bill. We think it is terribly important and badly needed. We think, on the whole, that it is well-drafted. We very much appreciate and applaud your personal concern for what we view as vitally important legislation.

Senator BAYH. Thank you very much. You have been very helpful to us. We look forward to working with you. I appreciate the suggestions you have made about how we can improve the bill. I hope you will continue to let us have your thoughts.

Mr. FRIEDMAN. Thank you.

[The prepared statement of Paul R. Friedman follows:]

PREPARED STATEMENT OF PAUL R. FRIEDMAN

My name is Paul R. Friedman and I am managing attorney of the Mental Health Law Project. The Project is a not-for-profit public-interest organization engaged in law-reform advocacy on behalf of mentally disabled persons. It has been responsible for legal research and litigation which have established a number of basic rights for the consumers on mental-health and mental-retardation services. On behalf of the Project, I am grateful to have the opportunity to comment on S. 1393.

For reasons which I will elaborate below, it is the view of the Mental Health Law Project that S. 1393 is vitally needed. As the Subcommittee on the Constitution is no doubt aware, the Attorney General has, with increasing frequency in recent years, brought actions to enjoin state officials from widespread and pervasive violations of the federal constitutional rights of residents confined to state institutions. Until recently the courts hearing such cases had taken for granted the Attorney General's assertion that he had inherent auhority to enjoin serious and systematic violations of the constitutional rights of state institutional residents. But in *United States* v. *Dr. Neil Solomon, et al.*, C.A. No. 74-181 (D. Md., filed Feb. 21, 1974), the United States District Court for Maryland granted a motion to dismiss filed by the defendants on the grounds that, in the absence of express Congressional intent, the Attorney General had no inherent power to bring such a suit. Shortly thereafter, this same line of reasoning was followed by the United States District Court for Montana in *United States of America* v. *Robert Mattson, et al.*, C.A. No. 74-1-138 BU (D. Mont., Filed Nov. 8, 1974), another case brought by the Department of Justice on behalf of residents of a public mental-retardation institution alleging "large scale and substantial deprivations" of civil rights guaranteed by the Eighth, Thirteenth and Fourteenth Amendments.

These troubling decisions would deny the Department of Justice the power to use its substantial resources to protect the constitutional rights of this most underrepresented and vulnerable of our minority groups. Recognizing the irreparable harm this might cause, the Mental Health Law Project has filed briefs supporting the Department of Justice on behalf of the American Association on Mental Deficiency, the Children's Defense Fund, the National Association for Retarded Citizens and the National Coalition for Children's Justice in the appeal of the *Solomon* and *Mattson* cases. While we seek to establish that the Attorney General does have inherent authority to litigate such cases even without an express declaration of Congressional intent, the same result would be accomplished more straightforwardly by Congressional enactment of S. 1393.

In support of this most important legislation, I would like to stress three points which I believe are of central concern: that there is a documentable and universally acknowledged "national emergency" involving our country's

mental institutions; that mentally retarded and mentally ill adults and children in residential facilities have a number of important constitutional rights which are being violated; and that because other sources of advocacy are at present entirely inadequate to meet the need, action by the Attorney General, with his superior resources for maintaining complex and protracted litigation, is indispensible to the already well-established Congressional concern for protection of the civil rights of these institutionalized persons.

In elaborating on each of these three points, I will be drawing heavily upon the Mental Health Law Project's brief in *United States* v. *Solomon*, written by Patricia M. Wald shortly before she left the Mental Health Law Project to become Assistant Attorney General for Legislation in the Department of Justice.

I. THERE IS A DOCUMENTABLE AND UNIVERSALLY ACKNOWLEDGED EMERGENCY INVOLVING OUR COUNTRY'S MENTAL INSTITUTIONS

The plight of the institutional residents in Rosewood State Hospital, which gave rise to the *Solomon* case, represents a national problem which has resisted solution for decade. The evidence elicited in pretrial discovery documented Rosewood's overcrowding, lack of program staff, use of behavior-modifying drugs as a substitute for programming, absence of individualized habilitation plans, relegation of residents to debilitating idleness and constraints, such as handcuffs. The same evidence has been found in dozens of other state institutions throughout the country. Several United States district courts have found "inhumane" conditions in such institutions—for example, "failure to protect the physical safey of . . . children . . . and deterioration rather than improvement . . . . [T]he loss of an eye, the breaking of teeth, the loss of part of an ear bitten off by another resident, and frequent bruises and scalp wounds were typical of the testimony." *New York State Association for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752, 756 (E.D.N.Y. 1973).

I can confirm from personal experience that such conditions are typical of institutions throughout the country. I will never forget Bryce Hospital for the mentally ill and Partlow State School for the mentally retarded in Tuscaloosa, Alabama, which I toured on behalf of a consortium of consumer and mental-health professional organizations, friends of the court in the case of *Wyatt* v. *Stickney*. We were overcome with the stench of urine and feces. We discovered countless violations of fire safety standards. We learned that in the words of one expert from HEW "malnutrition was being programmed into the patient population." We heard of serious injuries and even negligent homicides from drug overdoses, physical assaults and scalding water from faucets without temperature controls. We saw how absence of personal privacy and basic autonomy deprived the residents of any hope of meaningful treatment, of any hope for cure or improvement of functioning which might help them regain their liberty and return to the community. At one of the hearings in that case, a nationally renowned expert explained how the lack of stimulation and meaningful programming meant that the residents' functioning would inevitably deteriorate. Not only were Alabama's institutions failing to provide adequate treatment, he said, but they were not even serving as custodial warehouses, because the residents were in jeopardy of serious injury to life and limb. After touring Partlow State School for the mentally retarded, this expert noted deterioration in all aspects of functioning and commented, "People who could walk had stopped walking, people who could talk had stopped talking, people who had been toilet trained lost bowel control." At the close of the testimony on Partlow, Federal District Court Judge Frank Johnson, having, in his own words, "been impressed by the urgency of the situation," issued an emergency order "to protect the lives and well-being of the residents of Partlow." In that order, Judge Johnson 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 for the mentally retarded and is conducive only to the deterioration and 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*, 344 F. Supp. 387, 391 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

These institutional deprivations, in the Mental Health Law Project's view, constitute a national problem. As the experts in the *Wyatt* case testified, conditions at Bryce Hospital and Partlow State School were no worse than conditions at institutions in some of our largest and most wealthy states.

The American Bar Association has recently stated to the United States Supreme Court: "It is unfortunate but true that many of our nation's public mental institutions do not provide minimally adequate habilitation or rehabilitative programming, but in fact may subject their patients or residents to inhumane or unsafe living conditions, destructive psychological process and even physical abuse by other patients or residents or by staff members, all in violation of constitutional guarantees." *Amicus curiae* brief in *Bartley* v. *Kremens*, No. 75-1064, p. 12.

Judge Johnson's assessment is nationally applicable: "The gravity and immediacy of the situation cannot be overemphasized. At stake is the very preservation of human life and dignity." *Wyatt, supra,* at 394.

While I cannot begin today to document fully the institutional abuse suffered by residents of our public mental institutions, it is important to emphasize how many persons are affected by the conditions sketched out above. A recent statistical analysis compiled by the National Institute of Mental Health notes that in 1975, 435,176 persons were admitted to state and county mental institutions. Mental Health Statistical Note No. 132, Department of HEW, July 1976. This staggering figure does not include admissions to psychiatrict units of general hospitals, VA facilities or private mental hospitals. (In 1974, 183,185 inpatients were treated in VA psychiatric facilities alone. Veterans Administration, Annual Report, 1974, p. 30.) It was estimated by NIMH that in 1972, 1,645,367 persons were confined at some time in inpatient psychiatric facilities. Data calculated by Division of Biometry, NIMH, April 25, 1975. At any one time, there are probably around 200,000 persons confined in state and county mental institutions. A recent survey by the National Association of Superintendents of Public Residential Facilities reported that there were an additional 190,000 persons in public residential facilities for the mentally retarded, most of them in the categories defined as severely and profoundly retarded. "Current Trends and Status of Public Residential Services for the Mentally Retarded," National Association of Superintendents, 1975.

Before proceeding, I will pause to look briefly at the conditions in institutions for children, because this is such a quintessentially vulnerable population. According to the National Science Foundation's Advisory Committee on Child Development, 95,000 children and adolescents live in institutions for the retarded (where "educational program are generally inferior; drugs are extensively used to control behavior; and many children spend their days, weeks and years focused on one stimulus, television"); 78,000 children live in residential centers for the emotionally disturbed ("the majority [of which] confirm, extend, and fix the children's worst fears about themselves"); approximately 150,000 children live in detention and training schools for delinquents, or "children in need of supervision"; 37,000 children live in institutions for the physically handicapped and 98,000 in institutions for dependent and neglected children ("in which the programs are heavily custodial, supplemented by marginal school programs").

The National Science Foundation Committee concluded from its five-year review: "The plight of institutionalized children calls for major reform. The federal government should take the lead. . . ."

The Advisory Committee's estimate—that between 250,000 and 500,000 children live in public and private residential institutions and that most are members of minority groups—is consistent with the estimate in the Juvenile Delinquency Annual Report, 1974, Senate Rep. No. 94-1030, United States Senate Committee on the Judiciary, 94th Cong, 2d Sess. 4 (1976), which put the annual number of children in detention facilities at 500,000.

In 1969 the Joint Commission on the Mental Health of Children reported, in "Crisis in Child Mental Health: Challenge for the 1970's" 6 (1969), that each year thousands of disturbed children were removed from their homes,

schools and communities and confined to hospital wards with psychotic adults or to depersonalized institutions which deliver no more than custodial care. The report cited shortages of professional staff, untrained attendants, failure to provide education and recreation, "outmoded facilities" operating on "long abandoned theory," and it concluded pessimistically that "instead of being helped, the vast majority [of children] are the worse for the experience." Another investigator of juvenile facilities testified before the Senate Subcommittee on Children and Youth:

"For the past three years, I have been traveling the country, investigating conditions in residential child care institutions, including county jails and lock-ups, juvenile correctional facilities and institutions for the emotionally disturbed, through whose doors approximately half a million youngsters pass each year. . . . In the worst of these residential 'treatment' institutions, children are being beaten, thrown into solitary confinement for days at a time, sexually molested, injected with dangerous drugs to keep them 'manageable', and isolated from friends and relatives. Even in facilities where overt forms of maltreatment are rare, the children are suffering from a kind of benign neglect. Remedial education, adequate health care, special dietary needs, appropriate psychological counseling and therapy—all are absent or present in insufficient quality and quantity." Testimony of Kenneth Wooden, Director, National Coalition for Children's Justice, September 8, 1976.

The Mental Health Law Project its familiar with the harms suffered by children through its participation in *Morales* v. *Turman*, 364 F. Supp. 166 (E.D. Tex. 1973), 383 F. Supp. 53 (E.D. Tex. 1974), 535 F.2d 864 (5th Cir. 1976), *rev'd and remanded*, —— U.S. ——, 45 U.S.L.W. —— (U.S. March 21, 1977). The Project has cited the extensive literature on the often irreversible harms to children of institutionalization in its *amicus* brief on behalf of the American Orthopsychiatric Association, American Psychological Association, Federation of Parents Organization for the New York State Mental Institutions, National Association for Mental Health, National Association for Retarded Citizens, National Association of Social Workers and National Center for Law and the Handicapped in *Kremens* v. *Bartley*, No. 75-1064, which I would also like to submit for the record with this statement.

II. THESE SAD CONDITIONS IN OUR PUBLIC MENTAL INSTITUTIONS INVOLVE VIOLATIONS OF THE FUNDAMENTAL CONSTITUTIONAL AND HUMAN RIGHTS OF THE RESIDENTS

As I have written recently in "The Rights of Mentally Retarded Persons" (part of the American Civil Liberties Union Handbook series, published by Avon Press in 1976), mentally handicapped citizens traditionally have been cared for under an "alms" model of services. Habilitation, education, vocational training and even protection from harm were viewed as "favors" which could be granted by legislators or administrators within their unreviewable discretion. The mentally handicapped had no effective recourse when such favors were denied. Recently, however, lawyers and other advocates representing mentally handicapped persons have made a systematic effort to articulate and implement the constitutional rights of this historically neglected minority groups. As a result of landmark legal decisions, mentally handicapped persons have come into their own as citizens, views as "consumers" rather than "alms seekers." Actions on their behalf have aimed to stop abuses of their civil rights and to improve the services available to them. Beginning with the decision in *Wyatt* v. *Stickney*, *supra*, mentally handicapped persons have prevailed in every court case, either at the trial level or on appeal, in which they have asserted that the constitution guarantees them a humane and safe environment and a certain minimum level of adequate and effective services under either a constitutional right to treatment or a right to protection from harm.

On April 13, 1972, the United States District Court in *Wyatt* v. *Stickney*, *supra*, made history by ruling for the first time that mentally retarded persons involuntarily confined to a state institution have a constitutional right to treatment.

The *Wyatt* court found that the three essential elements of meaningful habilitation were a humane psychological and physical environment, an individualized habilitation and training plan for each resident and qualified pro-

fessional and paraprofessional staff in sufficient numbers to deliver individualized habilitation and training. More specifically, the standards which the *Wyatt* court ordered the state of Alabama to implement included prohibition against institutional peonage; a number of protections to insure a humane psychological environment; minimum staffing ratios; detailed physical standards; minimum nutritional requirements; individualized evaluation of residents, habilitation plans and programs; a requirement that residents released from Partlow State School would be provided with appropriate transitional care; and a requirement that every mentally handicapped person has a right to the least restrictive setting necessary for habilitation.

The *Wyatt* court also appointed a seven-member "human rights committee" for Partlow State School and included a mentally handicapped resident on this committee. The human rights committee "review[s] . . . all research proposals and all habilitation programs to ensure that the dignity and human rights of residents are preserved." It also advises and assists residents who allege that their legal rights have been infringed or that the mental-health board has failed to comply with the judicially ordered guidelines.

These standards were agreed upon and recommended to the court by plaintiffs, defendants, the United States Department of Health, Education, and Welfare and a number of mental-health and retardation professional and consumer organizations which had participated as *amici curiae* in the *Wyatt* litigation. They were supported in written and oral testimony by nationally recognized experts who participated in the *Wyatt* proceedings.

Similar relief was secured under a right to protection from harm theory in the "Willowbrook" case, *New York State Association for Retarded Children, Inc.* v. *Carey*, 393 F. Supp. 715 (E.D.N.Y. 1975) (approving consent judgment).

The Willowbrook trial on the merits began October 1, 1974 and ended January 6, 1975. During that time, more than 50 witnesses appeared on the stand and nearly 3,000 pages of court testimony were recorded. Noted physicians, researchers, professors and parents appeared as witnesses and reported bruised and beaten children, maggot-infested wounds, assembly-line bathing, inadequate medical care, cruel and inappropriate use of restraints and insufficient provision of clothing at Willowbrook State School. The conclusion forced by this testimony was that the mentally retarded residents confined to Willowbrook had deteriorated physically, mentally and emotionally during their stay.

The Willowbrook lawsuit was resolved when the plaintiffs and defendants signed an extensive and detailed consent decree, ratified on May 5, 1975. The decree absolutely forbids seclusion, corporal punishment, degradation, medical experimentation and the routine use of restraints. It sets as the primary goal of Willowbrook the preparation of each resident for development and life in the community at large. To this end, the decree mandates individual plans for the education, therapy, care and development of each resident.

Provisions in the decree require:

Six scheduled hours of program activity each weekday for all residents;

Educational programs for residents including provision for the specialized needs of the blind, deaf and multi-handicapped.

Well-balanced nutritionally adequate diets;

Dental services for all;

No more than eight residents living or sleeping in a unit;

A minimum of two hours of daily recreational activities—indoors and out—and availability of toys, books and other materials;

Eyeglasses, hearing aids, wheelchairs and other adaptive equipment where needed;

Adequate and appropriate clothing;

Physicians on duty 24 hours daily for emergency cases;

A contract with one or more accredited hospitals for acute medical care;

A full-scale immunization program for all residents within three months;

Compensation for voluntary labor in accordance with applicable minimum wage laws; and

Correction of health and safety hazards, including covering radiators and steam pipes to protect residents from injury, repairing broken windows and removing cockroaches and other insects and vermin.

A very important feature of the consent decree is the creation of a seven-member consumer advisory board, comprised of parents and relatives of residents, community leaders, residents and former residents, to evaluate alleged dehumanizing practices and violations of individual and legal rights.

While consent decrees ordinarily have only the status of a contractual agreement between the parties, the precedential value of Willowbrook's was substantially enhanced when the court issued a formal order ratifying the consent decree and an additional memorandum discussing the constitutional basis for the decree. In his memorandum, the presiding judge noted that:

"During the thee-year course of this litigation, the fate of the mentally impaired members of our society has passed from an arcane concern to a major issue both of constitutional rights and social policy. The proposed consent judgment resolving this litigation is partly a fruit of that process.

* * * * * * *

"[The steps, standards and procedures in the consent decree] are not optimal or ideal standards, nor are they just custodial standards. They are based on the recognition that retarded persons, regardless of the degree of handicapping conditions, are capable of physical, intellectual, emotional and social growth, and . . . that a certain level of affirmative intervention and programming is necessary if that capacity for growth is to be preserved, and regression prevented.

* * * * * * *

"The consent judgment reflects the fact that protection from harm requires relief more extensive than this court originally contemplated, because harm can result not only from neglect but from conditions which cause regression or which prevent development of an individual's capabilities."

Before the Willowbrook case, the "right to protection from harm" theory, which is premised on the Eighth Amendment's prohibition against cruel and unusual punishment, had generally been regarded by advocates as less likely to provide major improvements in the conditions affecting institutionalized persons than their due process "right to treatment."

The reason was that historically the Eighth Amendment has been applied primarily in the prisoner-rights area. Courts measuring conditions in institutions against the prohibitions of the Eighth Amendment have traditionally acted to eliminate only conditions which are truly barbarous or inhumane or "shocking to the conscience." It was assumed, therefore, that under an Eighth Amendment standard the court might be willing to enjoin the most obviously barbarous conditions but not to order the creation of affirmative programs. After hearing extensive expert testimony, however, the federal judge in the Willowbrook case accepted the plaintiff's contention that in an institution for the mentally retarded it is impossible for the condition of an individual resident to remain static. Inside such institutions, without active programming the functions of the residents will inevitably deteriorate. Therefore, in order to keep residents from being harmed it is necessary to provide the full range of affirmative relief ordered under the right to habilitation in such cases as *Wyatt* v. *Stickney, supra.*

On the basis of this important legal precedent, advocates for the mentally handicapped now have a second major constitutional theory, based upon the Eighth Amendment, which they may use as an alternative to a due process right-to-treatment theory, based upon the Fourteenth Amendment, in seeking to improve habilitation and training services as well as safe custody for the mentally handicapped.

While mentally handicapped persons may be entitled to equivalent relief under either theory, the right to protection from harm goes beyond the right to treatment in one important respect. As discussed above, it is possible that the right to treatment may be limited to persons who have been "involuntarily" deprived of their liberty for the purpose of treatment or habilitation. By contrast, the Willowbrook "right to protection from harm" theory would apply to any mentally handicapped resident for whom the state has accepted responsibility—whether on an involuntary or a voluntary basis. This it is possible that the right to protection from harm, as articulated in Willowbrook, may offer relief to a larger class of the mentally handicapped and may make it unnecessary to resolve the difficult legal issue as to whether "voluntary" residents have a constitutional right to treatment or habilitation.

Although a lack of financial resources may be cited by administrators as a justification for failure to implement a court order requiring provisions of adequate and effective treatment, such an excuse will not be accepted where constitutional rights are involved. As the district court held in *Wyatt* v.

Stickney, *supra*, "failure by defendants to comply with this decree cannot be justified by a lack of operating funds. . . . [T]he unavailability of neither funds, nor staff and facilities, will not justify a default by defendants in the provision of suitable treatment for the [mentally handicapped]."

The constitutional right to treatment for the mentally ill and mentally retarded has been recognized by a number of federal and state courts besides the *Wyatt* and Willowbrook courts. *See, e.g.*, *Davis* v. *Watkins*, 384 F. Supp. 1196 (N.D. Ohio 1974) (class action on behalf of the mentally ill); *Dixon* v. *Weinberger*, 405 F. Supp. 974 (D.D.C. 1975) (class action on behalf of the mentally ill); *Gary W.* v. *Louisiana*, Civ. Act. No. 74-2414 (E.D. La., July 26, 1976) (class action on behalf of mentally retarded and mentally disturbed children); *In re Ballay*, 482 F.2d 648, 659 (D.C. Cir. 1973); *Kesselbrenner* v. *Anonymous*, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1972); *Renelli* v. *Dept. of Mental Hygiene*, 340 N.Y.S.2d 498 (1973); *New York State Association for Retarded Children* v. *Carey*, 357 F. Supp. 732 (E.D.N.Y. 1973), 393 F. Supp. 715 (E.D.N.Y. 1975). *See also* consent decrees in *Horacek* v. *Exon*, Civ. Act. No. CU 72-C-299 (D. Neb., Oct. 31, 1975); *Ricci* v *Greenblatt*, Civ. Act. No. 72-569-T (D. Mass., Nov. 12, 1973).

There is also a widening body of precedent holding that there is a constitutional right to treatment for persons committed under "non-penal" statutes for the purpose of care and treatment: (a) juvenile delinquents, *Nelson* v. *Heyne*, 355 F. Supp. 451, 459 (N.D. Ind. 1972), *Aff'd*, 491 F.2d 352, 360 (7th Cir. 1974), *cert. denied*, 417 U.S. 976 (1976); *Inmates of Boys Training School* v. *Affleck*, 346 F. Supp. 1354, 1364 (D.R.I. 1972); (b) "persons in need of supervision," *Martarella* v. *Kelley*, 349 F. Supp. 575, 585, 598-600 (S.D. N.Y. 1972), *enforced*, 359 F. Supp. 478 (S.D. N.Y. 1973); *M* v. *M*, 336 N.Y.S.2d 304, 71 Misc. 2d 396 (Fam. Ct. 1970); *In re I*, 316 N.Y.S.2d 356 (Fam. Ct. 1970); (c) sexual offenders and defective delinquents, *Stachulak v. Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973); *Davy* v. *Sullivan*, 354 F. Supp. 1320, 1328-29 (M.D. Ala. 1973) (three-judge court); *Gomes* v. *Gaughn*, 417 F.2d 794, 800 (1st Cir. 1973); *Sas* v. *Maryland*, 334 F.2d 506 (4th Cir. 1964), *cert. denied*, 407 U.S. 355 (1972); *In re Maddox*, 351 Mich. 358, 88 N.W.2d 470 (1958); *Commonwealth* v. *Page*, 339 Mass. 313, 159 N.E.2d 82 (1959); *Director of Patuxent Institution* v. *Daniels*, 243 Md. 16, 221 A.2d 397 (1966), *cert. denied*, 385 U.S. 940 (1966); *Silvers* v. *People*, 22 Mich. App. 1, 176 N.W.2d 702 (1970); and (d) persons incompetent to stand trial, *United States* v. *Walker*, 335 F. Supp. 705, 708 (N.D. Cal. 1971); *United States* v. *Pardue*, 354 F. Supp. 1377, 1382 (D. Conn. 1973); *Nason* v. *Superintendent of Bridgewater State Hospital*, 353 Mass. 604, 612-13, 233 N.E.2d 908, 913-14 (1968); *Maatallah* v. *Warden, Nevada State Prison*, 86 Nev. 430, 420 P.2d 122 (1970).

The constitutional right to treatment or release for involuntarily committed mental patients has received an unusual amount of scholarly discussion and support. The first articulation of the right is found in Birnbaum, "The Right to Treatment," 46 *A.B.A.J.* 499 (1960). In the last 15 years more than 50 law review articles have been published on the subject, virtually all of them supporting a constitutional right to treatment or release for the involuntarily confined. *See, e.g.*, Comment, "Developments in the Law—Civil Commitment of the Mentally Ill," 87 *Harv. L. Rev.* 1190 (1974); Note, "Rights of the Mentally Ill During Incarceration—the Developing Law," 25 *U. Fla. L. Rev.* 494 (1973); Comment, "*Wyatt* v. *Stickney* and the Right of Civilly Committed Mental Patients to Adequate Treatment," 86 *Harv. L. Rev.* 1282 (1973); Robitscher, "Right to Psychiatric Treatment: A Socio-Legal Approach to the Plight of the State Hospital Patient," 18 *Vill. L. Rev.* 11 (1972); Murdock, "Civil Rights of the Mentally Retarded: Some Critical Issues," 48 *Notre Dame Lawyer* 951 (1972); Chambers, "Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives," 70 *Mich. L. Rev.* 1108 (1972); Goodman, "Right to Treatment: The Responsibility of the Court," 57 *Georgetown L.J.* 680 (1969); Katz, "The Right to Treatment—An Enchanting Legal Fiction," 36 *U. Chi. L. Rev.* 755 (1969); Note, "Civil Restraint, Mental Illness and the Right to Treatment," 77 *Yale L.J.* 87 (1967); Drake, "Enforcing the Right to Treatment," 10 *Am. Crim. L. Rev.* 587 (1972); "Adequate Psychiatric Treatment—a Constitutional Right?" 19 *Catholic Law* 322 (Autumn 1973); Comments, "Relief for the Civilly Committed: A Constitutional Right to Treatment," 63 *Ky. L.J.* 469 (1974-75).

Concern for the constitutional rights of persons in mental institutions is evidenced not only in judicial decisions and scholarly journals. In the past several years, Congress has exhibited a heightened awareness of the constitutional vulnerability of institutionalized citizens and of their need for federal protection and advocacy. *See, e.g.*, remarks of Congressman Schweiker, during passage of the Developmental Disabilities Act, 42 U.S.C. § 6010.

"Mr. President, the last five years have seen a dramatic increase in public awareness of the needs of institutionalized mentally retarded and developmentally disabled persons. This has been highlighted by scandals in many institutions, by court cases, and by efforts of the communications media. Testimony before our Committee demonstrates that standards in institutions for the developmentally disabled are urgently needed and *that the Federal Government should play a major role in improving the care and services provided to developmentally disabled citizens.*" Cong. Rec. S.16549, Sept. 23, 1975. Emphasis added.

The Developmental Disabilities Act of 1975 explicitly affirmed that "[T]he Federal Government and the States both have an obligation to assure that public funds are not provided to any institutional or other residential program for persons with developmental disabilities" that "does not provide treatment, services, and habilitation which is appropriate to the needs of such persons." 42 U.S.C. § 6010.

Section 113 in Title II of that Act requires state recipients of federal funds to adhere to a "Bill of Rights" for the developmentally disabled and encourage legal-advocacy efforts "to insure the protection of the rights of such persons." 42 U.S.C. § 6012.

Perhaps the intent of Congress to support and protect advocacy of the constitutional rights of institutionalized residents was best summed up by Senator Williams:

"*All indications point toward little change, unless substantial legal and advocacy pressure is forthcoming.* While much can be said about the lack of funds to improve conditions at these institutions, at some point this country must draw the line. The abuses are too commonplace to point at a single institution or a single abuse and say that it is anomaly. Over the last two years the Committee on Labor and Public Welfare has taken testimony or received reports of: Inappropriate admissions because of lack of community services, inappropriate and inhuman experimentation with residents, sterilizations and other operations performed for convenience of treatment, starvation and malnutrition, abuse and physical punishment, inadequate food and living conditions, and death." Cong. Rec. S.9362, June 3, 1975. Emphasis added.

Strong recognition of and commitment to the constitutional rights of mentally handicapped persons is also contained in other important federal legislation such as the Rehabilitation Act of 1973, 29 U.S.C. § 794 (Supp. 4, 1974), and the Education of All Handicapped Children Act of 1975, Pub. L. No. 94-142 (Nov. 29, 1975). And this concern is consistent with that articulated by major professional and consumer groups such as the American Association on Mental Deficiency, the Mental Health Association and the National Association for Retarded Citizens, as well as by a number of state legislatures.

Congress has evidenced a similar concern with protecting institutionalized juveniles from deprivation of their constitutional rights and with actively promoting advocacy. The Juvenile Justice and Delinquency Prevention Act of 1974, 42 U.S.C. § 5601, states in its findings that: ". . . understaffed, overcrowded juvenile courts, probation services, and correctional facilities are not able to provide individualized justice or effective help. . . ."

I would also not briefly that the United States has a financial interest in protecting its investment of funds in state institutions which continue to violate the constitutional rights of their residents. For example, Rosewood State Hospital, the institution for retarded citizens involved in the *Solomon* case, received $14.1 million in federal funding in fiscal year 1974-75. The United States has invested billions of dollars in other state institutions and programs for the mentally retarded, for the mentally ill, for the physically handicapped and for dependent and delinquent children through grant-in-aid programs. The ability of the Attorney General to file suit in appropriate cases is one of the mechanisms necessary to insure that this substantial investment is a sound one.

III. PRIVATE ADVOCACY RESOURCES ARE CURRENTLY INSUFFICIENT TO PROTECT INSTITUTIONALIZED RESIDENTS FROM DEPRIVATION OF THEIR CONSTITUTIONAL RIGHTS

If the Attorney General is not authorized to participate in litigation on behalf of institutionalized residents, for many such persons there will be no hope of a remedy for violations of their constitutional rights. Involuntarily institutionalized persons have little or no access to lawyers because of their total confinement; they are typically indigent and without resources to pay for counsel; the law often considers them incompetent to bring suits in their own name. Most do not know or comprehend their legal rights to resist encroachment on their constitutional domain. They are peculiarly subject to intimidation, harassment and retailiation from custodians when they do complain. Rarely will state agencies who are part of the same "executive family" as their custodians bring suit on their behalf. Realistically, they must depend for relief on legal service poverty lawyers, private nonprofit advocates or the Justice Department. *See generally*, "Advocacy" in "The Mentally Retarded Citizen and the Law," M. Kindred, J. Cohen, D. Penrod and T. Schaffer (eds.) (1976), at Ch. 19. A quick look at the present capacities of legal service poverty lawyers and private nonprofit advocates makes it clear how desperately Justice Department participation is needed.

According to 1970 census data, there are nearly 29 million people with incomes below the poverty line. Studies indicates that a minimum annual caseload from this population should mean 6.7 million cases a year, if their needs were being met. Yet programs funded by the Legal Services Corporation handle only about one million cases of 15 percent of the need. Twelve million poor persons live in areas where no legal services programs are accessible. Of the remaining 17.2 million persons, 10 million have only token coverage—less than one attorney per 10,000 poor persons—and only 1.2 million have "minimally adequate coverage"—2-4 attorneys per 10,000 poor persons. The Legal Services Corporation describes its own programs as "woefully inadequate to keep pace with the demand for such assistance." These figures and the quotation are taken from the *amicus curiae* brief filed by the Legal Services Corporation in *Parsley* v. *West Virginia Legal Services Plan*, Civil Action No. 76-0181-H (D. W.Va. 1976), pp. 4-6. *See also* Budget Request Testimony of Thomas Ehrlich before the House Rep. Subcommittee on the Departments of State, Justice and Commerce of the Committee on Appropriations, March 11, 1976.

Although no figures are available on the number of cases being handled by legal service lawyers for institutionalized persons, the inability of such persons, particularly the mentally handicapped and children, to physically travel to lawyers' officers, as well as the heavy caseloads and slim budgets of these poverty lawyers which make protracted, expensive, institutional litigation almost impossible, dooms this sub-class of the poor to a category even less likely to obtain representation from legal service lawyers than the figures cited above indicate.

The resources of private advocacy groups are even more limited. *See* CAPIL (Council for Public Interest Law), "Balancing the Scale of Justice: Financing Public Interest Law in America" (1976). In 1975 the budget of all tax-exempt public-interest law centers in the United States was approximately $40 million, less than the combined income of two major Well Street law firms (CAPIL, p. 5). Of the 92 public-interest law centers listed in a recent national study, only six were devoted principally to children's issues and only a small portion of the resources of these six were devoted to institutionalized children; only 15 other centers spent one-fourth or more of their time on children's cases; only two centers had a client population consisting principally of the mentally impaired. Of the 57 private firms or lawyers identified nationally as specializing in public-interest work, five spent over 10 percent of their work in children's cases and six spent over 10 percent of their work in issues involving the mentally impaired. Moreover, this number is not likely to grow significantly larger. (CAPIL at 13.)

Citizen groups who represent the interests of children and the mentally deficient typically suffer from the same syndrome of need far out of proportion to resources. They lack the money and manpower to sustain protracted and expensive lawsuits necessary to right institutional wrongs.

In the case of the mentally handicapped, this observation has been particularly valid. A recent report of the United States Department of Health, Edu-

cation and Welfare, "Advocacy Under the Developmental Disabilities Act" 4 (1976), points out that:

"Rights of the developmentally disabled are no more self-enforcing than rights of others. There is, however, an obvious and special need for advocacy services for those so disabled in general, and the institutionalized in particular. Effective representation is currently provided to only a very small minority of developmentally disabled persons with socio-legal problems. The default of legal and human rights is occasioned in part by lawyers' lack of familiarity with mental retardation, autism and other disabilities which impair self-advocacy and the special problems arising from that condition or social status. And disabled people's use of the courts, lawyers and the law has tended to be episodic and unsystematic. No matter how aggrieved they feel or how well intentioned their advocates, without access to sustained socio-legal backup assistance, violations of their legal and human rights may neither be identified nor corrected. In the majority of states just such a sociolegal backup center is conspicuously lacking."

Although the Attorney General's power to bring suit against a particular institution as part of a national strategy should not and cannot be constrained by the availability of other forms of advocacy in that particular locality, there is in fact virtually no jurisdiction in the nation today where legal resources available to the institutionalized person can be termed "adequate" even by the norm of lawyers available to the general paying public. The Attorney General has consequently been a participant in a large majority of the landmark right-to-treatment and right-to-habilitation cases. Except in the event of a massive and unlikely infusion of funds into legal service programs and private advocacy groups, it is impossible to forecast progress in the advancement of civil rights for the institutionalized citizen without the continued presence and resources of the Department of Justice.

Recent cases in the Supreme Court have added new obstacles to advocacy by "private attorney generals." These include cases on standing which curtail access to the federal courts (*Warth* v. *Seldin*, 422 U.S. 490 [1975]; *Simon* v. *Eastern Kentucky Welfare Rights Organization*, 96 S.Ct. 1917 [1975]); cases restricting the rights of lower courts to fashion appropriate remedies for constitutional violations (*Rizzo* v. *Goode*, 96 S.Ct. 598 [1976]); cases denying inherent judicial power to award attorneys' fees to "private attorneys general" (*Alyeska Pipeline Service* v. *Wilderness Society*, 421 U.S. 240 [1975]); cases prohibiting the joining in one federal suit of civil rights claims against individual officials and local governments (*Aldinger* v. *Howard*, 96 S.Ct. 2412 [1976]); cases according deference to state civil proceedings over civil rights actions filed in the federal courts (*Huffman* v. *Pursue, Ltd.*, 420 U.S. 592 [1975]); cases applying the Eleventh Amendment bar to civil rights actions where monetary relief comes from state treasuries (*Edelman* v. *Jordan*, 514 U.S. 651 [1974]; *cf. Fitzpatrick* v. *Bitzer*, 96 S.Ct. 2666 [1976]).

IV. CONCLUDING COMMENTS

I have attempted to show that conditions in many of our institutions for mentally handicapped persons and juveniles constitute a national emergency involving deprivation of fundamental constitutional rights and that the advocacy resources necessary to protect mentally handicapped adults and children in institutions are woefully inadequate. I hope, therefore, that this subcommittee will share the Mental Health Law Project's opinion that a bill such as S. 1393 is sorely needed. Before concluding, I shall turn to the bill itself as presently drafted and offer a few short suggestions as to how it might be improved.

First, I would delete "treatment" from Section 4(1), with the understanding that the bill would then provide for the redress of violations of constitutional rights of mentally handicapped adults and children in all facilities—including halfway houses, group homes, foster homes, hostels and other facilities—which provide a residence plus some additional services.

Second, I would delete the requirement of Section 2 that the Attorney General must certify that an action which "will materially further the vindication" of rights, privileges or immunities of mentally handicapped persons is "in the public interest." I hope this is a tautology.

Third, let me recommend that S. 1393 be modified to provide for a private cause of action to redress violations of the constitutional rights of institu-

tionalized persons, as a complement to direct action by the Attorney General. Such a provision is essential to implement the spirit of S. 1393 because even the Department of Justice, with its relatively large resources, cannot undertake all necessary enforcement in this area. Along with a private cause of action, there must be a provision for reasonable attorneys' fees to the prevailing party as part of the cost of such actions.

Moreover, to avoid unnecessary controversy with regard to this important provision I would recommend that the following matters be clarified either through modification of S. 1393 or in the relevant House and Senate reports.

It should be clear that a party is the "prevailing party" for the purposes of this Act even if there is no evidence of bad faith on the part of the defendant. In order to be a prevailing plaintiff, one should not have to prevail on all the issues raised. Indeed, a plaintiff should be deemed to have prevailed even if no relief is granted, where the suit itself has served as a catalyst in promoting some public policy. *See Parham* v. *Southwestern Bell Telephone*, 433 F.2d 421 (8th Cir. 1970). A prevailing party should also be permitted to recover an award *pendente lite*, *Bradley* v. *Richmond School Board*, 416 U.S. 696 (1974), and it should be considered proper for a court to award attorneys' fees where the litigation terminates by settlement or consent decree. A prevailing defendant should be entitled to an award of fees only where the plaintiff initiated the action in bad faith or vexatiously. *United States Steel Corp.* v. *United States*, 519 F.2d 359, 364 (3d Cir. 1975).

Following the rule set forth in *Newman* v. *Piggie Park Enterprises, Inc.*, 390 U.S. 400, 402 (1968), a court should ordinarily award the prevailing plaintiff counsel fees in the absence of special circumstances. A determination of special circumstances should be controlled by the existing case law, including but not limited to *Tillman* v. *Wheaton-Haven Recreation Association*, 417 F.2d 1141 (4th Cir. 1975).

The fees provision should apply to cases filed prior to the effective date of this proposed legislation and should include legal services rendered from the commencement of any appropriate action.

In computing a reasonable fee, courts should follow the principles set forth in *Johnson* v. *Georgia Highway Express, Inc.*, 488 F.2d 114 (5th Cir. 1974). The computation of a reasonable fee should be unaffected by the fact that counsel for a prevailing plaintiff may be a legal-service or public-interest organization, or that the plaintiff is indigent and unable to compensate his or her attorney.

A fourth and final suggestion: A statement of findings and declaration of rights should appear as a prologue to the Act. We believe that the purposes of this bill would be furthered by such clear Congressional recognition that institutionalized mentally handicapped persons and children do have certain fundamental constitutional rights, such as the right to treatment, the right to protection from harm and, in appropriate circumstances, the right to liberty, which are all too often denied. The courts would thus be encouraged to be especially vigilant in protecting the enumerated rights of these especially powerless and vulnerable groups.

* * * * * * *

During the hearing on the 1976 Civil Rights Attorneys' Fee Award Act (Cong. Rec., Sept. 21, 1976. S. 16251), the Honorable Hugh Scott, a member of this Subcommittee, described passage of that Act as "a great service on the continuing battle to eradicate discrimination in the United States," an evaluation with which I am pleased to concur. However, Representative Seiberling stated in the 1976 hearings in the House of Representatives, (Cong. Rec., Oct 1, 1976, H. 12163), "Unless you can get *adequate* legal representation, the civil rights laws are just a lot of words." (Emphasis added..) As I have attempted to document in these comments, the population for whose benefit S. 1393 is proposed—institutionalized persons—is far removed from access to adequate legal representation, both by virtue of incarceration and because of the extremely technical and specialized nature of the issues to be litigated. In our opinion, passage of S. 1393, by providing for increased advocacy resources, will help to assure that the constitutional right to services and to protection from harm can become a reality to our most vulnerable and underrepresented citizens—mentally handicapped persons and children who are confined in institutions.

Senator BAYH. I'd like to ask our next witnesses to join us as a panel. We have Ed King, the director of the National Senior Citizens Law Center in Washington. We also have Ms. Jacqueline Scimeca from Ocean-Monmouth Legal Services, Inc., of Red Bank, N.J. And we have Ms. Freida Gorrecht from the National Citizens Coalition for Nursing Home Reform from Detroit, Mich.

We appreciate very much your being here with us this morning.

I will leave it to you as to how you would prefer to proceed.

Mr. KING. Senator Bayh, I'm Edward King of the National Senior Citizens Law Center. We thought that we would begin with remarks by Ms. Scimeca, followed by remarks by Freida Gorrecht. I would go last in our panel if that is all right.

Senator BAYH. However you care to do it will be fine.

TESTIMONY OF JACQUELINE SCIMECA, OCEAN-MONMOUTH LEGAL SERVICES, INC., RED BANK, N.J.

Ms. SCIMECA. Thank you, Senator, for this opportunity. I am a para-legal employed by Ocean-Monmouth Legal Services.

As you can see from the statistics in the written statement that I have given you I am supposed to supply legal assistance for all the elderly population of Monmouth County and the statistics are very, very high. We are funded at $3,900 a year to do this. That is going to end next year.

As of the 1974 Senate Commission on Aging report, there were 20,000 nursing homes in the United States. Approximately $2 out of every $3 financing these institutions are public funds. One in five eligible persons spend time in a nursing home. Therefore, we in the United States seem to be entrusting a large number of Americans to an institutionalized setting, and we spend vast sums of money for this.

These elderly persons' lives are subsequently totally controlled by people who, outside of the pecuniary interest, have no relationship with them. They really don't care what happens to them. I have found that this kind of thing is ripe for repression, abuses, and disregard for personal and civil rights.

The government and the media have documented grievances in great detail. Beyond that I can't say anything else about documentation. The problems still exist. You can report all you want but it has not solved any problems yet.

I am not an expert in this field. Nor can I issue a blanket statement that these violations exist in every home. But the passage of the bill enabling the redress of violations of civil rights is essential. The mechanisms for patients to complain and receive the benefits of the court are at best poor. You can say they can make complaints but unless you provide them some way to do it nothing will happen.

I would like to see the Senate bill 1393 encompass the institutionalized in boarding homes also. As the examples I will give you indicate there is a desperate need for intervention and litigation there also.

I would like to give you some examples of conditions that I have encountered in my work in nursing homes. You have to remember

that I have only been doing this for a few months. I haven't visited every one of the 37 homes in my county. But in 3 months in the few homes that I have gone to I was appalled.

Senator BAYH. Are we talking basically about private nursing homes?

Ms. SCIMECA. I'm talking about homes that are mostly publicly funded through medicaid.

Senator BAYH. But they are privately owned?

Ms. SCIMECA. Yes.

Senator BAYH. The care of the patients and residents there is paid basically through medicare; is that right?

Ms. SCIMECA. Medicare and medicaid, yes.

Senator BAYH. Generally, what are the ages of the patients?

Ms. SCIMECA. I could not really tell you. I would imagine they must average out to about 60 or 70 years of age.

Senator BAYH. We're talking about older people then?

Ms. SCIMECA. Yes.

From the narrative that I'm going to give you now I am confident that you will agree that the Attorney General of the United States should be empowered to represent the people in institutions whose civil rights are being violated.

With your indulgence I will try to reiterate a couple of the stories that I have related in my written statement. But I would like the whole statement to be put in the record.

Senator BAYH. We will place it in the record.

Ms. SCIMECA. Three of these clients are in nursing homes and one is in a boarding home.

The policy of the first home is to have the patients request to go to the bathroom one-half hour in advance. This is a basic human function so you can see how they try to interfere with even the most basic needs of these people. This is the directive of the director of nurses and I have had a couple of aides verify this.

My client is a 93-year-old woman who is confined to a wheelchair. She obviously cannot get out of bed by herself. She had requested one evening to go to the bathroom. She requested and requested and her requests were ignored. Being rather a vocal person she raised a ruckus and the two male aides came over to her and hit her over the head. Her ear became cut and bloody.

Over a period of a few weeks she requested to go to the doctor several times. She felt bugs crawling in her ears. Her requests were ignored. This went on for a period of some time. She was unable to remember exactly how long. Finally she was taken to a doctor because medicaid would pay for a hearing aid for her. This was when the ear was treated. It's not the first time that this has happened to her.

Under similar circumstances of asking to go to the bathroom the same client was taken into the bathroom by two male aides again and dropped on the toilet. She claims that she cracked two vertabrae at the time.

On another occasion she was taken to the bathroom and dropped on the toilet in such a way that her feet became entangled in the support railing and the aides left her there to dangle for quite some time.

One of the clients in my office worked as physical therapy aide in this home. She has given us affidavits. According to her information the home had not paid their pharmacy bills. As a result of this there was no medication to be dispensed. They had a reserve fund for medication and when that was depleted there was no medication for the patients.

An elderly man who was to be given a dose of Valium suffered a seizure because of lack of medication. He actually went into a dead faint on the floor in front of her. She doesn't know what happened to him after he was taken to his room. But there was no medication to give him. So you can take it from there.

My client observed that some of the male and female patients were bathed together. She walked into the bathroom in the evening and saw a plump elderly woman and an elderly man being put into the shower together.

The man began molesting the woman and the aides stood there and laughed. Apparently it was their little show for the evening.

I'd like to tell you about another nursing home if I may. This investigation was done at the request of the physical therapist who was employed there. It is a seven-story structure and houses 50 patients per floor. They employ one nurse and eight aides per floor. The elevators do not work. In the case of fire the evacuation plan is to have two of the aides come, pick up one of the patients, wrap them in a blanket, carry them down the stairs, run back up the stairs, wrap the next patient up and so on. I figured it would take 70 minutes to evacuate one floor. So you can imagine what would happen during a fire.

Numerous complaints have been registered about this home with the State department of health. Our State department of health is the licensing certification agency. It signed a contract with HEW to more or less monitor these homes.

These are complaints that I found when I examined the records of the State department of health.

First, a diabetic patient was denied special menus. In other words, they were going to pump her full of sugar. The physician ordered lab work, but it was never done. Bed sores were untreated, mucous ran freely from her eyes.

Second, a cyanotic patient was given a peanut butter sandwich for lunch. Apparently because of his condition he had difficulty swallowing. Naturally he began to choke. The department of health inspection team's nurse just happened to be there that day. She observed this. She called for help. There were no nurses or orderlies on the entire floor. She did the logical thing and tried to dislodge the food. She was able to do so and then she called for oxygen because the man had completely blacked out. There was no oxygen in any of the tanks.

On the same day when she was making an inspection tour the nurse observed puddles of urine on the floor with patients being served lunch on the same table as the dirty bedpans and urinals.

She also observed that they clothed the patients from the waist up and tied them in wheelchairs. She saw one patient being dragged in a wheelchair, not pushed but dragged, totally nude down the corridors of the hospital.

Also the administrator seems to conserve things. He orders 12 towels per floor—and remember there are 50 patients per floor. The orderlies then use these towels to wipe down all 50 patients after they use the bedpans. That might save money but that's about it.

Last year a woman pleaded to be transferred from the home. She was not transferred and she jumped to her death from the seventh story window.

Senator BAYH. How do they get there in the first place? Do they go voluntarily or are they committed by the State or a court?

Ms. SCIMECA. They may go there voluntarily. Other times when the local welfare board finds that they need help, they have an adult services unit which places the people in the homes.

Seven months ago, a partially paralyzed woman was put into a bath tub and the aide left her in the tub while the water was running. The aide returned and the woman was dead. The coroner's report showed that she was killed as a result of third degree burns over her entire body. The patient was literally boiled alive in this bath tub. They fired the aide and rehired the aide back a month later.

Now I would like to describe conditions that I found at one particular boarding home. My client was a 66-year-old retired steel worker and was a recipient of retirement benefits and SSI. He had suffered a heart attack and had a slight speech impediment. Other than that he seemed fairly fine to me. He voluntarily went to a licensed boarding home. He had noticed that his mail was beginning to be delivered to him opened. His daughter had sent him a birthday card with $20 in it and it never reached him. So, logically, he got a post office box. The practice of this particular home seemed to be that when the patient received a social security check they would call the patient down, flip it over, and have him sign it and then deposit it for him.

He didn't like that either so when he got his post office box he called the Social Security Administration and asked to file a change of address. The woman at the other end of the phone, the claims service person from Social Security, said that he was incompetent and couldn't do it. He was shocked and went down to the Social Security office. He had been told at that time that the physician in the boarding home had declared him incompetent and the administrator of the boarding home had been appointed as his representative payee. In other words, all his funds would now go to the administrator of the boarding home.

But what everybody failed to notice at this time was that the doctor who had declared him incompetent and the man that was appointed to be his payee were the same person. The doctor is a pediatrician. He used words like chronic schizophrenic, an inactive ulcer, and an alcoholic. There was absolutely no medical basis for this.

He asked for reconsideration which in the administrative process is the first step for Social Security hearings. The notice of the reconsideration was sent to him so he could appear. However, the administrator gave it to him 3 months after the hearing was held. Naturally Social Security went ahead and implemented their process. He could not get his money if he wanted it.

My "incompetent patient" then filed for the next level of hearing. At that time the judge called me and asked me if I would represent him.

The day after he received the notice of hearing the administrator—the client and I all received it at the same time—the client appeared at my office. He was so shaken and in such a state of mental and physical strain that I was frightened. He said that he had been called down to the administrator's office after he had found out about the hearing. The administrator called him a liar, a homosexual, and a drunk. The man had then been pushed around by the orderlies. He was locked in his room. His television was taken away. His friends were forbidden to see him. He asked me if he couldn't please be transferred.

I called the local adult services unit of the welfare board. The welfare board told me that they couldn't help him because they had talked to the doctor and found out that he was a homosexual, a liar, and a drunk, and also he had no money because the administrator, the doctor, had it all. So they couldn't help him.

I began trying to make arrangements to have him transferred. I kept in contact with him daily just to make sure he was still alive. Each day he told me a new horror story. One night he had been called into the administrator's office. The administrator had assembled three men who obviously, to my client, were retarded. They all claimed to have had homosexual relations with him. They then put one of these men in the room with him. The man kept, in his words, "trying to take him into the bathroom."

This man hadn't done anything wrong but all these insults were being heaped upon him.

We finally did get him transferred to an unlicensed boarding home that would accept him without any money. His funds were still, of course, being held by the administrator of his prior residence.

A hearing before an administrative law judge was held on June 13. There has been no decision rendered on this. My client was killed in a fire last weekend. The boarding home burned down. He was not able to move from this boarding home because he had no money because the administrator still has it. It took him 2 years to even get to hearing level. Now he has been burned alive. I think that sums it up.

The above cases are not isolated. They are evidence of the systemic problems that permeate the entire nursing and boarding home industry. It's merely the evidence that we have been able to discover. Numerous Federal and State investigatory bodies have reached similar conclusions. I won't go into that now.

I think these cases speak for themselves. To my knowledge no agency of the State or Federal Government has actively attempted to redress the grievances of those whose civil rights have been violated. The New Jersey State Department of Health has sought to correct the living conditions in nursing homes, but it is not equipped to correct violations of civil rights or in nursing homes. Legal services, with its present financial difficulties, cannot be expected to shoulder the entire burden. My office has three attorneys. I am the only one designated to handle these problems. It can't be done.

The U.S. Attorney General can draw on the expertise of all the agencies of the Federal Government and is capable of coordinating

cases on a national level. Senate bill 1393 will have a salutory effect on existing conditions in nursing homes and if amended as I suggest, also on the boarding home industry as well.

Those institutions engaged in a pattern of practice of gross violations of civil rights will be placed on notice that the enforcement powers of the Federal Government are now available to be used and the Attorney General will be on notice of the intention of the Congress that the rights of the institutionalized elderly poor be vigorously enforced.

Thank you very much.

Senator BAYH. Thank you very much, Ms. Scimeca. You have given us a graphic picture of the kind of problems that obviously do exist.

[The prepared statement of Jacqueline Scimeca follows:]

STATEMENT OF JACQUELINE SCIMECA

I am Jacqueline Scimeca, a para-legal working at Ocean-Monmouth Legal Services, Inc., in Red Bank, New Jersey,

Ocean-Monmouth Legal Services, Inc., is a Federally funded law office that provides legal assistance for the indigent. My position, that of senior citizen para-legal, is funded under Title III of the Older Americans Act of 1955 specifically for legal assistance for the elderly in Monmouth County. As of the 1970 census, there are 54,772 people in Monmouth County over the age of 62. Of these, 22,354 have an income of $1,730.00 per year or less and are therefore potential clients of my office. This is a very large number of elderly indigent and it can be attributed to the fact the area that I cover is on the New Jersey seashore and includes a large number of people that have retired to that area. My office has four attorneys and a staff of ten. Because of budget problems, however, this will be reduced to three attorneys and a staff of nine. We have handled 1,106 number of cases in the past year with this limited staff. We cannot possibly handle the number of problems that I have uncovered with my elderly clients. For this reason alone the passage of Senate Bill 1393 would be welcomed by myself and Ocean-Monmouth Legal Services, Inc. In the elderly population that I work with, the most serious problems, and most prevalent problems, and the most difficult problems are those encountered by those elderly indigent and have been placed in institutional setttings: either in nursing homes or in licensed or unlicensed boarding homes.

The elderly in nursing and boarding homes are the largest group of institutionalized persons in the country. They are particularly vulnerable. They live in a total institutional environment, that is they depend on the home and its staff for all of their needs. Their lives are totally controlled by people who, outside of a pecuniary interest in their presence in the home, have no relationship with them. Nursing and boarding home inhabitants are specifically old and sick and uprooted very often have no family or contacts with the outside world. It would seem that of all people in institutional settings, they need the most protection.

The passage of Senate Bill 1393 would protect part of this population, those elderly indigent institutionalized in nursing homes, but not all. Senate Bill 1393 would not protect those in boarding homes, either licensed or unlicensed. So the instance I am going to describe to you have taken place in boarding homes and the rights of those elderly indigent in boarding homes would not be protected under Senate Bill 1393. Therefore, I strongly urge that section 4 of Senate Bill 1393 include in its definition of "institution" not just nursing home as is now the case, but also boarding homes. This may be accomplished by inserting the following language after the words "nursing home" in subsection (3) of section 4 of Senate Bill 1393: "including skilled nursing facilities, intermediate care facilities and custodial care facilities."

I would now like to recite to you four examples of why I believe it is imperative that Senate Bill 1393 be passed and signed into law. From these examples I hope you too will agree that the Attorney General of the United States should be empowered to represent the institutionalized civil rights are being violated. Before I begin with my narratives I would like to point out

that I am not going to use the names of any of the patients or particular nursing or boarding homes that are involved. To do so would, I believe, expose the patients that I talk about or the patients that are still in the homes that I talk about to unnecessary harm. Retaliation against the institutionalized elderly is not unknown, as you will see. Therefore, to name names at this point would literally place the lives of some of my clients in danger.

The policy of the first home that I would like to discuss is to have the patients to request to use the bathrooms half an hour in advance. This is the director of the director of nurses and I have verified this policy with two aides. My client is a 93 year old woman who is confined to a wheel chair. This woman, obviously unable to move from her bed at night by herself, had a request to use the bathroom completely ignored. Being a rather vocal person, in her words, she "raised such a ruckus" that two male aids hit her over the head. She suffered a cut and bloody ear. During a time span encompassing several weeks, she felt bugs crawling in her ear and she made several requests, ten or eleven by her count over that period of time, to be taken to a doctor. Her requests were ignored. Finally, she was treated when she was fitted for a hearing aid for her loss of hearing.

Under similar circumstances, that of the same client asking to be taken to the bathroom, two aids carried her to the toilet and dropped her on it. She claims that she cracked two vertabrae.

On another occasion she was taken to the bathroom and dropped on the toilet in such a way that her feet became entangled in the support railing and the aids left her there to dangle for quite some time.

A client of this office was employed by this home and reported that the same home had been paid the pharmacy bills. As a result the dispensing of medication was therefore stopped and the reserve medication depleted. The patients that should have been given daily medication were given nothing. An elderly man suffered a seizure because of the lack of medication. He was taken to his room and the aide that I interviewed did not know what became of him after he was taken to his room.

The client also observed in this home that male and female patients were bathed together; the aides put a plump, elderly woman in a shower with a male patient and watched, laughing, while the man molested the woman.

Second. Two of my clients were residents of what I will refer to as nursing home B. This nursing home obligated them to put all their excess monetary assets in an escrow account. One client placed $1,933.60 in this account, and the other placed $842.00 in this account; they have receipts for these sums.

I was not able to determine the number of waivers in this home during its course of operation. I believe the number of waivers of the Life Safety Code and the Quality of Care regulations to be approximately 93.

The administrator of this home was indicted twice for the possession of stolen goods. The stolen goods were proven to be in Court the property of the patients under his care. He was convicted once and plead guilty to a lesser charge once. He still has his license to operate a home.

The home was ordered by the State to transfer all the residents eventually. Two days after the patients were transferred, the home was destroyed by fire.

My clients were unable to obtain the funds they placed in the escrow account because the administrator claims that all the records were destroyed in the fire.

Third. I began an investigation of what I will call nursing home C at the request of a physical therapist who was employed at that home.

This home is a seven story structure and houses fifty patients per floor. They employ one nurse and eight aides per floor. The elevators do not work. In case of a fire, the evacuation plan consists of having two aids pick up the patient, wrap them in a blanket, and carry him down the stairs. It took one person, alone, seven and one-half minutes to walk down the stairs. It would therefore take ten trips to evacuate the floor in over seventy minutes.

Numerous complaints have been registered with the State Department of Health regarding this home. Among them:

1. A diabetic patient was denied special menus. The physician ordered lab work, but it was never done. Bed sores weere untreated, mucous ran freely from her eyes.

2. A cyanotic patient was given a peanut butter sandwich for lunch. He was bound into a wheel chair. He began to choke and voided. The Department of Health Inspection Team's nurse observed this and called for help. There were

no nurses or aids on the floor. She dislodged the food and called for oxygen. The oxygen tanks were empty.

3. On the same day, the nurse observed; puddles of urine on the floor patients were served lunch on tables littered with used bed pans and urinals.

4. The administrator ordered 12 towels per floor for fifty patients. After the patients used the bed pans, they are all cleaned with the same towels.

5. Last year a woman pleaded to be transferred from the home. She was not transferred. This woman jumped to her death from the seventh story window.

6. Seven months ago, a partially paralized woman was put into a bath tub and the aid left her in the tub while the water was running. The aide returned and the woman was dead. The coroner's report showed that she was killed as a result of third degree burns over her entire body. The patient was literally boiled alive. The aid had been dismissed by is now re-hired.

Fourth. Another client was a 66 year old retired steel worker, a recipient of retirement benefits. He had suffered a heart attack and had a slight speech impediment. A resident of a licensed boarding home, he noticed that his mail was being delivered to him opened, and that a birthday present which was to have been a $20 bill and a birthday card, had never reached him. He therefore took a post office box in town. He called the Social Security Administration, district office, to have his address changed and was told that he could not do so, as he had been declared incompetent. He went to the district office and found the boarding home had declared him an alcoholic and a chronic schizophrenic and the administrator of the boarding home had been appointed as the representative payee. The physician, who was a pediatrician, and the administrator were the same person. Although there was no prior notification to my client, this was entirely within the regulations of the Social Security Act. My incompetent client then asked for a hearing. The notice of the hearing was sent to him at the boarding home, but he did not receive it until three months after the hearing. He then asked for an appeal, which should have been heard before an Administrative Law Judge, and my office subsequently undertook his representation. The notice of hearing was mailed to my office, to the client and to the administrator. The day after our mutual receipt of the notice, my client appeared in my office in a state of emotional and physical strain. He said that he had received the notice of hearing, as did the administrator. The administrator called him to the boarding home's office and began to hurl epithets at my client, such as labeling him a drunk, a troublemaker, and a homosexual. After leaving the administrator's office, the aides on the home began to physically push him; he had been confined to him room; his TV was taken away; his friends were forbidden to visit him. After relating these circumstances to me, he asked that some arrangements be made to transfer him to another boarding home. Until such arrangements could be made, I contacted him daily and was told of new abuses, i.e., his new room mate was a homosexual and had made sexual advances at him. I contacted the local welfare office but was advised by them that they would not be able to help my client as he had no money to pay for a new boarding home. Therefore, independently of the social services board, I made arrangements to have him transferred to another home that would accept him without any money, as all his funds were still controlled by the administrator of the boarding home. The move was completed on May 16th, 1977. The issues was heard before the Administrative Law Judge on June 13th, 1977, two years after the implementation of the representative payee.

My client died in a fire that destroyed the new boarding home on June 23rd, 1977. The issue of the representative payee will never be resolved nor will his funds be restored to him.

The above cases are not isolated; they are evidence of systemic problems that permeate the nursing and boarding home industries. It is merely the evidence that we have discovered. Numerous federal and state investigatory bodies have reached similar conclusions. For example, the report of the report of the Senate Sub-Committee on Long-Term Care (the Moss Commission) have after fifteen years of study documented the omnipresence of fraud, abuse and patient neglect in nursing homes. In New York, the Stein and Moreland Act Commissions and in New Jersey the Fay Commission have reached similar conclusions.

These cases that I have related to you speak for themselves. To my knowledge no agency of the State or Federal Government have actively attempted

to redress the grievances of those whose civil rights have been violated. The New Jersey Department of Health has sought to correct the living conditions on nursing homes, but it is not equipped to correct violations of civil rights or bring lawsuits. Legal Services, with its present financial capacities, cannot be expected to shoulder the entire burden alone.

The United States Attorney General can draw upon the expertise of all the agencies of the federal government and is capable of coordinating cases on a national level. Senate Bill 1393 will have a salutory effect on existing conditions in nursing homes and if amended as I suggest, on the boarding home industry as well. Those institutions engaged in a pattern of practice of gross violations of civil rights will be placed on notice that the enforcement powers of the federal government are now available to be used and the Attorney General will be on notice of the intention of the Congress that the rights of the institutionalized elderly poor be vigorously enforced.

Senator BAYH. Ms. Gorrecht, you may proceed.

TESTIMONY OF FREIDA GORRECHT, NATIONAL COALITION FOR NURSING HOME REFORM, DETROIT, MICH.

Ms. GORRECHT. I am the recently elected chairperson of the National Citizens Coalition for Nursing Home Reform. It is a recent organization but I am here today to support Senate bill 1393.

In order to document my statement thoroughly I have drawn upon my experience since 1969 as president of Citizens for Better Care, a State consumer organization in the State of Michigan.

I have submitted testimony to you. I have further validation of that testimony. I would like to speak to that in my oral presentation.

Senator BAYH. We will put all of your printed documentation into the record.

Ms. GORRECHT. I think this documentation will do two things. It will show you what it takes to try to resolve some of these things which are still not resolved. It would give you some indication of the kind of power that is needed to do what Ms. Scimeca said has not been done in the cases of some of these people. I have detailed references which include letters to regulatory agencies, to HEW, letters to the State attorney general about these two particular situations. We have the official records of the inspections of these two homes. It is all in this packet of material that I am submitting to you.

What we are really saying is that we need a tool to further enforce what is at the present time a weak system of regulation within the States.

I think these two examples will point out why they are weak.

Not every State has an organization that can go to the lengths to document, as we have done in Michigan. Even with that documentation we still are frustrated. We think that your bill will give us the extra clout which we need to make sure that the civil rights of people are not constantly violated because institutions like this can enter into long drawn out procedures with the regulatory agencies.

Briefly, I would like to draw your attention to the situation in the nursing home called Conner Manor. On August 5 and 6 of 1975 the Michigan Department of Health investigated a complaint submitted by Citizens for Better Care regarding the death of a 63-year-old male patient. There were incidents about his death which led us to believe that all was not well in Conner Manor Nursing Home. That began the situation.

We pointed out in a long letter to the department of health 17 serious rule violations, some of the kinds of things that the first witness was talking about. They were found to be true in this nursing home.

Then I would like to read to you from a newspaper article on January 13, 1977. This is about the same nursing home.

This is the Detroit Free Press. It says,

> The Wayne County circuit judge temporarily prohibited the State department of public health Wednesday from transferring any patients from the East Side Detroit Nursing Home where five residents have died under questionable circumstances in the past 2½ years.

I hope I have not lost you. This is from 1975 to 1977.

A lot of things were going on but nothing was going on to resolve this question.

Senator BAYH. The judge would not let the patients be transferred out of the homes in which the deaths had occurred?

Ms. GORRECHT. That's right because Judge DiMaggio made a ruling in response to the charge by the Conner Manor Nursing Home that the State had illegally terminated its license without a prior hearing.

Senator BAYH. How many people have to die before you can terminate a license legally in the State of Michigan?

Ms. GORRECHT. You don't expect me to answer that do you?

I will tell you what is happening at Conner Manor and a few others. Then we can draw our own conclusions.

This article goes on further and says:

> Conner Manor was ordered closed after the death last Wednesday of Margaret Grant, 70, a resident. According to two former Conner nurses aides who say that they were fired after pleading with the staff to hospitalize the ill woman, the nurses on duty ignored their pleas and did not check Mrs. Grant's condition until 3 hours later when she was found dead.
>
> Frederick Trail, Chief of the Health Department Licensing Division, said a probe of Mrs. Grant's death confirmed that she had been left unchecked for 3 hours. In each of the four other deaths in the past 2½ years the question of negligence has also been raised.

That's a long article. It will be in this packet and inserted in the record.

Here's another article dated April 21, 1976, the previous year.

> The Michigan Department of Public Health has moved to deny the license of a Detroit Nursing Home where an epileptic patient drowned in a bath tub last month. The investigation by the Wayne County Medical Examiner's office showed that the patient may have been missing from her room for more than 11 hours before her body was discovered in the tub.
>
> The drowning victim, Mamie Butts, 49, was found at 7:45 a.m. on March the 31st at Conner Manor Nursing Home.
>
> Miss Butts who was able to move around herself in a wheelchair apparently suffered an epileptic seizure while bathing and drowned when there was no attendant to help her according to the investigators.

This upset the nursing home and they are saying that it's not true that she was missing 11 hours but that she may have been missing only 5 hours.

I submit to you that when you are dead you are dead. Then it doesn't matter whether you die at 11 hours without attendants or 5 hours without attendants.

This is April 29, 1976, which again is a newspaper article by the Free Press.

The Michigan Department of Public Health is investigating the death of a patient who drowned nearly two years ago in a bath tub at the Conner Manor Nursing Home.

Then it goes on to describe that the Health Department is serious about denying this license.

The current investigation centers on a death of Walter James, a blind diabetic with a history of heart trouble who was found dead in a tub shortly after 3 p.m. on July the 29th, 1974.

There is no point in carrying this part of my testimony any further.

I would like to read two things to you. There is included in this packet of material the most recent inspection reports of Conner Manor. There is a short sentence or two in summary. These are the official reports of the health department's inspection.

Summary: Conditions evident at the facility indicate continued deterioration of building and equipment and poor housekeeping practices. A structured effective system is not available for reporting maintenance problems or correcting such. Housekeeping is lacking and disorganized. A number of areas lack necessary ventilation and excessive hot water temperatures—which can cause people to be boiled alive—continue to exist. Conditions in the building are such that roaches are noted in various areas.

It is not even an aesthetic place in which to die.

The last thing I would like to read is a note I have made on this material.

Intent to deny license issued by the Department of Health to this home on April 1976. First administrative hearing held in June 1976. Hearing continued to November 1976 and again to February 1977. February 2, 1977, hearing postponed until April 14. Postponed again until May the 3rd. Postponed again until June the 29th. And finally postponed until August the 3rd, 1977.

I will be happy to write you a letter on August 4 and tell you when the next postponement date is. These are the procedures that we are faced with in State after State where you have the consumer organization like ours who can do this documentation and support by official documents why a home should be closed and still you need to ask me: Why is it not closed? It is not closed because we have a legal procedure to follow and the cards are stacked against the patients. We feel that your bill will give us an additional ace in that pack of cards. These people need it.

The kind of evidence that I have just read to you from the Conner Manor Nursing Home is also included in my packet of material.

To be fair we included a profitmaking organization which fits into this pattern.

We also included a church run and sponsored one, lest you think that ony profitmaking nursing home organizations have these problems.

Senator BAYH. A ch[illegible]h run organization had the same kinds of problems that the Conner Manor Nursing Home had?

Ms. GORRECHT. That's correct.

We had an adequate amount of official inspection complaints. There was a mentally retarded child as one of the first ones here. He was admitted to the nursing home with pneumonia and undiag-

nosed. Four days later he died. This began the saga of a new nursing home operated by a church.

I think this will help you somewhat to prove that nursing homes contain people who are retarded, children who are young as well as older sick people who also have some of these problems. They are in need of the protection of their Government.

Senator BAYH. We thank you very much for your testimony. That was a graphic description of conditions that are almost unbelievable. Our older citizens who have given so much to all of us, yet all too often they are warehoused as inanimate objects. Perhaps inanimate objects would be treated better because they would be worth some money.

We thank you very much.

[The prepared statement and documents submitted by Freida E. Gorrecht follow:]

PREPARED STATEMENT OF FREIDA E. GORRECHT

I am Freida E. Gorrecht, Chairperson, National Citizens Coalition for Nursing Home Reform. I am here today to speak in support of Senate Bill 1393, and in doing so will present material drawn from my active involvement with consumer action groups in the State of Michigan.

Senator Bayh stated, and it was so recorded in the Congressional Record of April 26, 1976:

". . . the need for authorizing legislation is immediate and unconditional. . . . This bill (S. 1393) creates no new substantive rights, nor does it open the doors of the Federal Courthouse to a new class of litigants. Under the standards I have proposed, the authority of the Department to bring suit on behalf of the institutionalized is limited to cases alleging widespread deprivations of Constitutional and Federal rights, and thus poses no threat to state officials of repeated Federal intervention on behalf of individuals alleging *isolated* instances of abuse. In fact, by clarifying once and for all the authority of the Department to participate in suits to redress *systematic ongoing* violations of institutionalized persons rights, this legislation will minimize proliferation of separate suits by individual litigants."

As an active member of a state and a national reform organization, dedicated to the securing of the individual rights within nursing homes, homes for the aged, and other after-care facilities, it is my opinion that we desperately need Congress to provide an effective enforcement mechanism for securing those rights guaranteed through the Constitution and through our Federal laws for all Americans. I believe that S. 1393 will give us the mechanism to insure that individuals will not be deprived of their right to decent, humane, and adequate medical, custodial maintenance care within these institutions.

I have with me today a collection of documents which, when read in sequence, will alarm you. They trace a procedure entered into by a consumer organization, state regulatory agencies, nursing home owners and administrators, the county prosecutor, Health, Education and Welfare personnel, and people at the mercy of a system; a procedure as bazaar and as vicious and as hopeless as Catch 22. I hope these two examples of why we need S. 1393 will elicit your favorable response at this hearing. These two examples are not isolated and particular. They are examples of what goes on across the country. The difference between these events and others is that a consumer organization was able to be a part of this miserable happening and has documented it with observations, official documents, proven facts, relatives, and opinions. We have continued to fight the system on behalf of those persons both dead and alive who are the victims.

EXAMPLE 1.—CONNER MANOR

1. Letter from CBC to Dr. Reizen detailing serious deficiencies at the facility and requesting notice of intent-to-deny licensure (date March 25, 1976).

2. Letter from DPH responding to above letter, stating that the facility wants only basic Medicaid certification (date April 1, 1976).

3. Letter of April 1, 1976 from CBC to Regional HEW Director asking revocation of basic certification if DPH fails to act appropriately.

4. Memo of April 1, 1976 to Dr. Ziel from two nurse consultants reporting on their investigation of death of patient Mamie Butts.

5. Letter of April 6, 1976 from CBC to Harry Luchs to file formal complaint against Connor Manor re death of Mamie Butts.

6. Letter of April 13, 1976 from CBC to Dr. Reizen supporting DPH intent-to-deny licensure letter and asking DPH to take additional steps.

7. Letter of April 20, 1976 from CBC to Wm. Cahalan requesting Prosecutor's Office investigation into criminal negligence re death of Mamie Butts.

8. Newspaper article on death of Mamie Butts resulting from CBC news conference on April 21, 1976.

9. Publicity of April 29, 1976 regarding second drowning of patient at Connor Manor.

10. After death of another Conner Manor patient in early January, 1977, DPH attempts to close home on emergency order but closure order overturned in court.

11. Most recent inspection reports.—Intent to deny issued by DPH in April, 1976. First administrative hearing held in June, 1976. Hearing continued to November, 1976 and again to February, 1977. February 2, 1977 hearing postponed till April 14, postponed again till May 3, postponed again till June 29, and finally postponed again till August 3, 1977.

EXAMPLE 2.—FRIENDSHIP MANOR

1. October 15, 1976: Letter from Chuck to Dr. Reizen detailing history of problems in the facility and requesting denial of the license. Copy sent to the administrator October 18, 1976.

2. October 26, 1976: Dr. Reizen responded that conditions in the facility had been improving.

3. November 12, 1976: We submitted formal complaint to WCDPH on problems staff observed in the facility.

4. December 21, 1976: Letter from Henry Langberg, attorney to Dr. Reizen, protesting WCDPH non-enforcement. 12/23—copy sent to Attorney General, Frank Kelly.

January 6, 1977: Letter from Chuck to Congressman Claude Pepper, U.S. House Committee on Aging.

January 6, 1977: Letter from Chuck to Richard Friedman, HEW.

January 6, 1977: Letter of intent-to-deny licensure issued by WCDPH.

March 23, 1977: Last WCDPH inspection.

April 7, 1977: Letter of intent-to-deny awarded. First hearing on license denial held February 16, 1977. Continued hearings scheduled and cancelled on April 19, May 11 and 12, June 7 and June 8. Next hearing scheduled July 12 and July 13, 1977.

Here are a few excerpts from the Connor Chronicles—Exhibit No. 1—a letter from CBC to the M.D. Health dated March, 1976. Listen to some quotes from several newspaper articles about the death of patient Mamie Butts. The official inspection reports of March 1977 detail continued miserable conditions.

Status of hearings are part of our continuing fight to restore the rights of these patients to decent care—care paid for by our tax dollars and provided by private business.

If the Committee wishes me to do so, I am prepared to read some excerpts from the material relevant to the continuing conditions in Friendship Manor, another setting but the same problems and the same lack of ability of a consumer group to "beat the game".

S. 1393 will change the odds in favor of the client and those who advocate for them.

Thank you for listening.

[Exhibit No. 33]

Citizens for Better Care,
Detroit, Mich., March 25, 1976.

Dr. Maurice Reizen,
Director, Michigan Department of Public Health,
Lansing, Mich.

Dear Dr. Reizen: I am writing as a result of action taken by the Citizens for Better Care (CBC) Board of Directors at its March 15, 1976 meeting, concerning the Conner Manor Nursing Home in Detroit. Based on a review of survey reports prepared by your Department, investigation reports compiled by the Michigan Department of Public Health (MDPH) on complaints about Connor submitted by CBC, and other information about the facility obtained by our organization, we believe that this nursing home falls far short of the minimal standards established by the State of Michigan for licensure and the Department of Health, Education and Welfare requirements for intermediate care certification in the Medicair program.

CBC is annoyed at the constant delaying tactics employed by the Department regarding this facility. Conner Manor has continually manifested numerous deficiencies, their scope and number warranting more stern and straightforward action on the part of MDPH than has been shown to date. The Department has allowed repeated violations to go unreprimanded, and despite the widespread problems now existing at the home, has still not deemed it appropriate to issue an intent to deny licensure. The following discussion of Department of Public Health findings regarding Conner should be convincing evidence of the need for stronger methods in dealing with this home—namely, an immediate intent to deny licensure notification! (then, other ultimatums we ask you to deliver to the home, the substance of which are elucidated in the following text).

On August 5 and 6, 1975, the MDPH investigated a complaint submitted by CBC regarding the death of a 63-year-old male patient. According to the MDPH complaint report, the patient was discovered by the facility's charge nurse at 6.30 one morning in a "flowerbed in front of building with abrasions on his arms and legs and covered with mud." Although the investigation was not able to conclusively pinpoint the way the patient left the building, the complaint report suggests that the elderly man wandered out through the basement exit. The MDPH complaint investigation documented that the patient had tried to leave the building several times previously and although required by state regulations, incident reports had not been prepared by Conner on these trips, including one in which "the patient was found walking on I-94."

The MDPH investigated another CBC complaint on August 6, involving the death of a male patient, apparently as a result of poor care and other medical complications. According to the report, "maggots were observed in his (the patient's) bedsores. The dressings had not been changed for several days. The bedsores were not treated properly." A review of the medication sheet revealed that the patient did not receive his medication prescribed by the physician on numerous occasions without any notations as to the reasons. "Problem outlined in the nurses' notes were not mentioned in the progress notes. The problems of the decubiti were never mentioned in the progress notes during the time they were such a problem prior to the patient's death." This complaint investigation, as well as the one previously discussed, involved two rule violations on the facility evaluation reports.

A routine inspection of Conner was conducted on August 4 and 5 by three nurses from the MDPH. Seventeen rule violations were spelled out on their facility evaluation report. Under the heading "Michigan Licensing Deficiency" the accompanying field report stated flatly that "sufficient nursing personnel is not available to provide continuous twenty-four hour nursing care and services sufficient to meet the nursing needs of each patient in the home." The nursing home care that did exist was inadequate. Other problems observed were irregularities in dispensing and recording medications and a lack of a social services program. Glaring deficiencies were also noted regarding intermediate care standards. The staffing, staff development, contents of medical records, and plans of care for rehabilitation, social services, recreational activities, and health care all come under attack in the nurse's report.

The same report found the environment of Conner Manor to be something short of aesthetic. "One patient had underwear soiled with dried feces in a basin in his night table." In addition, a number of records reviewed indicated patients with diarrhea.

A visit by a dietition on December 12 unearthed no items of noncompliance, but a sanitarian found five rule violations on December 15 and 16, and an additional violation on January 19, 1976, in an investigation prompted by another CBC complaint. His findings included the detection of a stale urine odor in one wing, a dried puddle of urine in a patient's room, and "what appeared to be fecal matter was noted on the floor of the first floor dayroom." A December 8 and 9 nursing field report reiterated many of the August nursing inspection findings. An insufficient administrative staff was plaguing the home, "Staffing is not sufficient in numbers, competency, or performance, to carry out the policies, responsibilities, or programs of the facility." A written health care plan had still not been developed nor implemented by nursing staff, and clinical records still lacked necessary data. And the in-service education requirement had still not been met.

The summary concluded that "while there is evidence of substantial progress in meeting standards in certain areas such as physical therapy, social services, and the activities program, there remain important areas of non-compliance, such as the provision of nursing services, staff development, and documentation of care and services. The provision of nursing services continues to be substandard in basic personal care as well as the restorative/rehabilitative aspects of care." A nurse also investigated Conner following the third CBC complaint. Appropriate methods were lacking to keep a female patient from wandering from the "safe" area of the nursing unit, resulting in a journal upon Conner Avenue, which occurred about December 12.

Plans of care for other patients mentioned in the complaints were non-existent or not carried out in any consistent or appropriate manner. The summary strongly recommends that:

1. Appropriate patient care plans be developed for each patient, defining their particular nursing and related needs, and the specific intervention to be taken in order to care for that need;
2. Individual assignments be given to each nursing aide in order to assure that they are knowledgeable and competent to carry out these patient care plans;
3. The charge nurse should be responsible and accountable for assuring that all medical orders are carried out, when appropriate, on the day that they are written.

The sanitarian's report not only totally substantiated CBC's complaints, but found other problems in the facility. The preventative maintenance program was still inadequate, and the infection control policy still exhibited numerous deficiencies. The sanitarian stated that "the general information regarding the facility was the same as in the August field reports." In January, he asserted that "since the evaluation of December 16, 1975, the housekeeping program has deteriorated from an acceptable level to an unacceptable level." CBC has two Ombudsmen who regularly visit Conner Manor, and they substantiate many MDPH findings. Floors are often filthy, toilets dirty. The aides lack sensitivity to the needs of patients—there have been complaints of physical abuse. The activities program at the home has come under criticism. Nursing staff shortages and housekeeping problems are a continual blight on the home's efforts.

At the request of James Claucherty of the Department, a meeting was held with the Conner attorney and administrator, and various Department personnel. The concensus there was devastating to Conner, concluding that inadequate nursing care had been delivered to patients, including: (1) staffing deficiencies: (2) no assessment of patient needs; (3) no patient care plan; (4) no rehabilitative nursing care; (5) no in-service training of any significance; (6) lack of documentation for medication administration; (7) gross medication errors; (8) incomplete and inaccurate medicals records; (9) poor nursing apparently due to lack of supervision by the Director of Nursing.

Cheri-Nan Jansen, a registered nurse who had conducted inspections in the home throughout, stated that in her professional opinion the most basic elements of daily patient care are not being delivered i.e., (*a*) patient grooming;

(*b*) bathing and cleanliness; (*c*) positioning of edematous patient limbs; (*d*) observation of patient food and fluid intake; and (*e*) oral hygiene.

In light of these numerous and multifarious findings and complains, Citizens for Better Care wants you to issue an intent to deny licensure to Conner Manor within ten days of the receipt of this letter, because the house does not meet state licensure or even basic certification standards. State rules have been continually violated, basic certification standards have not been satisfied. In addition, CBC is disturbed about the manner in which the "compromise" was handled, the home being allowed to continue under basic certification without an intent to deny its license being issued, despite findings conclusive enough to justify such an action on the part of the Department. Our interest in being notified of an intent to deny licensure order is not motivated solely by a desire to see the home closed. We would like to see the home open, operating in a fashion which is appropriate for a health care facility. It is clear, however, that this home shows few, if any, indications of prospective change. Therefore its receipt of an intent to deny licensure would signal to the home that dramatic improvement is necessary. And though we are aware of the fact that few homes are ultimately closed, the situation seems to warrant this action unless significant improvements are made in the functioning of Conner Manor. We would like a copy of the intent to deny notification. And once the intent to deny is issued, the MDPH should conduct weekly unannounced inspections by at least a nurse and sanitarian, covering all shifts, weekdays and weekends. In addition, we want Conner Manor to show good faith efforts to effect changes with respect to easily identifiable violations within ten days. Along with the intent to deny licensure notice, we ask you to order the home to make the following corrections, giving them ten days in which to comply.

First, we would like a full-time Administrator and Director of Nursing hired within that time period, if this has not already been done. Certain violations noted in the January 19 sanitarian's report could readily be corrected. Clean, operating cubicle curtains must be in place in every patient's room. Refuse must be disposed of in proper containers. Deteriorated mattresses must be immediately replaced. The facility must take measures to see that patients are fully dressed (in day wear, whenever possible). The December sanitarian's report contains a plethora of violations which could be dealt with within ten days. Chairs and couches which are broken, torn or burned must be replaced. The nurse call system does not register the individual room from which a call is being placed. To ensure that patients can receive prompt and adequate nursing care, this and all illumination panels must be provided with properly operating light bulbs. Several pieces of food service equipment not clean and sanitary, or not in good repair, must be cleaned or repaired. Certain maintenance problems could be rapidly alleviated—among items mentioned were broken furniture, broken cords on nurse call receptacles (sic) in several rooms, cracked walls in the east wing and broken handles on openable windows. In many areas of the facility the floors and/or walls are not being maintained in a totally acceptable manner. This situation can also be rectified.

The August 5 and 6 report of the health analyst rightly called for screens on all windows and for bed checks from 11.30 p.m. to 6 a.m. These recommendations should also be implemented within ten days.

Then, notwithstanding the home's performance regarding these initial changes, we feel that within 45 days, if the conditions in Conner have not improved to the point where they approach minimal standards, you as the Director should invoke emergency closure of the home.

The following discussion outlines what we consider to be necessary changes during this 45-day period. A number of recommendations made in the August 4 and 5 nursing report should be heeded. Adequate nursing staff must be hired to meet state requirements. Job orientation for nursing personnel must commence; a plan for weekly in-service training needs to reach fruition. The in-service director should develop a list of training priorities, an outline for each area, and schedule classes. In light of the August 5 and 6 report of the health care analyst, someone should be assigned to watch the front door nightly and all alarms should be operable.

Considering the massive housekeeping problem at Conner, the facility should contract with an outside custodial firm to alleviate the all too often filthy conditions in the home. Failing that, its own efforts will need to be drastically

improved to meet sanitation standards. The sanitarian himself addressed this issue in his January 19 investigation. "It would appear that the facility should reevaluate (its) housekeeping program and assign additional employees on the week-ends and provide personnel for the afternoon and midnight shifts." A public lobby also must be provided, according to the sanitarian.

The December nursing report certainly mandates change within this period. An activities calendar for the next three months should be developed. Staffing must be improved in all respects, in numbers, competency and performance, so that the policies, responsibilities, and programs of the home can be effectively carried out. The general provision of nursing services must be qualitatively raised, above the substandard level now in existence. And clinical records must be complete and accurate, containing all necessary data. Nine of the 14 nursing violations cited in August were still afflicting the home in December.

The recommendations outlined earlier in this letter by the nurse in her January investigation of a CBC complaint, also bear the home's attention within this 45-day period. Ultimately all the areas mentioned in the February 13 memo should show pronounced improvement within this time frame. If not, the home should not be allowed to operate under such conditions.

CBC has been concerned for a long time about the situation at Conner, as evidenced by our complaints, our Ombudsman participation, and our interest in state inspections of the facility. By writing you directly, we are indicating our desire to be involved in decisions made by the MDPH regarding Conner. Let me stress that most of the changes we have urged have been made on other occasions by MDPH personnel in their facility evaluation, field and investigation reports. Our concern lies with the welfare of the patients in this facility—they certainly deserve a far greater quality of care than they have been receiving at this home for a seemingly interminable period of time.

Under Title 45 of the Code of Federal Regulations, Section 244.33(ii)(A), the Department of Public Health, as the survey agency, is required to maintain a "written justification of . . . findings" regarding deficiencies in nursing homes which jeopardize the health and safety of patients or which are of such character as to seemingly limit the provider's capacity to render adequate care. I do not know if the Department has lived up to this requirement, but if such written justification exists, we would appreciate a copy of such justification, as it might help us understand why Conner is still allowed to operated with an unfettered license.

Your immediate attention to these matters is requested. We expect to hear from you regarding the intent to deny licensure within ten days.

Sincerely,

RANDY HILFMAN,
Legal Counsel.

APRIL 1, 1976.

RICHARD FRIEDMAN,
Regional Director, Health, Education, and Welfare, Region V, Chicago, Ill.

DEAR MR. FRIEDMAN: Citizens for Better Care, as a Michigan consumer advocate organization for nursing home patients, is extremely distressed at the recent action of the Michigan Department of Public Health in its licensing and certification decisions regarding a Detroit nursing home, Conner Manor. Enclosed are copies of a memo documenting a February 13, 1976 meeting involving representatives of Conner and the Department of Public Health, a memo summarizing conditions at Conner from August 1975 to January 1976, and a letter to Dr Reizen, the Director of the Michigan Department of Public Health, explaining our concern and requesting quick action on the part of the state.

The state has been reluctant to invoke stern measures against Connor Manor, despite widespread, longstanding problems with the home. If the state does not act within the guidelines set forth in the letter to Dr Reizen, we ask HEW to revoke the home's basic certification. I look forward to hearing from you in the next ten days.

Sincerely,

RANDY HILFMAN,
Legal Counsel.

Enclosures.

[Exhibit No. 34]

State of Michigan,
Department of Public Health,
Lansing, Mich., April 1, 1976.

Mr. Randy Hilfman,
Legal Counsel, Citizens for Better Care,
Detroit, Mich.

Dear Mr. Hilfman: We wish to acknowledge your letter of March 25, 1976 regarding the Conner Manor Nursing Home, Detroit, Michigan.

The above facility has been and continues to be under surveillance by the Michigan Department of Public Health and alternative actions in regard to the licensure and certification of the facility are under consideration.

As you know, from a review of the facility's licensure and certification file, there have been a number of improvements in the operation of the facility. In addition, the facility has requested licensure and certification as an intermediate (basic nursing) care facility effective April 30, 1976. A number of skilled patients have been transferred to other facilities and it is anticipated that the transfer of all skilled patients will be complete by the above date.

On the other hand, we wish to point out that the above arrangements do not preclude the Department's choice of another alternate course of action should a change in the situation demand such action.

We also wish to point out that the owners of the Conner Manor Nursing Home are also responsible for the operation of several other nursing homes in the Detroit area which are licensed and certified on the basis of substantial compliance with applicable requirements. This and the evidence of progress to date tends to support, to some extent, the contention of the facility owners that the facility can be brought into compliance wih licensure and ICF cerification requirements in the near future.

We have asked Mr. Fred Traill to keep you informed of any change in the facility's licensure and certification status.

Thank you for your letter.

Sincerely,

Theodore R. Ervin,
Deputy Director
(For Maurice S. Reizen, Director).

[Exhibit No. 35]

April 1, 1976.

Richard Friedman,
Regional Director, Health, Education, and Welfare,
Region V, Chicago, Ill.

Dear Mr. Friedman: Citizens for Better Care, as a Michigan consumer advocate organization for nursing home patients, is extremely distressed at the recent action of the Michigan Department of Public Health in its licensing and certification decisions regarding a Detroit nursing home, Conner Manor. Enclosed are copies of a memo documenting a February 13, 1976 meeting involving representatives of Conner and the Department of Public Healtth, a memo summarizing conditions at Conner from August 1975 to January 1976, and a letter to Dr Reizen, the Director of the Michigan Department of Public Healtth, explaining our concern and requesting quick action on the part of the state.

The state has been reluctant to invoke stern measures against Conner Manor, despite widespread, longstanding problems with the home. If the state does not act within the guidelines set forth in the letter to Dr Reizen, we ask HEW to revoke the home's basic certification. I look forward to hearing from you in the next ten days.

Sincerely,

Randy Hilfman,
Legal Counsel.

Enclosures.

[Exhibit No. 36]

Michigan Department of Public Health,
April 1, 1976.

Memorandum to: Dr. Ziel.
From: Cherie Nan Jansen, R.N., Delphine Shott, R.N.
Subject: Conner Manor—The death of Mammie Butts.

Upon arriving at Conner Manor at approximately 11:15 A/M, three (3) police cars and two (2) police vans were observed in front of the facility. We were met at the front entrance by Robert Savery, Administrator and Marilyn Neubauer, R.N., Director of Nursing. Mr. Savery explained that a patient, Miss Mammie Butts had been found dead at 7:00 A/M partially submerged in a bathtub.

We were taken to view the body and encountered a number of police officers and personnel from the coroner's office. We identified ourselves and were given a brief resume of the preceding events by the police officers. We were told to contact the coroner's office in the afternoon for a statement regarding the cause of death. We were further told that a complete report would be available to us.

The director of nursing, the night supervisor and the nurses aide who discovered the patient were interviewed. The patient's roommate was also interviewed.

The director of nursing had been notified at 8:15 A/M and could offer no further information. Mr. Rich, L.P.N., Night Supervisor, stated that he had come on duty arriving late at approximately 1:30 A/M. Mr. Rich reported that he had not received a written or verbal report for the previous afternoon shift. Further, due to his late arrival, assignments had not been made out. He stated that he made rounds that night in the facility at 1:30 A/M and at 3:45 A/M. He stated further that rounds are normally made at least every two hours. Other than during rounds, he was not on the unit in question until 6:30 A/M. He reported that he was involved at that time with assisting patients' in getting ready for breakfast due to a shortage in staff.

Mr. Rich reported the following staffing for the night shift: "One licensed practical nurse responsible for One-East and Two-East; One licensed practical nurse responsible for One-West and Two-West; Two nurses aides assigned to One-East, the unit in question. Overall staffing for the entire facility on the night of March 31, 1976 was: Three (3) licensed practical nurses and (10) nurse aides. Thirteen (13) nursing personnel on this night shift would meet minimal staffing requirements."

The nurse aide who found the patient in the tub stated that she "found the patient lying on her back in the tub with her face in the water, turned to the left side and her left arm raised out of the water." Two other nurses arrived and assisted in lifting the patient out of the tub, lying her on the floor and attempted resuscitation. They observed no vital signs and they transferred the patient to an empty room where we viewed the body.

A roommate —— was interviewed and gave the following information:

"Mrs. —— stated that she and Miss Butts were planning on watching a T.V. program at 8:30 P/M in their room. Miss Butts left the room at approximately 8:00 P/M to take a bath. Miss —— stated that it was Miss Butts's usual practice to take her bath in the evening. She did not return for the planned television program and Miss —— retired for the night. Miss —— reported that she awakened at 2:00 A/M to go to the bathroom and noted that Miss Butts had not returned and the bed had not been disturbed. She returned to bed and awoke at approximately 5:00 A/M and again observed that Miss Butts was still not in bed and the bed remained undisturbed. She reported that some time between 5:00 and 6:00 A/M a nurse aide came to the door and said, "It's time to get up." Miss —— arose and dressed and some time after 6:00 A/M left for the dining room. Miss —— further stated that the door was closed all night and she heard no one make rounds.

"Miss —— stated upon questioning that she had noticed nothing unusual about Miss Butts's behavior during the previous days."

The clinical record was reviewed. The patient was a 49 year old, admitted to the facility from Caro State Hospital on January 17, 1969. Her diagnosis was epilepsy and cerebral ataxia and mental retardation. The clinical record indicated that her last seizure was December 15, 1975. It was reported, however, that she had "periodic seizures."

The last physician's progress note was on March 9, 1976. The last orders were simply for the reorder of the usual medication of phenobarbital gr. ¼ three times daily, berocca 1 tablet daily and elavil 25mgm., three times daily. She had received her 6:00 P/M medication on the night she died. (according to record)

A detailed nursing assessment appeared on the clinical record, without however being utilized in the development of the nursing components of the plan of care. On March 9, 1976, the only nursing notation on the patient's care plan identified a problem with coordination and defined the planned approach as continuing physical therapy. However, according to the physician's progress notes, physical therapy had been discontinued in January 1976. It was noted further that the patient "did well walking with the walker."

There was input on the patient care plan from both social services and diversional activities staff. One note stated, "patient stays to herself quite a lot—not unsociable, but a loner." Another note said "easy to talk to" and "must be encouraged by all staff to participate in activities."

The last nursing note preceding the episode in question was on February 20, 1976 between 7:00 and 3:00 P/M. Nothing unusual was charted in this note other than the patient's cold symptoms were subsiding.

On March 31, 1976, the following nursing note was written:

"7:15 A/M. Mrs. Lacey (N.A.) went to room 116 looking for Miss Butts. Patient not in her room. Her wheelchair gone. Her bed appeared made and not slepted in.

"7:30 A/M. Breakfast trays up. Patient not in dining room. Mrs. Lacey and I (Mrs. McGhee, R.N.) continued to search for patient.

"7:45 A/M. Mrs. Lacey found Miss Butts lying in a bathtub of water in the prone position, her head submerged facing the left side of the tub. Her left arm sticking up out of the water and her nose saturated with old blood and mucous. No pulse or respiration noted or palpable. Supervisor paged. (Head taken out of the water.)

"8:00 A/M. Mrs. Latessa (Supervisor) arrived in the bathroom. Patient lifted out of the tub and placed on the floor beside tub in an attempt to resuscitate the patient.

"8:15 A/M. Director of Nursing Mrs. Neubauer called Dr. Gold's answering service notified immediately, about the patient's change in condition. Observed a stripped yellow, green, blue dress, one white slip, one white bra, one pink robe, one pair of pink slippers, one white pair of panties and one white towel lying in patient's wheelchair.

"8:15 A/M. Patient's body transferred from off the floor into a bed and placed in room 105. Mr. Savery (Administrator) and Mrs. Neubauer, R.N., (Director of Nursing) notified of patient's condition.

11:00 A/M. Police and homicide division here to investigate. Body taken away per coroner.

"1:30 P/M. Mrs. —— (patient niece) taken all of the patient's belongings." Signed by J. M. McGhee." (Quote taken from handwrittten patient record as accurately as possible.)

The evidence would indicate that the patient was in the bathtub from approximately 8:00 P/M until her body was discovered. Certain questions unanswered by documentation are:

1. What are the provisions for supervision of patients, particularly patients with known problems such as seizures?
2. Is the responsible staff member making rounds as provided in policy?
3. Who was responsible for the supervision and care of this patient on the afternoon and night shift in question?

The report from the coroner's office and from the homicide division of the police department has been requested.

[EXHIBIT NO. 37]

APRIL 6, 1976.

MR. HARRY LUCHS,
Bureau of Health Facilities,
Detroit, Mich.

DEAR MR. LUCH: I am writing to submit a formal complaint against Conner Manor Nursing Home in Detroit. My complain concerns the death of Mamie Butler in the facility during the night of March 30-31, 1976.

I know you are currently investigating this case and look forward to prompt receipt of your investigation report.

Thank you,

Sincerely,

SUSAN WASSERMAN KAUFMANN,
Complaint Investigator.

[EXHIBIT NO. 38]

APRIL 13, 1976.

MAURICE REIZEN, M.D.,
Michigan Department of Public Health,
Lansing, Mich.

DEAR DR. REIZEN: We have been informed by means of a phone call from Mr. Harry Luchs, that the Michigan Department of Public Health has issued an intent to deny licensure letter to the Conner Manner nursing home. We would like to commend the State Health Department on this step and we hope that the nursing home takes the necessary action to improve the care provided and to bring it into compliance with State and Federal standards.

In order to facilitate this we are asking the Department to take the following additional steps:

(a) Inspect the home weekly to insure that patients' lives, safety, and welfare are not threatened and to make sure that the facility makes immediate improvements as outlined in our March 25 letter to you;

(b) Invoke emergency closure if patients' lives, safety and welfare become seriously endangered; and

(c) In the owners of Connor Manor appeal and request a hearing of the intent to deny notice, schedule that the hearing within ten days of Connor's hearing request.

We do have some concerns about the State's position concerning Connor's certification for intermediate care under the Medicaid program. We may be communicating with you further about this.

Sincerely,

CHARLES CHOMET,
Executive Director.

[EXHIBIT NO. 39]

APRIL 20, 1976.

MR. WILLIAM CAHALAN,
Wayne County Prosecutor,
Frank Murphy Hall of Justice,
Detroit, Mich.

DEAR MR. CAHALAN: Citizens for Better Care requests a formal investigation of possible criminal conduct by the staff and owners of Conner Manor Convalescent Center, a nursing home at 5201 Conner in Detroit.

During the night of March 30-31, a resident named Mamie Butts drowned in this facility. While taking a bath, apparently unsupervised, Ms Butts suffered an epileptic seizure, slipped under the water and drowned. The autopsy, done by Dr. S. Khasnabis of the Medical Examiner's Office, indicates drowning as the cause of death and epileptic seizure as a contributary factor. Ms Butts entered the bath at approximately 8 p.m. and she was not discovered until 7:45 the following morning.

We believe the facility was possibly negligent in this incident and ask you to determine whether the case should be prosecuted as a manslaughter. Conner Manor did violate a State of Michigan nursing home licensing regulation during this incident. Rule 64(1) states that: "Nursing care and services shall

include . . . (e) A complete tub bath or shower taken by or given to an ambulatory patient *under supervision* . . . unless the physician orders otherwise." Clearly, Ms Butts was so unsupervised that she died and remained undiscovered for approximately 12 hours.

As you are aware, a violation of a Michigan Department of Public Health licensing rule is a misdemeanor (MCLA 325.12). Based on this and possibly other rule violations, and on the fact that a death has occurred under questionable circumstances, CBC is asking, once again, that you investigate this matter fully and prosecute the nursing home accordingly.

In order to provide you fuller documentation on this case, we are attaching the investigation report of the Michigan Department of Public Health. For the latest background information on conditions at Conner Manor, you may contact either CBC or the MDPH for their Field Reports and Facility Evaluation Reports dated March 31, April 1, April 2 and April 6, 1976. Those reports list 35 rule violations uncovered by MDPH during their most recent visits.

Sincerely,

CHARLES CHOMET,
Executive Director.

[EXHIBIT No. 40]

[From the Detroit News, Apr. 21, 1976]

REST HOME LOSING LICENSE AFTER DEATH: PATIENT DROWNS IN TUB

(By Kirk Cheyfitz)

The Michigan Department of Public Health has moved to deny the license of a Detroit nursing home where an epileptic patient drowned in a bathtub last month.

An investigation by the Wayne County Medical Examiner's office shows that the patient may have been missing from her room for more than 11 hours before her body was discovered in the tub.

The drowning victim, Mamie Butts, 49, was found at 7:45 a.m. on March 31 at the Conner Manor Nursing Home, 5201 Conner, where she had been a patient since 1969.

Miss Butts, who was able to move around by herself in a wheelchair, apparently suffered an epileptic seizure while bathing and drowned when there was no attendant to help her, according to investigators.

Robert J. Savery, the nursing home administrator, said Tuesday that an attendant should have been nearby to watch over the patient. He acknowledged that the drowning represented a failure by the home's nursing staff to meet its "responsibility . . . for care of the patients."

But Savery also said that the home intends to appeal the denial of its license. He added that the patient may not have been missing all night before her body was discovered.

Dr. Hermann A. Ziel Jr., a public health official, said Tuesday that investigations "all point to the fact that there was not the level of . . . nursing control that was necessary to identify, within a reasonable period of time, that this patient was missing."

Ziel said the health department had not decided to deny the home's license specifically because of the drowning incident.

He added, however, that the circumstances of her drowning "very directly support the conclusion that we had reached" that the home's nursing services did not meet the department's minimum standards.

Citizens for Better Care (CBC), a Detroit-based public interest group, had also been looking into irregularities at the home.

CBC plans to hold a news conference Wednesday about the drowning and "other severe patient care problems in the nursing home." Officials of the group declined to discuss details of the case until the press briefing.

Chuck Chomet, director of CBC, did say Tuesday that his organization had requested on March 25—nearly a week before the drowning—that the health department deny the home's license.

The health department took action to deny the license on April 9. Officials said, however, that they had been aware of problems at the home since July 1975.

"We have been closely following their activities and attempting to get them to improve," said James Claucherty, an official in the health department's licensing division.

"They simply, after almost a year of waiting, have not improved enough to meet the (department's) minimum standards," Caucherty said.

Savery, the nursing home's administrator, said the home would be able to demonstrate that it now is complying with the health department standards, in its appeal of the license denial.

While the denial is appealed—aprocess that could take several months—the home will remain in operation. It now has about 165 aged and disabled patients for whom the state pays approximately $20 a day, Savery said.

The nursing home is still conducting its own investigation of the drowning death of Miss Butts, Savery said.

He said the circumstances surrounding the death are not yet clear. But he maintained that the patient may not have been missing for more than 11 hours before her body was found.

"I have personnel who are swearing up and down to me . . . that they saw her as late as 6 o'clock in the morning," less than two hours before she was discovered in the tub, Savery said.

The report of the county medical examiner's office, however, said that the patient was last seen alive at 8:30 p.m. on the night before her body was found.

And Mrs. Rose Ward, the dead woman's aunt, said Tuesday that she visited the nursing home on March 31 and found that her niece's bed had not been slept in the night before.

The Conner Manor home is owned by Conner Manor Associates. Savery said Tuesday that this corporation is controlled by Ted Weiswasser, a man who also owns three other nursing homes—two in Highland Park and one in Warren.

[Exhibit No. 41]

[From the Detroit Free Press, Apr. 29, 1976]

State Probes Second Tub Death

(By Kirk Cheyfitz)

The Michigan Department of Public Health is investigating the death of a patient who drowned nearly two years ago in a bathtub at the Conner Manor Nursing Home in Detroit.

Conner Manor, 5201 Conner, is the same nursing home where an epileptic patient drowned in a tub last month. Since that incident, the health department has moved to deny the home's license.

The current investigation centers on the death of Walter James, 60, a blind diabetic with a history of heart trouble, who was found dead in a tub shortly after 3 p.m. on July 28, 1974.

Health department officials said Wednesday that they are concerned because the nursing home apparently failed to inform the department of James' drowning.

"I have searched the records . . . and there's nothing in our records relating to the death of this patient," said James Claucherty, an official in the health department's licensing division.

"It is the first time that I know of that we don't have something in the file on an unusual death," Claucherty said.

Health department officials said that it is customary for nursing homes to immediately inform the department whenever a patient dies under unusual circumstances.

Frederick Trail, chief of licensing for the health department, said he has ordered an investigation to determine whether the nursing home filled out the mandatory report on the death. That report, which does not have to be forwarded to the department, should be in the home's files, Trail said.

The investigation will also attempt to determine whether the victim's medical condition was such that the home should have had him under closer supervision while he was bathing.

Detroit police investigated James' death in 1974. A case report indicates that he may have been alone in the bathroom for some 45 minutes before his body was discovered by a staff member of the home during a routine check of the bathroom.

The Wayne County Medical Examiner's Office performed an autopsy on the body and concluded that James apparently suffered a heart attack in the tub and then drowned. The medical examiner ruled the death accidental.

James' death was brought to the health department's attention by Citizens for Better Care (CBC), a Detroit-based public interest group that watchdogs health care facilities.

Robert Anson, a CBC official, said Wednesday that his organization learned of James' drowning from an anonymous telephone caller. CBC then filed a formal complaint against Conner Manor and requested the health department to investigate the incident, Anson said.

CBC wants to know "how much supervision was necessary (for James) and was he closely supervised," Anson said. "I don't feel he was," Anson added.

"When a person is blind or has other physical limitations he usually requires closer monitoring . . . That means special precautions should be taken. That's where the home really looks bad," he said.

James, who originally came from Texas, was a widower with no living relatives. His body was donated to the Wayne State University Medical School.

One Detroit woman, identified in official records as a friend of the dead man, said she had made numerous phone calls to Conner Manor in 1974 but was unable to obtain detailed information on the circumstances surrounding his death.

The woman, a housewife who asked that her name not be used, said, "My daughter is a registered nurse and she was absolutely furious" when she discovered that James had drowned in a tub.

"She said that . . . he was not to be in that bathtub unless he was supervised," the woman said.

The heart attack might have killed him anyway, the woman said. But she added, "Immediately he should have been pulled from that water, and he might have been saved."

She said one official of the nursing home did tell her that James was not being supervised when he died because he "was a strong-willed man" and had gone to take the bath without telling any attendants or nurses.

At the time of James' death, Conner Manor was owned by Alden Care Enterprises Inc. of Southfield, according to health department records. Since that time the home has been taken over by another corporation.

Dr. Dennis Moss, top official of Alden Care, could not be reached for comment Wednesday.

The nursing director at Conner Manor ejected a reporter Wednesday and refused to answer any questions.

Robert J. Savery, the nursing home's administrator, was not at the home Wednesday, the nursing director said.

Theodore Weiswasser, a Southfield attorney who has been identified as the home's present owner, also was unavailable for comment.

Conner Manor is a modern two-structure facility near the corner of Conner and Warren on Detroit's east side. It houses approximately 165 aged and disabled patients. Room, board and nursing care for most of the patients is paid for by the state.

Conner Manor became headline news last week when it was revealed that a 49-year-old patient, Mamie Butts, had drowned in a tub after suffering an epileptic seizure while bathing. Miss Butts' body was found floating in the tub at 7:45 a.m. on March 31.

Investigations indicate that Miss Butts may have been missing from her room for more than 11 hours before her body was found by a staff member of the home. The health department has concluded that the home did not provide the proper nusing supervision to Miss Butts.

Since then, Miss Butts' sister, Frances, has filed a $5-million lawsuit against Conner Manor charging that the home's negligence caused the death.

On April 9, the health department informed Conner Manor that it intended to deny the home's license. An official of the home has said that the denial of the license will be appealed.

94-420 O - 77 - 54

[EXHIBIT NO. 42]

[From the Detroit Free Press, Jan. 13, 1977]

CLOSING OF NURSING HOME RULED ILLEGAL

(By Susan Morse)

A Wayne County circuit judge temporarily prohibited the state Department of Public Health Wednesday from transferring any patients from an east side Detroit nursing home where five residents have died under questionable circumstances in the past 2½ years.

Judge Andrew DiMaggio made the ruling in response to charges by the Conner Manor Nursing Home, 5201 Conner, that the state had illegally terminated its license without a prior hearing.

In its suit, the nursing home protested the state's order Saturday to close after the death last week of a patient.

The nursing home claimed the state's order was unfounded and based on "unsubstantiated" and "hearsay testimony of alleged nurses' aides." The state's order also went against the findings of a hearing officer who ruled Tuesday that there was no emergency situation at the home, the complaint said.

A Health Department spokesman denied the nursing home's charges about the alleged testimony of nurses' aides.

Conner Manor was ordered closed after the death last Wednesday of Margaret Grant, 70, a resident.

According to two former Conner nurses' aides, who say they were fired after pleading with the staff to hospitalize the ill woman, the nurses on duty ignored their pleas and did not check Mrs. Grant's condition until three hours later when she was found dead.

Frederick Traill, chief of the Health Department's licensing division, said a probe of Mrs. Grant's death confirmed that she had been left unchecked for three hours.

In each of the four other deaths in the past 2½ years, the question of negligence has also been raised.

According to Chuck Chomet, executive director of a Detroit area group called Citizens for Better Care, some 20 of about 150 patients have left the home in the past two days. Chomet complained that some of those leaving had problems reclaiming their personal funds. He also charged that there were not enough blankets at the home for those patients remaining, and said his group planned to call the Red Cross for help if these were not quickly provided.

Nursing home officials could not be reached for comment, Wednesday.

According to home suit's Mrs. Grant died of a heart condition. The incidents preceding her death were related in the suit as follows: On the day of her death, a nurse saw Mrs. Grant at about 5 p.m. when the patient ate half her dinner and took half her liquids. At 6 p.m. Mrs. Grant appeared in "acute distress." She was given medication at 6:15 p.m. and wheeled to the nursing station.

At 6:45 p.m. she reportedly complained of nausea and her skin felt cool to the touch. At 7 p.m., when she was put to bed she appeared "weak and lethargic" but her vital signs were reported stable. Close observation was ordered.

The suit says, "A doctor was attempted to be called at 7:05 p.m., but there was no answer." The last report showing Mrs. Grant was alive was at 8:05 p.m. when she was reportedly sleeping comfortably. At 9:50 p.m. she was found dead on the floor near her bed.

The suit claimed that the nursing home is valued at between $2.5 million and $3 million and that $3 million would be lost if all the patients were transferred. It also claimed that 300 employees would lose their jobs.

A hearing is set for Monday at 2:15 p.m. before Circuit Judge William Gioyan.

[EXHIBIT No. 43]

Michigan Department of Public Health
BUREAU OF HEALTH CARE ADMINISTRATION
Division of Standards and Licensing

#1

FIELD REPORT

Visit to:
( ) Hospital
(X) Nursing Home
( ) Home for Aged
( ) Med. Care Fac.
( )

By:
( ) Nurse
( ) Engineer
( ) Sanitarian
( ) Physician
(X) Dietitian
( ) Administration

Type of Visit:
(X) Evaluation
( ) Consultation

Program:
(X) Lic./Certif.
( ) Medicare

Facility: Conner Convalescent Center
City: Detroit County Wayne
Administrator: Jean Hayden
Date of Visit: 3/14/77

PARTICIPANTS: Jean Hayden, Administrator
Eunice Watkins, Dietetic Technician
Amelia Sabra, Dietetic Technician
W. Jean Jackson, R.D., Consultant Dietitian
Mary Ghesquira, Assistant Administrator
James Claucherty, Administrative Consultant, M.D.P.H.
R. Drake, Chief, Physical Plant Section, M.D.P.H.
Bruce Van Farowe, Sanitarian, M.D.P.H.
Elizabeth Eiwanger, Chief, Nursing Section, M.D.P.H.
Sheri Nan Jansen, R.N., Nursing Section, M.D.P.H.

Items of Non-Compliance -Certification - Cross Reference to T 75-79 (ICF)

1. The dietetic personnel are not involved in developing, reviewing, or revising patient care plans. To provide an acceptable level of care it is necessary to have input from all disciplines. Also, policies and procedures must be developed and taught to all appropriate personnel on maintaining specific food acceptance records on each patient and on the method of communicating the information between disciplines.

Items of Non-Compliance - Licensure

1. There were several cockroaches in the kitchen office and the dishwashing room.

   These insects can transmit diseases. They are nocturnal and, therefore, when found in brightly lighted rooms, are an indication that they are present throughout the building. Methods of eliminating them must be determined and implemented.

2. At the tray assembly, the temperature of potato salad was 56°F. and when served in the patient area it was 62°F. In the same period of time hot food dropped by 50°F. to 60°F.

   The tray assembly was very efficient and four carts of trays were in the 2nd floor dining room before the first one was unloaded in a period of 22 minutes.

   It is highly recommended that loaded carts be alternated between floors. If such staggering is not effective other methods of maintaining temperatures must be found.

   NOTE: The potato salad should have been prepared earlier for complete chilling to a safe temperature of 45°F. before serving.

Submitted by: Ann J. Hains, R.D., Carol Hacala, R.D.
Health Dept.: Michigan Department Public Health
Date: 3/18/77

Distribution: Facility Administrator
Local Health Officer
MDPH Lic/Cert. Folder*
MDPH Medicare Folder
Consultant

* When MCF is visited, this copy should be routed to the Director of County Dept. of Social Services. Another copy should be routed to the State Director of Social Services.

R242C 11/76

3. There were no thermometers in the medication room refrigerators.

   Reliable thermometers must be provided for all refrigerators to be able to monitor safe temperatures of 40°F. to 45°F.

4. The inside of the canopy hood above cooking equipment was not made of a readily cleanable material.

   An NSF approved hood which is readily cleanable should be considered as soon as feasible.

5. Items which were either not clean or were in poor repair:

   One faucet at the pot washing sinks was wrapped with a wash cloth as it was broken and leaking. Also, there was a spewing leak on the overhead spray of dish washing.

   Floor mats in the pot washing area, and, especially in the dish washing room were very dirty.

   Most of the flatware cylinders had broken edges.

   Caulking of the shelf in the nourishment area and hand washing lavatory was either partially missing or excessive and not smooth with an accumulation of visible soil.

   The top of the booster heater and the element control box in the dishwashing room were rusty and corroded. In addition there was some lime deposit on some outside portions of the machine and on base boards behind it.

   There was one broken wheel on a trash container and on the mixer bowl stand.

   Paint on the floor mounted mixer was chipped. There was soil on it and on the base of the attachment ring.

   To minimize the sources of contamination, provide for a safe and sanitary service, and lengthen the useful life of equipment, it is necessary to have all of it in good repair and have it cleaned on a regularity scheduled basis.

6. The maximum recording thermometer showed the final rinse at the dish surface to be 150°F. and 162°F. at two different times of the operation.

   In order to sanitize dishes it is necessary to maintain the final rinse at 180°F. to 190°F. at the manifold with a drop of 10°F. to the dish surface. The gauge did registe the 180°F-190°F. but there was too great a temperature drop. The gauge must be checked for accuracy so employees can monitor actual temperatures.

Other Observations and Recommendations

1. The cooks document the kinds and amounts of food used. This is acceptable practice and works well when the census is relatively stable. However, in recent months the census has fluctuated by 30-40 or more. In such instances it is necessary for the supervisor to specify the quantities to use especially of the protein content of combination entrees.

2. There was too much finger handling of the eating end of the flatware.

   A method of washing in flat racks, sorting into cylinders with the eating end up (instead of in baskets), re-washing, and emptying over sanitized cylinders was explained. Until sufficient cylinders are available, storage may be in the sectioned tote boxes if the latter are sanitized each meal.

3. The in-service education records of sessions provided by the consultant dietitian are documented well. There is almost no record of the sessions given by the supervisors or the attendance at those. These class outlines may remain as written. Then a class sheet should be completed with only subject noted and the attendance.

   Also, it was recommended a separate listing all employees be kept, with subject and date at the top and a column to check attendance. Then one can tell at a glance which employees were not exposed to some of the material presented.

4. In the exit interview, the administrator stated that the patients were all custodial care. From the standpoint of the dietary department, it makes no difference what the level of care is. The essentials are the same: Nutritional adequacy of food served; accuracy of therapeutic diets; awareness of individual patient needs; a safe and sanitar service.

Michigan Department of Public Health
BUREAU OF HEALTH FACILITIES
Division of Standards and Licensing

FACILITY EVALUATION REPORT

Visit to:
( ) Hospital
(X) Nursing Home
( ) Home for Aged
( ) Med. Care Fac.

By:
( ) Nurse
(X) Engineer
( ) Sanitarian
( ) Physician
( ) Dietitian
( ) Administration

Facility: Connor Manor
City: Detroit County Wayne
Administrator: Joan Hayden
Date of Visit: March 14, 1977

MICH. PUBLIC HEALTH Rule No.	SOCIAL SECURITY ADMIN'N Cond-ition	Std	Items of Non-Compliance (For consultant's use on next visit . . . . .)	Improved	No Change	Corrected
65(2)			Mattresses are not clean such as in rooms 228, 229.			
114(1)			East wing of structure has severe wall cracks.			
114(6)			1. Rooms such as wheelchair rooms, clean linen rooms, basement storage room, basement maintenance room do not provide mechanical ventilation. 2. Medicine rooms do not provide for continuous ventilation. 3. Interior offices in basement do not have continuous ventilation.			
4(9)			Areas in electrical panel room have holes in ceiling. Ceiling tiles are missing in some areas of structure.			
118(9)			Night lighting is not provided in patient toilet rooms.			
118(10)			Flameproof cubicle curtains are not provided for each bed such as in room 217.			
122(2)(c)			A nurse call station is not convenient to bathtub such as in room opposite two west nurse station.			
124(4)			Grab bar is not secure at bathtub in two east wing.			
126(9)			Hot water is not tempered to patient plumbing fixtures and exceeds 125°F			
128(2)			Area in parking lot near solid waste container is not maintained in a clean condition.			
128(3)			Auxiliary burner for incinerator is in disrepair.			
31(1)			Soiled linen is not collected at sufficiently frequent intervals from one east soiled utility room.			

Submitted by: [signature]
Ronald A. Drake, P.E.
Health Dept.: MDPH
Date: March 17, 1977

DISTRIBUTION:
MDPH Lic/Cert folder (3)
Consultant

H-239 REV. 3/73

MICH. PUBLIC HEALTH	SOCIAL SECURITY ADMIN'N.		Items of Non-Compliance (For consultant's use on next visit)	Improved	No Change	Corrected
Rule No.	Condition	Std.				
132(6)			1. Items in kitchen are not in properly labeled containers. 2. Rusty food containers are in storage room.			
132(8)			Thermometers are not provided for nourishment refrigerators on floors.			
134(1)			Roaches are evident in patient sleeping rooms, bathrooms and service rooms.			
135(1)			The building, equipment and furniture is not in good repair. 1. Window panes are frosted or cracked 2. Screens are not tight fitting or in good repair. 3. Bed lamps are not in good repair 4. Sinks and tubs do not have drain stoppers 5. Exhaust fan for toilet room is not working 6. Handles for bed cranks are missing 7. Toilet paper holders are broken 8. Light bulbs are burned out. 9. Chairs have rips and tears 10. Sinks are not sealed to wall 11. Water closet seats are deteriorated 12. Duplex outlets are not in good repair 13. Ceiling tiles are not in good repair 14. Shoe molding is missing 15. Cubicle curtains, drapes and bedspreads are torn and ripped. 16. Tile is missing from floors 17. Trim on counters is not in good repair 18. Plumbing fixtures are not working or not supplied with water. 19. Handles for window sash are missing 20. Second floor ice machine is not working 21. Drawers in cabinets are broken 22. Patient lockers are warped or deteriorated 23. Holes exist in walls and ceilings 24. Foot pedals missing at sinks and valves and controls not in good repair 25. Refrigerator in first floor pantry not working 26. Burner for incinerator is not working 27. Fan on roof is noisy 28. Mattresses are badly stained 29. Window sills, walls are dirty and soiled 30. Floors are sticky, dirty and soiled. 31. Walls are soiled with dirt, dust, food and soil			

MICH. PUBLIC HEALTH	SOCIAL SECURITY ADMIN'N.		Items of Non-Compliance	For consultant's use on next visit		
Rule No.	Condi-tion	Std.		Improved	No Change	Corrected
135(1)	Cont.		32. Bathtubs are not clean 33. Water closet seats are not clean 34. Furniture is not clean			
138(4)			Soap and single service towels are not provided for all service rooms.			

Michigan Department of Public Health
BUREAU OF HEALTH CARE ADMINISTRATION
Division of Standards and Licensing

FACILITY EVALUATION REPORT

Visit to:
( ) Hospital
(X) Nursing Home
( ) Home for Aged
( ) Med. Care Fac.
( )

By:
( ) Nurse
( ) Engineer
( ) Sanitarian
( ) Physician
(X) Dietitian
( ) Administration

Facility: Conner Convalescent Center
City: Detroit County Wayne
Administrator: Jean Hayden
Date of Visit: March 14, 1977

MICH. PUBLIC HEALTH Rule No.	SOCIAL SECURITY ADMIN'N Cond-ition	Std	Items of Non-Compliance (For consultant's use on next visit . . . . .)	Improved	No Change	Corrected
132 (5)			There were several cockroaches in the kitchen office and the dishwashing room.			
132 (7)			At the tray assembly, the temperature of potato salad was 56°F. and when served in the patient area it was 62°F. In the same period of time hot food dropped by 50°F. to 60°F.			
132 (8)			There were no thermometers in the medication room refrigerators.			
132 (11)			The inside of the canopy hood above cooking equipment was not made of a readily cleanable material.			
132 (12)			One faucet at the pot washing sinks was wrapped with a wash cloth as it was broken and leaking. Also, there was a spewing leak on the overhead spray of dishwashing.			
			Floor mats in the pot washing area, and, especially in the dishwashing room were very dirty.			
			Most of the flatware cylinders had broken edges.			
			Caulking of the shelf in the nourishment area and hand washing lavatory was either partially missing or excessive and not smooth with an accumulation of visible soil.			
			The top of the booster heater ~~and the element~~ control box in the dishwashing room were rusty, and corroded. In addition there was some lime deposit on some outside portions of the machine and on base boards behind it.			
			There was one broken wheel on a trash container and on the mixer bowl stand.			
			Paint on the floor mounted mixer was chipped. There was soil on it and on the base of the attachment ring.			
(13)			The maximum recording thermometer showed the final rinse at the dish surface to be 150°F. and 162°F. at two different times of the operation.			

Submitted by: Ann J. Hains, R.D., Carol Hacala, R.D.
Health Dept.: Michigan Department Public Health

DISTRIBUTION:
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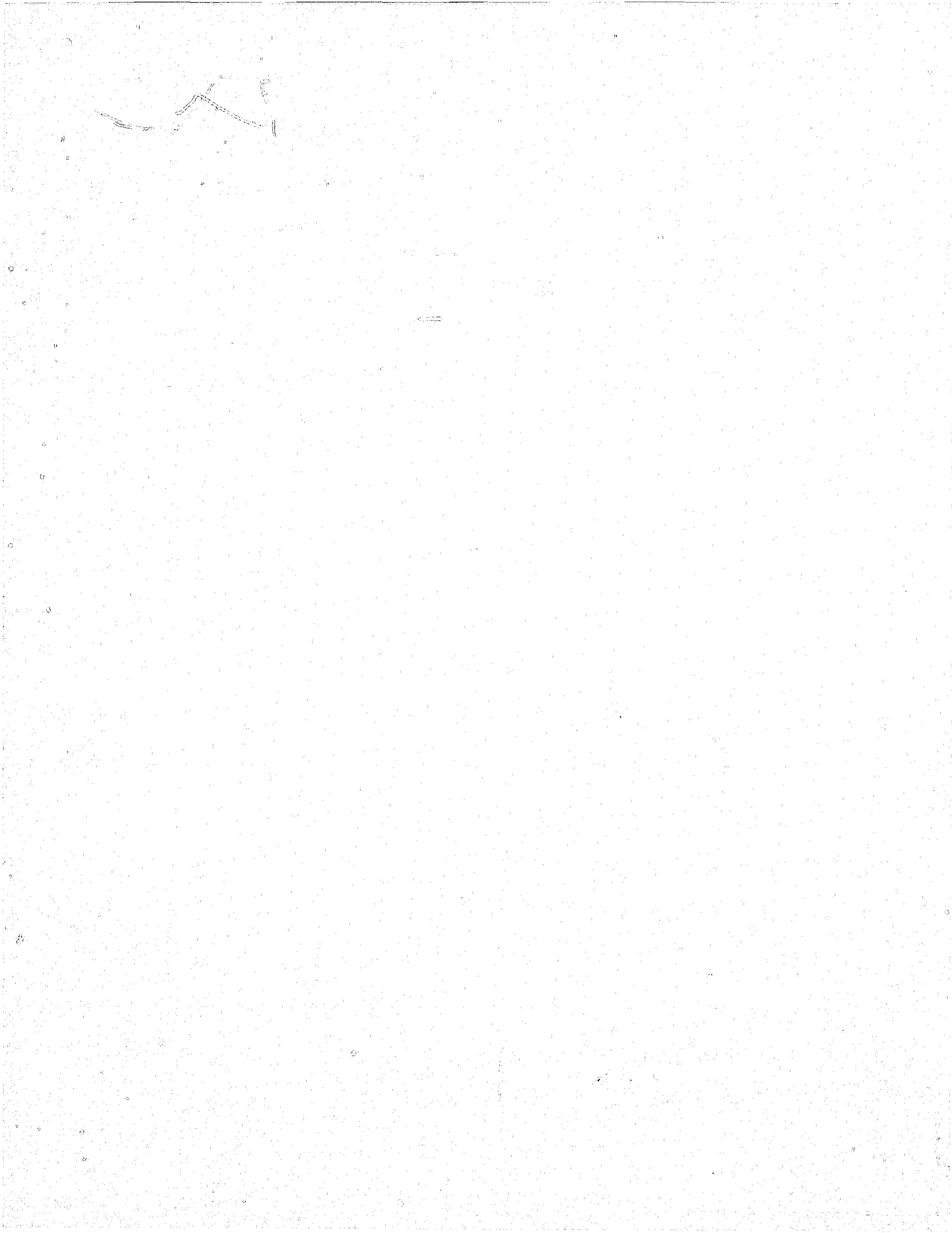
R 239C 11/76



CONTINUED

Michigan Department of Public Health
BUREAU OF HEALTH FACILITIES
Division of Standards and Licensing

FIELD REPORT

Visit to:
( ) Hospital
(X) Nursing Home
( ) Home for Aged
( ) Med. Care Fac.
( )

By:
( ) Nurse
(X) Engineer
( ) Sanitarian
( ) Physician
( ) Dietitian
( ) Administration

Type of Visit:
( ) Evaluation
( ) Consultation

Program:
(X) Lic/Certif.
( ) Medicare

Facility: Connor Manor
City: Detroit County Wayne
Administrator: Joan Hayden
Date of Visit: March 14, 1977

PARTICIPANTS: Joan Hayden, Administrator; Cliff Scruse, Maintenance; Mrs. Mary Ghesquiere, Assistant Administrator, Connor Manor. E. Eiwanger, R.N.; C. Jansen, R.N.; James Claucherty; A. Hains, R.D.; Hugh McFarlane, R.S.; R. Drake, P.E., MDPH

General Information

Connor Manor is a two story and basement structure served by the City of Detroit water and sewer systems. The nursing home is currently in litigation. On March 14, 1977 the two west wing including room numbers 224 to 231 were not occupied with patients.

1. The facility does not have a written program for reporting repairs needed and building deterioration. An organized preventive maintenance program is not available. The home indicates that only a single maintenance person is on duty at the facility. Maintenance is not at a satisfactory level as evidenced by:

   a) Double pane windows are in disrepair and windows having a leak forming moisture between window panes such that view through window is obstructed. This problem is typical in rooms 110; 119; 201; 211; 212; 214; 217; 218; 219; 223; 228; 230; window in second floor west dayroom and second floor central dayroom (3 windows). It is reported that some of the window panes have been in this condition from six (6) months to one (1) year. The window panes need to be replaced.

   b) Screens for windows throughout home are not tight fitting. Typical examples are a ½" gap for windows in room 228; 231; 224; 128; 125; 115; etc.

      Some areas do not provide screens such as windows for room 108, room 221, window at center exit landing between basement and first floor, etc. Some screens are deteriorated such as torn screen serving room 223, torn screen room 232, screen warped away from frame in one east wing dayroom, hole in screen second floor center dayroom, et

   c) Window panes are cracked and/or broken such as a hole in window room 227, hole in window room 225, two (2) large cracks in window pane room 212; one level east wing dayroom has a window cracked in two areas; window in basement physical therapy room is cracked; front door glass section is cracked; a 2" crack in window pane of employees' dining room, etc.

   d) A number of bed lamps lack light bulbs and are not operative such as one bed lamp 228; one bed lamp 229; one bed lamp 225; one bed lamp 231; one bed lamp 233; two bed lamps not working room 108; one bed lamp not operative 107, etc.

Submitted by: [signature]
Ronald A. Drake, P.E.
Health Dept.: MDPH
Date: March 16, 1977

Distribution: Facility Administrator
Local Health Officer
MDPH Lic/Cert. Folder*
MDPH Medicare Folder
Consultant

* When MCF is visited, this copy should be routed to the Director of County Dept. of Social Services. Another copy should be routed to the State Director of Social Services.

R-242 rev 2/75-10M

e) None of the lavatories or bathtubs have sink stoppers. Rags or similar items are used for stoppers for bathtubs. Each lavatory and bathing facility should be provided with a stopper to facilitate filling of sink or tub fixture.

f) No air movement existed through exhaust grilles of west wing toilet room. Examination of exhaust fan on roof indicated that exhaust fan was not in operation. Necessary exhaust ventilation was therefore not provided for west wing toilet rooms.

g) Handles for bed cranks were missing from many beds such as two missing handles for one bed and one handle for a second bed in room 227; one bed handle control 231; one handle 233; one handle missing for two beds 201; etc.

h) Toilet paper holders are broken. It was indicated that some parts of toilet paper holders have been missing for over six (6) months. Broken toilet paper holders exist in toilet serving 227-228; public toilet room opposite 202; bathroom in east wing; bathroom near janitor's closet on first floor east wing, 121, etc.

A number of rooms with water closets were not provided with toilet paper such as water closets serving 229; 225-226; 221; 235; bathroom second floor east wing; 121, etc. Toilet rooms are not maintained to meet needs of patients.

i) Light bulbs are burned out in various locations such as above lavatory serving 227-228; light fixture of lavatory serving 224; exit light near second floor center dayroom; light fixture in second level pantry; east wing janitor's closet on second floor; light fixture above lavatory in bathroom adjacent to east janitor's closet; fluorescent light tubes in west nurse station; light fixture above lavatory in bathroom near room 115; light fixture above lavatory in basement male locker room; bulb burned out in two exit lights at basement level, etc. All light fixtures must be in good repair.

j) A number of chairs have rips and tears in material such as chair in 229; chairs in second level central dayroom; couch in second level central dayroom; chair in 218, etc. Numerous chairs have burns in covering materials. Furniture needs to be maintained in good repair.

k) Light fixtures are missing covers or safety lens such as fluorescent fixture two west soiled utility room; medicine room two west; linen closet near second floor central dayroom; linen closet two east wing; soiled utility room two east wing; soiled utility room near 126; wheelchair-stretcher room one west; janitor's closet one west; linen closet one west; office area in basement, etc. To protect patients, staff and visitors light fixtures shall have protective lens or covers.

l) Sinks are not caulked between back of fixture and wall such as sink in two west soiled utility room; lavatory in nurse toilet room two west; water fountain two west unit; sink in bathroom near one east nurse station; caulking is disintegrating at wall and tub in room serving 115.

m) Handles are missing to bedside stands such as in 226.

n) Duplex outlet near bed on exterior wall reflects reversed polarity and wiring is not correct. This duplex outlet needs to be rewired.

o) Water closet seats are deteriorated as evidenced by cigarette burns in water closet serving 225-226; bathroom near one west nurse station has cigarette burns; bathroom near janitor's closet one east; seat is stained in water closet serving 229; loose seat in room serving 121; cigarette burn on seat in bathroom opposite one east nurse station, etc.

p) Exhaust fans are not in working order in areas such as elevator; two west medicine room; soiled utility room near 126 fan is missing and reportedly burned out.

q) Duplex outlet in room 225 is painted over and not usable. All electrical outlets should be in working condition.

r) Lavatory in bathroom near 234 is cracked at left rear section and needs to be replaced. It was reported that the lavatory was in this condition some six (6) months ago.

s) Ceiling tiles are stained from water leaks. Brown stained tiles were noted in areas such as area above bathtub in room opposite 224; tile in linen closet second level east; stain in corner of room 209 from leak which reportedly occurred four or five months ago; above water closet in toilet serving 127; above bathtub near 123; one west staff toilet room; bathroom near one west nurse station; janitor's closet one west; toilet room serving 116; tub room near 115; soiled utility room one west; wheelchair room one west; bathroom near janitor's closet one east; basement corridors. This indicates chronic problems with leaks and lack of prompt attention to replace deteriorated ceiling tile section.

t) Shoe molding is not in good repair such as section missing in corridor near two west dayroom; loose molding in two west nurse station; molding missing near entry door of 221; loose molding under windows second level central dayroom; shoe molding missing two west linen room, etc.

u) Ceiling tile sections are cracked or missing in areas such as second floor center dayroom; janitor's closet two west wing; soiled utility room opposite 108; first floor pantry has large holes in ceiling tile, one 2' x 10" and one 8" in diameter; tile is missing in bathroom opposite one east nurse station.

v) Cubicle curtains are torn and in disrepair such as in 231.

w) Tile is missing from wall in toilet room serving 231.

x) Floor tiles are missing in toilet room serving 231.

y) Seat of wheelchair is torn and wheels are rusty in two west dayroom.

z) Trim on back of counter in medicine room two west is broken and pulled away from wall.

aa) Doors are marred with wood splinters in two west and one east medicine rooms.

bb) Lavatories are loose from structure in two west nurse toilet room; water fountain is not secure to structure in two west wing; lavatory is loose at wall in two west bathroom; lavatory loose at wall of toilet serving 115.

cc) Plumbing fixture are not provided with water such as two west soiled utility room where no hot or cold water was available to sink; no water pressure is available at lavatory in two west bathroom; the sink in second floor pantry has no hot or cold water, drain line is apparently in disrepair. Lavatory serving 201-202 has a leaky faucet; faucet is leaking in toilet room serving 127; no hot water is provided to first floor pantry sink; faucet leaks in first floor one west soiled utility room.

dd) Cart stored in two west linen room is in disrepair with top buckled.

ee) A cord is missing from nurse call station serving room 233.

ff) Handles for window sash are missing such as second floor central dayroom; window near central second floor telephone, etc.

gg) Ice machine is not working in second floor pantry. Reportedly ice machine has not been in working order for six or seven months.

hh) Area under pantry sink on second floor has a large gapping hole in wall.

ii) Drawers in cabinets are broken and not in proper working order in second floor pantry; drawer is missing for bedside cabinet 219; first floor pantry; drawer in first floor medicine rooms, etc.

jj) Patient lockers are warped and not in good repair in 203; 217, 210 (2 lockers); 126; locker hinge is broken 129

kk) Grab bar is loose and not secured to structure for bathtub near janitor's closet two east wing.

ll) A foot pedal control is missing at soiled utility room sink in two east unit.

mm) Valve leaks at clinic flush rim sink in two east soiled utility room.

nn) Controls for lavatory in two east medicine room are not adjusted. Controls overlap such that water flow and temperature cannot be readily controlled.

oo) Clinic sink in soiled utility room near 126 was clogged and not usable.

pp) Refrigerator in first floor pantry is not in working condition.

qq) Draperies are sheared and torn such as in 131; curtain is torn near hooks 218; drapes torn 128; three 4" holes in curtain 134, etc.

rr) Bedspreads are sheared and torn such as 8" tear in spread 121; four holes in spread 210; one 6" hole, one 4" hole in spread for bed in 211; 8 holes in spread of bed in 108; torn curtain 106.

ss) Cubicle curtain tracks have been removed and are lacking for one bed in 217.

tt) The fan cover is hanging loose at ceiling level in one east janitor's closet.

2. The building is not maintained in a clean and sanitary condition as evidenced by:

a) Mattresses are blood stained and soiled in rooms such as 228, 229 (2 mattresses) and soiled in rooms such as 228; 229 (2 mattresses); 230; 226 (2 mattresses) 231 (2 mattresses); 233.

b) Window sills are dirty in rooms such as 228 pantry on second floor, etc.

c) Floors throughout have a "sticky" feel and flooring has no luster indicating an organized on going floor cleaning and sealing of floors is not implemented.

d) Floors are soiled as evidenced by empty beer cans and cigarettes on floor in 227; cigarettes and dirt on floor of two west soiled utility room; floor of bathroom serving 224 has dust and dirt in corners of room; area under radiators is not clean such as in 226; window is soiled with "sticky" substance room 226; paper and cigarettes on floor of wheelchair room two west; powder and soil on floor tile of two east bathroom; cigarettes on floor of second level linen room; floor in 233 has "sticky" material on floor; paper and debris on floor of 221; lint and soil under beds such as 235; floor in two central dayroom has "sticky" material; brown liquid material on floor two central dayroom; floor in two east medicine room has black "sticky" material; floors have lint and liquid soil 217; soil, dirt and urine spill on floor 207; grime and dirt on floor of toilet room serving 121; etc.

e) Door of toilet room serving 231 has "splashes" of soil on door.

f) Walls are soiled such as 231 where soil is on wall behind bed with material having dripped and run down wall; walls are dirty with gray material in second floor pantry; area around telephone, second floor dayroom has grease and soil on wall; stains are on wall near light switch in two east linen closet and room needs redecoration; exterior walls above heating units have a gray-black grimy appearance in rooms such as 127; 128; 126; 129; 125; food spillage is noted near head of bed in room 127; food and/or blood are splashed on wall in 128. Drip lines from spillage some 4' in length is evident in first floor hallway near telephone. A brown soil is on wall near bed in alcove of room 120; a brown soil and food material is on wall and shoe molding near entry to 122.

g) Bathtubs are not clean with slime or fine dirt in tubs such as in bathroom opposite 224; two east bathroom opposite nurse station.

h) The seat of water closet and bowl were soiled with feces in bathroom opposite two west nurse station.

i) The fan in two east janitor's closet had a heavy accumulation of lint and black soil; area around fan in two east soiled utility room has heavy black soil.

j) The sink in two east janitor's closet had a dirt and a slimy film at base of sink.

k) Linen cabinets in two east had lint and fine dirt on shelves, on the top and underneath shelves; shelves were not clean in two west linen closet.

l) Inside of patient lockers are not clean as evidenced by dirt in locker in 222.

m) Wall and ceiling are stained with brown coloration in 235 apparently caused by a leak. It is reported condition has been this way for over three months. The area is in need of redecoration.

n) The second level exterior porch is not given routine cleaning with four (4) beer cans in gutter around periphery of roof.

o) Chairs are not clean with a material appearing to be vomit on chair in second level central dayroom; rear of chairs have a greasy soil in two west dayroom, this material being easily removed with a wet rag, etc.

p) Curtains have a soiled and dirty appearance in second floor pantry.

q) Yellow bedspread have a gray-black appearance such as in rooms 126, 128, etc.

r) Corridor walls are soiled from body contact, food splash, etc., and need to be washed and redecorated. In corridor 120 as an example, black and brown material exists on wall.

s) Wall near drapes have lint and fine material on wall such as in rooms 128, 127, etc., indicating walls are not routinely cleaned.

t) Interior wall near toilet room serving 126 is discolored and needs to be redecorated.

u) Cubicle curtains in 126 have a black sooty appearance and need to be properly cleaned. Soil and what appears to be blood exists in cubicle curtain in room 134.

3. Night lights are not provided in patient toilet rooms or bathrooms. Patient toilet rooms and bathrooms must be provided with night lights.

Bathtubs in rooms such as opposite 224; two west opposite nurse station; two east bathroom, bathroom next to 206; bathroom opposite 123; bathing fixture serving 123 etc., do not have a nurse call station. A thin string has been extended from nurse call in room. The cord cannot be readily pulled to actuate nurse call and is not satisfactory. A separate nurse call station convenient to bathing fixture is needed.

5. Hot water to patient fixtures is not tempered. Hot water temperature was measured at 148°F in medicine room two west; over 140°F in two west bathroom; 148°F in toilet room serving 127. Tempered water needs to be provided to each patient plumbing fixture.

6. The nurse call system is not a modern system. It consists of a buzzer in the nurse station and a console is not available at the nurse station to identify the source of the call. Rooms have lights above sleeping room doors. The nurse call system should be modernized and a console provided to identify the origination of nurse calls.

7. Thermometers are not provided in medicine refrigerators such as two west medicine room; in second floor pantry refrigerator.

8. Nurse toilet room on two west is not provided with single service towels. Dispenser was empty of towels and none were available in room. Single use towels must be provided to facilitate good handwashing technique. Second floor pantry does not provide single service paper towels.

9. Medicine refrigerators are misused such as two west refrigerator where staff juice and lunches were stored. Medication refrigerators should be restricted to medications.

10. Mechanical ventilation is not provided for second level linen closet near central dayroom; for linen closet in two east; wheelchair and stretcher closets on both floors; linen closet in one east and west; east end basement storage room. Each interior room must be provided with mechanical ventilation.

11. Solid wastes and soiled linen are not removed at sufficient frequencies from soiled utility rooms. In mid-afternoon some seven (7) bags of linen were placed on floor in one east soiled utility room. The bags covered the floor such that fixtures in room were not usable since aisle space was not available for access to fixtures. Either larger soiled utility rooms or more frequent collection of materials are needed.

12. Medicine rooms on each care unit were hot. The only ventilation for these interior rooms were fans keyed to light switch. As such, the fans did not operate continuously. The fans must be rewired to operate continuously. A similar situation exists in first floor pantry.

13. The fan in one east medicine room was not functioning properly in that the wall switch was in disrepair and the bad contact did not permit fan to operate properly at all times. The switch needs to be repaired and fan wired to operate continuously.

14. Floors are not in good repair with 10 small ceramic tiles missing from one west soiled utility room; nine (9) small tiles missing from floor in one east soiled utility room.

15. Cubicle curtains are missing for one bed in room 217; for a bed in 113; a section of curtain missing in 106.

16. Soap and paper towels are not provided in first floor pantry. Soap and individual towels are needed to facilitate proper handwashing.

17. Insects are not controlled with six (6) roaches noted emerging from behind mirror in bathroom opposite one west nurse station; a dead cockroach was noted in 121; a cockroach was noted in sink on one east soiled utility room; cockroaches were noted in bathroom opposite one east nursing station, etc. This indicates housekeeping and maintenance do not deter cockroaches because of the poor quality program carried on.

18. Building settling and subsequent structural damage has occurred in the east wing. In room 110 a crack traverses one wall; the toilet room serving room 110 has a crack above door frame approximately ½" wide; in 105 a crack exists in block wall some 3/16" wide near entry door; the east wing dayroom has a long crack in wall; in the one east medicine room a ½"-3/4" crack exists the full length of two walls with a wide gap near door frame and rear work counter is loose from wall with a space between concrete blocks; soiled utility room has a ½" wide crack in wall, etc. This east wing corner reflects deterioration. A person knowledgeable with building construction must provide information on cause of building settling and corrective measures to be taken.

19. A handrail extension is needed on roof for continuation of ship ladder in hallway landing. The handrail extension would eliminate potential hazard in climbing to roof level.

20. The exhaust fan reportedly serving the dishwashing room had a loud banging noise indicating that proper maintenance was not being given to unit.

21. The supply air unit on roof reportedly serving the laundry did not have side covers on unit with result that air was by-passing the filters. The unit was not being properly maintained.

22. The ventilation unit serving east end basement offices was not working with result that no air movement was evident in the interior offices.

23. The east end storage room was cluttered with stored items such as furniture, christmas ornaments, many of these items stored on the floor with no aisle space to rear of room. The condition of room was not sanitary and would encourage growth of insects.

24. The shower stall of male employee locker room had an accumulation of dirt, pieces of paper, cigarette stubs indicating poor housekeeping attention.

25. Exhaust grilles in laundry have an accumulation of lint and black sooty material. The grilles need more frequent cleaning.

26. The area behind the washing machines has a heavy lint deposit indicating routine cleaning is not provided this area.

27 The auxiliary fuel burner for incinerator is in disrepair and has been out of service for some time. As such, proper combustion temperatures are not provided. The facility could also not provide an incinerator permit for operation of unit. The boiler room housing incinerator lacked ventilation with noticeable odors of burning material in room and evidence on wall and ceiling of backdrafting of equipment.

28 The clean linen room in basement is an interior room and lacks ventilation. Mechanical ventilation is needed for room. In addition, evidence of smoking with some nine (9) cigarette stubs were present in room. Smoking should not take place in a clean linen room.

29. The electrical panel room and other rooms have holes in ceiling where pipes penetrate the ceiling. All openings must be sealed to minimize harborage for vermin such as roaches.

30. The housekeeping-maintenance room is an interior room without ventilation. The room was warm on March 14, 1977. The room is in need of mechanical ventilation.

31. The marble window ledge in employee dining room is cracked with a section removed, six (6) of seven (7) light fixtures lack cover lens, the area below heating grille is soiled with brown and black coloration, floor tile is dirty and lacks luster. The area is not given routine housekeeping and maintenance attention.

32. Kitchen - The kitchen was visited in late afternoon of March 14, 1977 and following were noted:

a) Some ceiling tiles are missing and four (4) tiles are stained near kitchen office. Repairs are needed in this area.

b) The kitchen office is hot and lacks mechanical ventilation. A wall space fan is needed. Mechanical ventilation is needed for this room.

c) Some rusty cans of condiments were in food storage rooms. Rusty cans should be discarded.

d) Plastic container indicating "sugar" contained what appeared to be rice. A container with soap was not labeled. All containers should be labeled as to their proper contents.

e) A water leak exists near supply line valve to dishwasher. This leak in plumbing needs to be corrected.

f) Some chipped and cracked plastic cups exists in kitchen area. All chipped, marred, cracked food contact items must be discarded.

g) A wall fan near coolers has a frayed cord which could result in an electrical shock. It is reported that fan is to remove heat from coolers in summer time. The fan is not in good repair and should be removed from kitchen. A wall fan is not suitable in that it distributes in an uncontrolled manner heat and dirt into food preparation area. A grille to a central exhaust fan should be provided near freezers.

33. No current policies or actions have been taken by facility with respect to infection control. The last minutes were on March 12, 1976 and were not substantive in nature.

34. No records or evidence of a preventive maintenance program were available.

35(The following ANSI criteria are not met:

a) Door identification to hazardous areas such as mechanical rooms, electrical rooms, utility rooms, etc., are not provided.

b) A telephone for handicapped is not available. Coin slot and receivers are too high for easy use.

c) Plumbing fixtures in public toilet room are not designed for physically handicapped.

d) Handrails do not extend behind top and bottom steps. Handrails should extend at least 12" behind step. State barrier free provisions require an 18" extension.

36. The area in parking lot where the solid waste container is located has considerable debris and glass on ground. This area needs to be given a thorough cleaning.

SUMMARY

Conditions evident at the facility indicate continued deterioration of building and equipment and poor housekeeping practices. A structured effective system is not available for reporting maintenance problems or correcting such. Housekeeping is lacking and disorganized. A number of areas lack necessary ventilation and excessive hot water temperatures continue to exist. Conditions in building are such that roaches are noted in various areas.

Michigan Department of Public Health
BUREAU OF HEALTH CARE ADMINISTRATION
Division of Standards and Licensing

FACILITY EVALUATION REPORT

Visit to:
( ) Hospital
(x) Nursing Home
( ) Home for Aged
( ) Med. Care Fac.
( )

By:
(x) Nurse
( ) Engineer
( ) Sanitarian
( ) Physician
( ) Dietitian
( ) Administration

Facility: Conner Manor, 5201 Conner Avenue
City: Detroit 48213 County Wayne
Administrator: Joan P. Hayden
Date of Visit: March 14, 15, 1977

MICH. PUBLIC HEALTH Rule No.	SOCIAL SECURITY ADMIN'N Cond-ition	Std	Items of Non-Compliance (For consultant's use on next visit . . . .)	Improved	No Change	Corrected
35(1) (2)			Employee files, as reviewed, did not contain evidence of adequate health supervision. For example: Nine (9) of twenty (20) records contained no evidence of testing for tuberculosis; and nine (9) of twenty (20) records contained no evidence of any health supervision.			
41			The feelings, attitude, sensibility and comfort of a patient are not always fully respected by the personnel.			
42(3)			Policies are not reviewed annually.			
61(9)			No records were available for review to substantiate that any new employee had received a thorough job orientation. The administrator reported that it was done verbally at this time.			
64(a)			Oral hygiene is impossible for the greater number of patients because of lack of toothbrushes, toothpaste and mouthwash.			
64(c)			Staff were not observed assisting patients to wash their hands and face before and after meals. There were no towels and washcloths available at patients' bedsides for this purpose (Rule 65(12)), nor were soap and disposable paper towels available in the patients' bathrooms.			
64(d)			At least six (6) male patients were observed who, in the opinion of the evaluators, were in need of shaving as necessary for comfort and appearance. There was no documentation of an order by the patient or the physician, to indicate that this was not necessary, as specified in this rule.			
65(11)			There is insufficient supply of linens at the nursing station required to meet the nursing needs of the patients.			

Submitted by: Elisabeth Eiwanger
Health Dept.: M. D. P. H.
Date: March 24 - 1977

dms 3/24/77
DISTRIBUTION:
MDPH Lic/Cert folder (3)
Consultant

B239C 11/76

MICH. PUBLIC HEALTH	SOCIAL SECURITY ADMIN'N.		For consultant's use on next visit .... Items of Non-Compliance	Improved	No Change	Corrected
Rule No.	Condition	Std.				
65(12)			A clean individual towel and washcloth was not found on a towel rack at the bedside of each patient. (The count was stopped at 42).			
68(1)			Insufficient evidence was found, (e.g., in inservice records, personnel files, patient care plans on nursing progress notes) to indicate that nursing personnel were skilled in the techniques of restorative nursing.			
85			There is no stop order drug policy for anticoagulants.			
102(i)			Twenty-six (26) records did not contain the physician's progress note written at the time of his visit describing changes in the patient's condition and other pertinent clinical observations.			
105			Six (6) accident/incident reports reviewed did not contain the following information:			
(c)			Two (2) did not contain the effect of the incident on the patient involved;			
(d)			Two (2) did not contain the time the physician was notified or the name of the physician notified even though the record did indicate that a physician was notified;			
(e)			Five (5) did not contain the physician's statement regarding the extent of the injuries, the treatment rendered or the disposition of the patient;			
(f)			Six (6) did not contain corrective action taken to avoid repetition of the accident or incident.			
107			Of twenty (20) employee records reviewed (12 licensed nurses and 6 newly hired nursing personnel):			
(b)			Five (5) did not contain a license or permit;			
(f)			Seventeen (17) did not contain references;			
(g)			Nine (9) did not contain results of T.B. test for tuberculosis.			

[Exhibit No. 44]

October 18, 1976.

Mr. John Laing,
Administrator, Friendship Manor Nursing Home,
Detroit, Mich.

Dear Mr. Laing: Enclosed is a copy of a letter and attached material sent to the Michigan Department of Public Health.

As that letter indicates, our goal is to gain good care in nursing homes. We are prepared to assist you in any way feasible to accomplish this objective.

Sincerely,

Charles Chomet,
Executive Director.

Enclosure.

Citizens for Better Care,
Detroit, Mich., October 15, 1976.

Maurice S. Reizen, M.D.,
Director, Michigan Department of Public Health,
Lansing, Mich.

Dear Dr. Reizen: Citizens for Better Care (CGC) is writing to request that the Michigan Department of Public Health issue an "intent-to-deny licensure" notice to the Friendship Manor Nursing Home, 3950 Beaubien, Detroit. Citizens for Better Care's request to you does not represent our interest in having this facility closed and patients precipitously transferred to other nursing homes.

Rather, CBC recognizes the need for good nursing home care and is attempting to work towards this goal. CBC has taken this position regarding Friendship, based on (1) the long-standing deficiencies which have existed at this facility; and (2) on the types of formal enforcement tools which are available to and can be used by the State Health Departments to bring about compliance with State nursing home standards.

1. As the enclosed report, which is based on State and Federal inspection surveys and CBC complaints received about the home demonstrates, Friendship Manor Nursing Home has experienced severe shortcomings in providing adequate care to its patients since the facility opened. The facility, in our opinion, as evidenced by the most recent MDPH inspection reports, is not operating in compliance with State standards. CBC staff members have recently met with representatives of the nursing home. The CBC staff was informed that new personnel have and are being employed to fill key positions at the facility and that other changes are being made.

2. While we recognize and support the intent of the changes, CBC also recognizes that issuing an intent-to-deny notice is the only formal tool available to the Department of Public Health which may be possibly effective in gaining compliance with State rules and which would require a facility to make needed improvements. As you are aware, an intent-to-deny-licensure notice gives the nursing home an opportunity to request an administrative hearing which is public. At the hearing, the facility can state its case and document what improvements it has or will make to correct the problems. In addition, the hearing may result in more inspections and closer monitoring of conditions on the part of the Department of Public Health than would ordinarily occur. Rarely—and only after continued violations have occurred subsequent to the MDH intent-to-deny notice—does this action result in a home's closure.

In addition to this action which CBC is requesting concerning State licensure, we are also asking that the MDPH monitor closely any violations reported on the Federal survey certification forms to insure that these problems are in fact corrected by the Automatic Cancellation Date.

After reviewing the most recent survey reports prepared by Department of Public Health personnel in September of this year regarding Friendship Manor Nursing Home, CBC is also disturbed about the manner which facility conditions are recorded on MDPH reports. The Field Report (FR) prepared by the MDPH nurse after her visits to Friendship Manor of September 7 and 8, 1976, describe deficiencies in the home's nursing care which are not listed as items of non-compliance in the Facility Evaluation Report (FER). For example, the Field Report states: "The nursing staff supposedly have been trained in rehabilitative nursing but there was no evidence of such observed in care being

administered nor on the care plans." However, the corresponding Facility Evaluation Report does not cite Rule 68(1) of the State's licensing rules, which requires that nursing staff "shall be sufficiently skilled in the techniques of restorative nursing" to perform a variety of patient care tasks. CBC would appreciate an explanation as to why apparent rule violations observed in the Field Report are not included in the Facility Evaluation Report. There are several other examples of apparent rule violation described in the FR which are not described on the FER.

Citizens for Better Care believes that the evidence of Friendship Manor Nursing Home warrants firm and immediate action by the Michigan Department of Public Health. CBC suggests that such action include an intent-to-deny-licensure letter to the nursing home.

I look forward to hearing from you within two weeks.

Sincerely,

CHARLES CHOME,
Executive Director.

BACKGROUND INFORMATION ABOUT PATIENT CARE AT FRIENDSHIP MANOR NURSING HOME IN DETROIT, OCTOBER 15, 1975

Citizens for Better Care (CBC) has reviewed both complaints we have received against Friendship Manor Nursing Home and the information in the Michigan Department of Public Health licensing file on that facility.

Information about inadequate care at Friendship has been obtained from reports of the Michigan, Wayne County and Detroit Public Health Departments, prepared since the facility opened. Similarly, CBC has received many complaints about the facility, the first one coming one March 14, 1974, when the home had been in operation less than 3 months. This material about Friendship Manor is reviewed chronologically.

The first public health department report to show significant problems in the home was written following visits on February 28 and March 1, 1974. Mary Covert, R.N., with the Wayne County Health Department, did Medicaid levels of care evaluations on those dates. She found, for example, that "History and physical exam sheets were not filled out by doctor, only documentation was admission diagnosis with no signature—no dates and no other notes. Also several charts had no progress notes or history and physical recorded." Medications were not documented regularly, and physical therapy notes contained neither goals nor any indication of progress. Ms. Covert found patient charts "very disorganized," a charge nurse complained of drinking by the night staff, and many patients were wet. Short staffing and skin breakdowns of newly-admitted patients were particular problems noted in Ms. Covert's report.

A March 12, 1974 visit to the home by Jeanette Fromm, R.N., of the Detroit Health Department, disclosed thirteen problem areas. Among her recommendations were that the home employ an R.N. in the child care unit, that nursing personnel not work both pediatric and adult floors, and that patients be examined by a doctor within 48 hours of admission. Ms. Fromm also recommended laboratory work for children as part of their admitting physicals, as well as physical examinations for pediatric lodgers when they stayed longer than overnight.

A complaint about Friendship Manor, received by CBC on March 14, 1974, was registered on behalf of Mrs. C., a resident. According to her sister, Ms. C.'s bedsores worsened seriously during her stay at the home. Harper Hospital records show that on February 21, 1974, Ms. C. was re-admitted through the emergency room, as an uncontrolled diabetic, semi-conscious and disoriented. A letter written to CBC on March 14, 1974 by a Harper social worker gives the patient's doctors' opinions of Ms. C.'s care at Friendship. One doctor believed that the "patient did not get optimal care regarding her diabetic control and care of bed sore definitely deteriorated (sic) with increasing infection." According to the other doctor, "Patient's condition at admission indicated patient was not turned; ulcers present on heels. Depth of sacral decubiti required debriding down to sacrum." The letter continues: "Nursing staff reported patient cringed when approached to give care upon admission and for several days following. It is hoped you will consider this adequate documentation to confront the nursing home administration and pursue the

matter for the protection of present and future patients." CBC did refer this complaint to the Michigan Department of Public Health (MDPH) soon after receiving it. The complaint was investigated on May 20, 1974 by Evelyn Jones, R.N., of the MDPH. Her complaint investigation report concludes:

"The diabetic status, circulatory, and related condition of this patient makes it difficult to prove that this patient's problems were related entirely to poor nursing care. Closer observation, better reporting and recording, might have been helpful."

Dorothy Chapple, R.N., with the MDPH Medical Review Unit, visited Friendship on March 26, 1974. She found that the facility was "quivering from lack of staffing, lack of inservice or proper orientation, and general lack of nursing and administrative know-how." Ms. Chapple found six areas of serious patient care problems during this visit, including: "Evidence of nursing observation, care and documentation less than acceptable."

On April 11, 1974, Carlean Williams, MDPH dietician, made the only one of her Friendship surveys ever to disclose substantial non-compliance. She uncovered fourteen dietary problems, seven of them rule violations. These problems included inadequate organization of the food service, inadequate staff, and therapeutic diets not followed. Furthermore, according to the facility evaluation report, "nutritional needs of patients were not always met." Ms. Williams found that the kinds and amounts of foods on hand, plus food bills, "indicated that purchasing practices were not consistent with written menus." As one of her final comments, she wrote that "It is highly emphasized that Rev. Johnson provide an adequate budget and allow his administrative staff and the dietician to purchase foods and supplies to meet minimum requirements for patients."

On May 20, 1974, Kate Davis, R.N. and Evelyn Jones, R.N., both of the MDPH, visited Friendship. They found urine odor, dirty floors and no full-time R.N. on the child care unit. In addition, patient care plans were not current, pharmacy services were inadequate, and breakfast trays were still on the floor at 11:30 a.m. The previous month, on April 12, 1974, Ms. Jones had also found substantial numbers of violations. Among the fifteen items on non-compliance cited, most pertained to shortages of licensed nursing personnel and to information missing in the patient records. According to Ms. Jones, "restorative nursing care was not reflected in the patient care observed nor in the nurses' documentation." In addition, Ms. Jones discovered that there was no diversional activities program, medications were not consistently charted, there were no nursing care plans on the child care unit and basic unit, and results of skin tests were missing from some records. Regarding staffing, Ms. Jones found that "staffing has been and remains a problem." As a particular example, on L.P.N. was assigned to both the pediatric unit on the second floor and an adult basic care unit on the fourth floor.

Mark Stanfield, MDPH sanitarian, found four rule violations on June 20, 1974; as in his subsequent survey, he found that wells, floors and ceilings were not maintained acceptably, nor were air vents. Necessary shelving was lacking, as were nurse call cords at patient beds, bathing facilities, and toilet rooms throughout the facility.

CBC received a call on July 17, 1954 from a social worker at Lafayette Clinic, who was also aware of problems at Friendship. According to her, the clinic had decided to stop placing children in the home's pediatric unit both because of unresolved questions about care and because of the home's lack of cooperation in working with clinic staff.

During her August 8-9, 1974 survey, Evelyn Jones found fifteen nursing deficiencies. As before, she found there was no R.N. in the pediatric unit. In addition, she discovered there was no director of nursing for the entire facility, nor any activities program for either children or adults. Ms. Jones also found short staffing and a lack of written policies governing patient tuberculosis testing, reporting of poisoning, food-borne disease and diarrhea to state and local health departments, and storage and use of commercial formula and water feeding solutions.

When she checked staffing, Ms. Jones found the following deficiencies:

Second floor (children)

Days: No R.N. on three occasions; Short one unlicensed person on two occasions; Evenings: Short one unlicensed person on two occasions; Night: one licensed person shared with adult unit on 11 occasions.

Third and fourth floors

Days: One-half to one licensed person short on four occasions. There was no licensed person on the day shift on Monday, July 8, 1974 for the third and fourth floors.

Carlean Williams, MDPH dietitian, visited Friendship Manor on August 21, 1974. Her facility evaluation report states that there were no items of noncompliance during the survey.

A major complaint was referred by CBC to the MDPH on October 16, 1974. The complaint involved the death of a 10 year old boy, L.K., following a six-day stay in Friendship's pediatric unit. After investigation by both the Detroit and Michigan health departments, it was determined that L.K. was admitted to the nursing home from Outer Drive Hospital with a diagnosis of cerebral palsy, mental retardation, and a fever (as high as 105°) of undetermined etiology. Nonetheless, with the possible exception of an admission examination, there was no evidence that he was seen by a physician before the time of death. It appears that required laboratory tests (urine analysis, hemoglobin, hematocrit) were not made on admission. The patient's clinical records, according to the Detroit Health Department, contain no evidence that his temperature was taken at any time during six-day stay, despite the admitting diagnosis. Further, there were no nursing notes during two days of the placement at Friendship. L.K. seems, in addition, to have been restrained without doctor's orders. For several hours after his death, the home seems to have been unable to make an accurate statement about the location of his body.

This is a brief summary of the problems that arose in this case, while many other questions reflect on the quality of care delivered in the home at this time. For example, on September 6, 1974, two weeks before L.K. died, Dr. Harrington of the Wayne County Health Department noted that "an R.N. is not usually employed in (the pediatric) unit . . . Seems to be shortage of personnel in all units. No director of nurses employed . . . Care offered is marginal. At the same time, Dr. Harrington observed: "Housekeeping appears minimal. No O.T. or social program employed, patients seem to sit around all day."

As early as October 11, 1974, an administrative conference was held at the Detroit Regional Office of the MDPH between Friendship's executive director, administrator and director of nursing, and Evelyn Jones, Carlean Williams and Clair Lewis of the MDPH. According to Mr. Lewis' October 22 memo describing the meeting, it was held as a result of the "Department's concern as to the operation of Friendship Manor Nursing Home. This concern was fostered as a result of certain findings generated . . . (by) on-site visits . . . In addition to these reports there have been several formal and informal complaints registered against the facility." Lewis ends his memo by noting that "the principals of home . . . were admonished that positive steps must be taken in the immediate future so as not to jeopardize future licensure."

A field report filed on December 16, 1974 by Evelyn Jones revealed several serious problems which were at that time, within one year of the facility's opening, reflecting on-going deficiencies. For instance, there was no activities coordinator; medications were not recorded consistently as ordered; nursing care plans had not been developed for many patients; and pre-employment physical exam, x-ray and TB skin test results were not available for most employees. She concluded her report by stating: "Compliance with license and certification requirements should be without further delay." The survey conducted by Mark Stanfield, MDPH sanitarian, at the same time showed two rule violations—neither walls nor general housekeeping throughout the facility were maintained in an "acceptable manner."

On December 17, 1974, Richard Londergan, utilization review consultant with the MDPH, recommended that Friendship's skilled Medicaid certification be denied due to the home's failure to comply with utilization review requirements. According to Londergan, in a letter of December 30, 1974 to Friendship's administrator, the home had made "no effort to comply with the Federal statutory requirements regarding Utilization Review. Further, that although consultation has been provided on five separate occasions, it would seem that no effort has been put forth to develop a Utilization Review Program."

A nursing survey, done on January 6, 1975 by Evelyn Jones, of the MDPH, revealed only two rule violations. However, Ms. Jones also noted that "the

long standing problem of inconsistent charting of medications still exist (sic)." Physical therapy orders, evaluations and progress notes were missing from patient charts, and there were no attendance records available for in-service classes. While Ms. Jones recommended full licensure, she stated that Medicare certification should be withheld until the home had demonstrated compliance with state rules and federal regulations for a six-month period. In addition, a February 10, 1975 transmittal sheet from M. Stanford, MDPH, to Elwood Mcleod, MDPH administrative consultant, recommended that Medicare certification be denied because the facility lacked acceptable housekeeping and maintenance.

A letter of January 17, 1975, from James Claucherty, MDPH Administrative Consultant, to the administrator of Friendship, stated that the MDPH would not approve "certification for Title XIX Medicaid reimbursement for Friendship Manor due to numerous deficiencies relating to the requirements for nursing services and utilization review . . ." The letter stated that the facility must submit an updated plan of correction indicating how deficiencies would be corrected and when "complete correction" would be achieved. In addition, the MDPH returned Friendship's application to participate in the Medicare program to the facility along with the January 17, 1975 letter. The reason for the return was that "outstanding deficiencies would not permit acceptance in the Medicare Program at this time."

A plan of correction was submitted to the MDPH by Friendship on February 6, 1975. In this document, Friendship's administrator claimed that all deficiencies cited in the inspection reports either had already been corrected or would be completely corrected by the end of March, 1975. There apparently was no follow-up survey conducted by the MDPH until April 8, 1975. The nurses' report of this inspection will be discussed later in this summary.

On February 14, 1975, Dr. Harrington of the Wayne County Health Department, found the by-now familiar list of problems: "Many of the (non-pediatric) patients receive inadequate nursing care . . . There is confusion in use of medication . . . Dressing changes are not performed as ordered . . . Multiple complaints about food offered. Housekeeping is very inadequate . . . Progress notes . . . offer little value in assessing progress of patients." Like Evelyn Jones, Dr. Harrington stated that equipment in the pediatric unit was adequate and that care "seems good."

The wife of another resident, Mr. R., complained to CBC about his care on March 7, 1975. Our file on the case includes two letters to CBC, one from a doctor and one from a nurse who treated Mr. R. upon admission to Harper Hospital from Friendship, after a stay in the nursing home of less than one month. Portions of the doctor's letter read: "The patient was received in acute distress, hypotensive . . . dehydrated, wasted looking and feeble . . . A large sacral decubitus . . . and a foley catheter which had been in place so long that a calculus had formed at the tip were further observations. The urine was grossly infected. The patient's wife informed me that her attempts to get this patient transferred to a hospital were met with great resistance by the staff of Friendship Manor. The patient expired . . . on March 8, 1975 secondary to sepsis." The nurse's letter contains similar observations and ends as follows: "I am writing this letter out of concern for the care given to the patients at Friendship Manor. I received a patient . . . in a similar state from that nursing home in February, 1974."

On March 25, 1975, Robert Laraway of the MDPH wrote to Marvin Hitt, with the Division of Long Term Care Standards Enforcement Office of HEW in Chicago. According to Mr. Laraway, "Friendship Manor has been in operation for something over one year and has exhibited many undesirable characteristics . . . The department was considering terminating licensure and certification . . . "However, Mr. Laraway expressed the opinion that "the operation of the facility (was, at the time of writing) immensely improved." The letter continued by stating: "The facility is currently licensed and certified on the basis of commitment to correct prior existing problems." In this letter Mr. Laraway stated that a "notable" change the facility had recently made was to hire "an experienced and qualified administrator." A March 7, 1975 letter from the nursing home to CBC informed CBC that Rev. Louis Johnson had been appointed administrator.

According to a April 8, 1975 survey by Evelyn Jones, R.N. of the MDPH, conditions at Friendship had improved. The Field Report concluded by stating that "the level of care being provided at the time of this visit was considered

adequate." The Facility Evaluation Report cited 5 items of non-compliance. Two of these items, however, were identical to deficiencies which Ms. Jones had cited a year earlier during her April 12, 1974 inspection: (1) medications were not being properly recorded; and (2) TB skin tests were not always in the patients initial examination. Based on her survey Ms. Jones recommended full licensure, plus skilled and basic Medicaid certification, for Friendship.

Problems at Friendship, though, were evident in 1975. A May 12-13, 1975 visit by Jeanette Fromm, R.N., of the Detroit Health Department revealed many shortcomings. To cite a few: "The physical therapy orders on most of the charts received were not dated or signed by the physician . . . There is still a problem of inconsistent charting of medications . . . An independent and group activity plan has not been developed yet for each resident . . . Some children were in restraints and no physician's orders noted on the charts for the restraints . . . Observed some (nursing) plans had not been developed yet . . . No patients are on a bladder restraining program."

Having discussed rather briefly the information pertaining to early portions of Friendship's history, we will now examine in some detail the documentation produced within the 13 months.

A report from Dr. Charles Truscon, D.O., with the Wayne County Health Department dated August 22, 1975 mentions many deficiencies at Friendship. Truscon makes 18 observations, 16 of which appear to indicate problems. To cite a few of his findings:

"1. Dr.'s progress notes brief and repetitive....

"3. Overutilization of O.T. & P.T. is evident, much of it without Dr.'s orders....

"5. Charting quality poor.

"6. Laboratory overutilization is evident. . . .

"12. Keys to drug room dangling in lock—area unattended....

"14. Medication dispensing is poor, many missed doses or erratically dispensed, directions are not followed, are haphazard.

"15. Nursing shortage was evident....

"16. Many patients found to be unkempt, unshaven and slovenly."

An August 25, 1975 report written by Mary Covert, R.N., WCHD, and sent to Dr. Willoughby of the MDPH Medical Review Unit by Dorothy Chapple, R.N., indicates many of the same problems Dr. Truscon had found three days earlier. For instance, Ms. Covert mentions nine cases of medications not documented as given according to orders. Vital signs were also not documented. Furthermore, "many" laboratory reports were not found in the charts for work ordered three months previously. Finally, Ms. Covert noted the following:

1. Day nurse observed sitting in chair sleeping about 3 p.m.
2. Many patients unshaven, unkempt untidy appearance.
3. Narcotic keys left in door while nurse was at other end of hall.
4. Two patients treated for lice in past 2 months. (Both patients had been in facility about 1 year.) Both unkempt and untidy appearance today.
5. Much teasing and agitating of confused patient on 4th floor by aides and attendants.

On September 2, 1975, Evelyn Jones, R.N. (MDPH) cited seven rule violations in her Facility Evaluation Report (FER). They include Rule 68(e): "Nursing personnel did not show evidence of sufficient skill in the technique of training residents in self care such as feeding, dressing and toilet activities;" Rule 82(2): "Medications not in use and outdated are not immediately discarded;" Rule 102(2): "Physicians order (sic) do not specify restorative procedures such as physical therapy;" Rule 105(f): "Some incident reports do not include corrective measures taken to prevent recurrence of the incident;" Rule 107(b): "There was no license or permit for three of the graduate nurses in the facility." Ms. Jones also noted that children in the pediatric unit "appeared clean, neat, and well cared for. Personal contact and interaction with the children was evident." She also found that most adult patients appeared clean, though many were dressed in night clothes. Regarding staffing, Ms. Jones indicated two occasions between August 3-23, 1975, on which the adult floors had been short two to three unlicensed personnel on the day shift.

On September 24, 1975, Curtis Wolf, an MDPH sanitarian, recommended in the transmittal sheet accompanying his FER and Field Report, licensure and certification "with reservation" for 170 beds in Friendship. He also recom-

mended, though, that licensure as well as Medicaid and Medicare certification be denied Friendship's fifth floor "prior to resolution of operational problems discussed in the accompanying FR and FER."

Friendship's fifth floor up to this time had not been permitted to be used for nursing care by the MDPH. A request to use the fifth floor as a Medicare unit of the home was submitted to the MDPH by Friendship in July of 1975. Wolf's September 3, 1975 FER for the entire facility shows nine rule violations, plus fourteen examples indicating the lack of effective maintenance and housekeeping programs. Among violations Wolf cites are mold growing on butter in the walk-in freezer, soiled linens in the hallways rather than the nearby soiled linen room, and mechanical ventilation inoperative generally throughout the building. He also found "numerous" burned out light bulbs, "numerous" broken or missing grab bars, two flooding toilet rooms, an "extremely dirty" bathtub, and an accumulation of "gross fecal soil" on walls, floor and furniture. During the same visit, Wolf saw a staff member "sitting in the dining room in full view of a patient sitting with his feet in a pool of urine." Another staff member was observed "ignoring the nurse call, making a personal telephone call, then . . . continuing to ignore the nurse call." Carlean Williams, the MDPH dietary consultant, found no violations on September 2, 1975, even though the next day Mr. Wolf discovered moldy butter and an improperly cleaned mechanical can opener and large electric mixer. Meals, Ms. Williams wrote in the Field Report, were "nutritious and well received."

On October 7, 1975, two weeks after Curtis Wolf recommended denial of licensure and certification for the fifth floor, Richard Londergan, the MDPH U.R. consultant made a similar recommendation. He asserted in a memo to James Claucherty, MDPH administrative consultant, that "the planned opening of the fifth floor has not progressed beyond the talk stage." Although the home wanted to begin housing patients on the floor, Londergan found it "totally vacant and devoid of any furnishings or equipment." Furthermore, the home did not appear to contemplate hiring any additional staff to accommodate patients in the new unit. Mr. Wolf's recommendation was not followed by the MDPH. In a memo of November 117, 1975 to Wolf from James Claucherty, MDPH Administrative Consultant, Claucherty stated that the facility would be licensed and certified, with the fifth floor being recommended for Medicare certification. According to the memo, "the basis for this decision is the recommendation for full licensure and certification of the fifth floor by the nurse and the dietitian, plus receipt from the facility of what appears to be a reasonable plan of correction..."

On February 18, 1976, CBC sent a formal complaint to the MDPH on behalf of a resident, Mr. F., who subsequently died. Mr. F.'s sister alleged that he had stage four, necrotic bedsores. In January, 1976, after having resided at Friendship since the day it opened, Mr. F.'s left leg was amputated because of gangrene. Upon re-admission to the nursing home from Art Centre Hospital, his condition apparently worsened. In an investigation of our complaint conducted on February 27, 1976 by Delphine Shott, R.N. and Mary Alice White, R.N. they found the following problems:

"Treatments to decubiti were charted, however, observation of the condition or appearance of the decubiti and response to treatment were not indicated. The frequency of dressing changes were not charted. There were notations that the patient was turned, however, frequency or position were not indicated. The patient's appetite was poor. The amount of urinary output was not measured nor the character of the urinary drainage noted . . . The patient had multiple decubiti with a foul smelling odor . . . The sacral decubiti was approximately 6" x 9" area (sic) with purulent drainage . . . The right ankle and foot were covered with decubiti."

The nurses drew this conclusion: "While records indicated care and treatment ordered except for blood pressure, were provided, documentation failed to establish of care and treatment, condition of the patient, response to treatment, and evidence of evaluation and planning for care." First among the nurses' recommendations was that the attending physician re-evaluate the patient and review the treatment plan. Mr. F. was hospitalized within three days and later died.

Dorothy Chapple, R.N. and Dr. Willoughby, with MDPH Medical Review, also visited Friendship in response to CBC's complaint. On March 19, 1976, they found that Mr. F. was no longer in the facility, but, while in the home,

they also examined several Medicaid recipients which they noted were not receiving recommended levels of care. During this review, the facility was cited for four violations of state licensing regulations. The following violations were listed: Rule 41: "The feelings, attitude, sensibility and comfort (of residents) are not always fully respected;" Rule 64–1–a: "Nursing care and services do not include care of skin, mouth, teeth, hands and feet and shampooing and grooming of hair;" Rule 64–1–b: "Prevention and treatment of skin irritation and decubiti are not provided to all patients;" and Rule 86–1: "All medications no longer in use or outdated are not disposed of immediately in accordance with federal or state laws and regulations." The accompanying Field Report describes one patient with an untreated open lesion. Another was discovered to have uncovered stage four bedsores on both feet—with no documentation of any treatment for the previous six days. The two available tubes of ointment were unused, while the physical therapist assistant stated that the patient had had physical therapy that morning. The statement about receiving therapy was according to the FR, "not proven to be true." Similarly, another resident listed as having received physical therapy that same morning was found unable to respond, with a foley catheter and feeding tube. Dorothy Chapple concluded that the "patients condition would not have warranted going to physical therapy." A final, recurring, problem mentioned in this Field Report concerns the failure of Friendship to have excess medication picked up by the pharmacy or otherwise removed.

Between March 30-July 29, 1976 CBC received four serious complaints about care provided in the nursing home. These complaints alleging serious problems with the medical care given the four patients. CBC is still investigating these complaints.

A June 28, 1976 memo from Robert Laraway and James Claucherty to the Chicago office of the Department of Health, Education and Welfare recommends not increasing Medicare certification to include the facility's third floor "until (the) facility corrects deficiencies with infection control and maintenance program. Performance record of facility has been marginal over past three years." On January 30, 1976, Rev. Johnson, administrator at Friendship, wrote to James Claucherty at MDPH to request that Medicare certification be granted for the third floor of the facility (the fifth floor had been approved for this the preceding November). The June 28, 1976 memo indicates MDPH position on this request.

The most recent complaint CBC has received about Friendship came on August 10, 1976, and involved a resident named Ms. W. A gerontology student working at Friendship reported to CBC that Ms. W. had gangrene in both feet with maggots present in the dead tissue. CBC contacted the resident's daughter, Ms. S., and began researching the case. Although we do not know the date of Ms. W's first admission to Friendship, CBC was informed by the daughter that on February 10, 1976 Ms. W. was admitted to Zieger Hospital from the nursing home, acutely ill. She seems to have been seriously dehydrated, withdrawn and unresponsive. She had been vomiting and had diarrhea for a week. and had gangrenous feet. Ms. W. stayed at Zieger for one month. According to the hospital transfer sheet, upon re-admission to Friendship on March 10, 1976, Ms. W. appeared to have had dry gangrene of all ten toes, but no decubiti. She was aphasic, with impaired hearing and sight. On August 13, 1976, Sue Kaufman of CBC contacted the afternoon shift supervisor at Friendship regarding Ms. W. She was told the patient's feet were getting worse and contained stage three decubiti. Ms. W. was admitted to Art Centre Hospital on August 16, 1976, at the request of her daughter, and she died on August 19, 1976. The death certificate indicates endotoxemia, bacteremia, multiple decubiti and anaerobic sepsis.

Dr. Charles Truscon of the WCHD completed the annual periodic medical review of Medicaid patients at Friendship on August 11, 1976. The following problems were discovered:

1. Of 121 charts reviewed in the geriatric section, 38 did not contain the results of lab tests ordered for patients.

2. Podiatry care that had been ordered was often "poor" or was not performed. Report stated: "An investigation should be done of the amount and quality of podiatry care being given at this facility since many patients deny having procedures performed that are documented as done."

3. Medications were not documented as given as ordered by physicians for 50 of 121 patients reviewed.

The report summarized conditions at Friendship by saying: "We do not feel that this facility is rendering adequate care—find questionable practice by the podiatrist." In the late summer, CBC was informed that Mr. John Laing had earlier become the home's administrator.

CBC received the most recent inspection reports on Friendship Manor, based on surveys conducted in September of this year, on October 7, 1976. Mary Alice White, R.N. with the MDPH, visited Friendship on September 7 and 8, and cited four items of non-compliance in the FER. These deficiences are:

"Feelings, attitudes, comforts (of patients) are not respected by all personnel.

"Insufficient supply of oral clinical thermometers and not cleaned in accord with an approved procedure.

"Individual towels/wash cloths are not available at bedside.

"Not all beds contained mattress pads."

In discussing these deficiencies in her Field Report, Ms. White stated: "There was a general lack of respect for the comfort and feelings of patients." In addition, other shortcomings regarding patient care at the home are described in the Field Report which are not listed in the FER's items of non-compliance. These shortcomings include:

1. "The nursing staff have supposedly been trained in rehabilitation nursing but there was *no evidence* of such observed in care being administered nor on the care plans."

2. "Closed clinical records lacked a physician discharge summary, and nurses notes in some records were incomplete."

3. "There were 38 adult incontinent patients none of which had an individually written bowel and bladder training program. These patients should be re-evaluated and placed in a training program as soon as possible."

4. "Some (children) were being bathed in an area that was unsafe due to carelessness of personnel. Water on floor, inappropriate area for laying small children, (wheeled stretcher), soiled and clean linen on the floor."

5. "Patient care plans on this unit (child care unit) need to be reviewed and revised in coordination with nursing care provided."

Although the items from the Field Report listed above were not listed as rule violations in the FER by the inspector, they do illustrate that long-standing deficiencies in the areas of nursing care, patient care plans, and record-keeping remain prevalent.

On September 10 Darwin Root, sanitarian with MDPH, inspected Friendship. There are four items of non-compliance listed on the FER, but two of them are all-encompassing violations:

"1. The facility is not being maintained in a clean and sanitary condition as evidenced by the following:

"(1) Floors in the patient rooms and in the bathing rooms are not promptly cleaned-up from spills or accidents;

"(2) Gross fecal material was noted on toilet seats...;

"5. Window (sic) to the exterior of the facility were obliterated with soil....

"2. The facility is not being maintained adequately as evidenced by the following maintenance problems:

"(3) Over 50 night-lights were burned out in the patient unit....

"(4) Considerable wall damage, especially in the patient rooms were (sic) noted.

"(10) Ceiling damage was noted in several of the patient toilet rooms due to leaking plumbing fixtures from the floor above.

"(12) The nurse call cords serving the nurse call switches in the patient toilet rooms were missing in several of these toilet rooms."

In his FR, Mr. Root stated that maintenance deficiencies which had been documented in the previous FR (from September 24, 1975 visit by Curtis Wolf) were still problems on the date of his visit. He also characterized the housekeeping performance at Friendship as "poor". In addition, one of his observations reflects on the patient care provided at the facility:

"Strong urine and feces odors were detected in many of the patient rooms, probably due to the lack of prompt clean-up of spills or accidents. Odors may also be attributable to the lack of prompt bed change of incontinent patients."

In summary, the FR indicates that housekeeping problems at Friendship "stem around the lack of adequate supervision, procedures, and in most cases

staffing to perform the required maintenance and housekeeping aspects for this facility." Consequently, serious housekeeping and maintenance deficiences persist today at that facility.

The dietitian's survey of Friendship occurred on September 3, 1976. The inspector was Carlean Williams, R.D., of the MDPH. Her FER lists no items of non-compliance at the time of the visit. In her FR, Ms. Williams states that "the two meals observed were nutritious and well received by the patients." Ms. Williams had made the same statement about meals in her Field Report of one year earlier. However, one week later, Darwin Root was to find that the freezer and ice machine in the dietary service were not in operation. In addition, final rinse temperatures in the dishwasher were too low. Both these violations are indicated in the FER following Root's September 10, 1976 visit.

To summarize, Friendship Manor is a facility with a long history of problems. Major deficiencies have occurred in 12 different categories, including the following: Nursing care, physician's services, medication administration, housekeeping, maintenance, utilization review, recordkeeping, staffing, development of patient care plans, activity program, professional administration, and admissions procedures.

[Exhibit No. 45]

State of Michigan,
Department of Public Health,
Lansing, Mich., October 26, 1976.

Mr. Charles Chomet,
Executive Director, Citizens for Better Care,
Detroit, Mich.

Dear Mr. Chomet: Thank you for your recent letter voicing the concerns of your organization regarding the Friendship Manor Nursing Home in Detroit.

Your review of the licensure file for this facility is accurate in its identification of longstanding deficiencies at the facility. We note, however, that there are primarily new deficiencies identified at each survey as opposed to the continuation of the same deficiencies. The operation of Friendship Manor to date has been less than ideal, but recent observations by our consultants provide evidence of steady progress and improvement toward compliance with applicable requirements.

The number of visits to Friendship Manor by consultants from this Department exceeds the normal number of such visits to such a facility and is indicative of the Department's awareness of and concern for the less than optimum operation of Friendship Manor to date. Our files indicate that the level of surveillance and consultation provided is beginning to result in improved operations at the facility, and further, we note that the most recently employed administrator is now actively seeking consultation and assistance from this Department and appears to be utilizing the assistance provided to good effect. We are also advised that the Non-Profit Homes Association is providing consultation assistance to the administrator of Friendship Manor as a part of their organizational effort to maintain the operational standards of one of their member facilities.

The decision regarding further licensure and certification of Friendship Manor will be made on the basis of surveys performed during the month of September; the type, extent and magnitude of noted deficiencies; and the facility's response to these deficiencies. As you know, the Department's continued efforts with licensed facilities are predicated on the concept of bringing facilities with deficiencies into compliance with lawful requirements. Our records indicate that this objective may be much nearer to accomplishment at Friendship Manor at this time than has been true in the past. At such time as a decision is made relative to the licensure and certification of Friendship Manor your organization will be notified in the customary manner.

Thank you for your expression of interest and concern in this matter.

Sincerely,

Maurice S. Reizen, M.D.
Director.

[EXHIBIT No. 46]

CITIZENS FOR BETTER CARE,
Detroit, Mich., November 12, 1976.

MAURICE S. REIZEN, M.D.,
Director, Michigan Department of Public Health,
Lansing, Mich.

DEAR DR. REIZEN: Citizens for Better Care is submitting a complaint on Friendship Manor Nursing Home in Detroit. On November 5, 1976 and November 10, 1976, CBC staff members visited Friendship. They observed the following problems. On the pediatrics unit, several deficiencies were noted:

1. On November 5, in Room 211, the bathroom floor was dirty; no towels or washcloths were available.
2. On November 5 and 10, the floor and bathtub in the tubroom were dirty; on November 5 several brushes and combs were lying mingled on the wheeled cot.
3. On November 5, there were no mattress pads in Rooms 208 and 210; on both November 5 and November 10, one of the cribs in Room 215 lacked a pad.
4. On November 5, a baby in Room 205 had vomited and apparently lain unattended for sometime, as he had spread the vomitus across his clothing and bedding.
5. During both visits, all nursing personnel appeared to be gathered in either the nursing station or the dayroom, as CBC staff observed none attending children in their rooms.

Moving to the geriatric floors, CBC observed these conditions:

1. Ceiling damage, apparently due to leaky pipes, was visible in the third floor hallway.
2. Corinne Blake, Room 319, and another resident of the same wing, both stated they rarely received their evening snacks, as the aides ate them. Since these residents also claim that supper is served at 4:30, these residents often appear to wait more than the prescribed 14 hours between meals. In addition, Ms. Blake is a diabetic, whose maintenance requires she receive food at regular intervals. On November 10, a resident in Room 404 stated that she is usually hungry, and that she finds lunch and supper unappetizing, although she enjoys breakfast. She stated that she often returns food on her tray because she finds it too unappetizing to eat. A man in Room 401 told CBC staff that nursing home dietary employees have never asked him his food preferences. When he returns food uneaten because he does not care for it, he is never offered a substitute, nor does either nursing or dietary staff appear to note that he is leaving quantities of food on his tray. Several residents on both the third & fourth floors stated they were persistently served foods they did not like, or which did not correspond with their therapeutic diets.
3. Floors in many third floor rooms need to be stripped of visible accumulations of wax and old soil.
4. Several beds on the third floor lacked mattress pads.
5. During both visits, CBC employees observed no nursing staff assisting any patients in their rooms on any of the three geriatric floors. On November 5, all nursing staff seen during a 1½ hour period on the day shift were in the nursing stations. On November 10, we observed four nursing employees at the third floor nursing station, plus one housekeeper on the floor. On the fourth floor, we saw one nursing employee in the dayroom and one in the nursing station, plus one housekeeper. On the fifth floor, there were two nursing employees at the nursing station. Since there were approximately 43–46 residents on each of the geriatric floors, it is also obvious that the home was short-staffed. There should have been six staff per floor, rather than 2–4.
6. At approximately 3:30 p.m. on November 5, a female resident of Room 302 was observed clothed in only a gown, with no underwear, she was restrained to a chair in the hallway, with her lower body exposed to view. When we asked the nurse on duty to have someone assist her, the nurse did not know why she had been placed in the hallway. When we saw this resident again at approximately 4:15, the only change in her condition was that she had been moved back into her room. CBC staff saw this patient again in her room on November 10; her condition was unchanged.

7. Many residents throughout the geriatric floors were seen in night clothes, many had overly-long fingernails, and many men needed to be shaven.

8. The other resident of Room 302, on November 5, had just attempted to empty her own bedpan. Having spilled urine from it onto the floor, she was wiping the spill with paper towels. This incident occurred during the change from day to afternoon shifts, and no staff appeared available to assist the resident.

9. At approximately 4:15 p.m. on November 5, a woman in Room 311 was sleeping on the floor.

10. Floors in the hallways on the third, fourth, and fifth floors were dirty, with an especially noticeable old spill next to the third floor nursing station visible during both visits.

11. Urine odor was quite pronounced on all three geriatric floors on both November 5 and November 10, particularly in the wing which would lie to the right as one faced the nursing station. The areas near the stairways and the elevators seem to present the greatest problem.

12. The only activity available to any resident at the times of both our visits appeared to be watching television. At no time did we see any indication of an activities program. There was no activities calendar posted on any of the patient floors, nor was the Patient Bill of Rights posted in any patient area of the facility.

13. The wall in the fifth floor hallway was damaged where a mounted fixture had been removed and the resulting holes not repaired.

14. There was a large dried urine puddle in the third floor dayroom.

15. Some residents appeared to lack pitchers of water and drinking glasses at their bedsides.

16. The posted copies of licenses for both the administrator, Jack Laing (license No. 00659) and the assistant administrator.
Janet Edwards, had expired on October 31, 1976.

In response to the problems observed by CBC staff during their visits to Friendship Manor, we would appreciate answers to the following questions:

1. Are both the administrator and the assistant administrator currently licensed?

2. Has the facility submitted plans of corrections following their most recent licensure and certification surveys? When were they submitted?

3. Has the home submitted to the MDPH a copy of a newly written preventive maintenance program?

4. What is the maintenance schedule for stripping floors? mopping? waxing? washing walls? painting? repairing damaged floors or ceiling tiles and walls?

5. Has the facility satisfactorily revised its soiled linen handling procedure?

6. Has this home submitted to the MDPH an acceptable infection control program?

7. Does the nursing home have an adequate supply of mattress pads, towels and washcloths? If they do, why are those articles not available to all residents in their rooms?

8. At what intervals are nursing personnel required to check each patient? At what intervals do they actually check them? How is the nursing staff supervised to assure that all personnel carry out assignments? How often does Mrs. Nash, the director of nurses, tour each floor?

9. Will the MDPH nursing consultant check all time cards for the three-week period immediately prior to November 15, to determine adequacy of staffing?

10. Will the MDPH dietary consultant survey all residents of Friendship Manor to determine whether residents receive all food which is planned for them? Will she also survey each resident for satisfaction with the food they are offered? What procedure does the home use to offer residents substitutes for food they do not like? How do they monitor the amount of food each resident returns on her tray? How is this information relayed to the nursing staff? How is adequate hydration monitored in each resident?

We look forward to prompt receipt of your complaint investigation report, plus accompanying facility evaluation reports.

Sincerely,

SUSAN W. KAUFMAN,
Assistant Project Director.

[EXHIBIT NO. 47]

LEGAL AID OFFICE,
SENIOR CITIZENS LEGAL AID PROJECT,
LEGAL AID AND DEFENDER ASSOCIATION OF DETROIT,
Detroit, Mich., December 21, 1976.

DR. MAURICE REIZEN,
Director, Michigan Department of Public Health,
Lansing, Mich.

DEAR DR. REIZEN: As counsel to Citizens for Better Care, I have carefully reviewed survey reports and other reports and memoranda prepared by your staff concerning Friendship Manor Nursing Home, 3950 Beaubien, Detroit; reports by the Wayne County Health Department and Detroit Health Department concerning Friendship Manor; and plans of correction submitted by Friendship Manor. I have also reviewed your letter of October 26, 1976, to Mr. Charles Chomet, Executive Director of Citizens for Better Care. I must sadly conclude that the Department of Public Health, and particularly the Division of Health Facilities Standards and Licensing, Bureau of Health Facilities, has condoned marginal patient care at Friendship Manor and inexcusably failed to discharge its regulatory responsibilities.

I regard the Department's sorry record with great concern and therefore wish to elaborate.

Your Department has failed to see that continuing deficiencies at Friendship Manor are uncorrected

In your letter of October 26, 1976, to Mr Chomet, you correctly note that Friendship Manor has had "long-standing deficiencies" but further asset that "there are primarily new deficiencies identified at each survey as opposed to the continuation of the same deficiencies." This assertion is simply wrong! In a conference memorandum written by James Claucherty, dated November 3, 1976, five "major" deficiencies were identified from the latest field reports: (1) poor maintenance; (2) inadequate housekeeping; (3) poor nursing care; (4) lack of infection control; and (5) no in-service training. The attached Addendum, I believe, more than amply illustrates that none of these deficiencies can be considered to be of recent origin.

License and certification surveys of Friendship Manor have not always been thorough

As you know, the last license and certification survey of Friendship Manor was conducted in September, 1976, by a nurse, a dietitian and a sanitarian.

The nursing survey was conducted on September 7-8 by Mary Alice White, R.N. Her Facility Evaluation Report (FER) and Field Report (FR), both dated September 21, 1976, and the Skilled Nursing Facility Survey Report (SSA-1569) and Intermediate Care Facility Survey Report (SSA-3070) which she prepared, cite several nursing care deficiencies, but completely overlooked the shocking deficiencies observed nine days later by Edward O. Willoughby, M.D., and Dorothy E. Chapple, R.N., of the Department's Medical Review and Nursing Evaluation (MRNE) staff. The MRNE team found, among other things, that Friendship Manor had a shortage of nursing personnel; that physicians' orders were not being followed; that medication was not being properly administered; and that patients were not receiving proper care for skin irritation and decubiti. The MRNE report further cited the case of a 68-year-old woman admitted to Friendship Manor in March, 1976, who subsequently developed Stage III and IV decubiti and gangrene; who was not not transferred to a hospital until after she had lost a toe to gangrene and was in danger of losing another; even then, she was not transferred to a hospital until five days after hospitalization had been suggested. She passed away three days after she was hospitalized, but was thought to be still at the nursing home by the staff a month later when the MRNE team wished to review her medical status. Not only did Ms. White's reports make no mention of these deplorable conditions, the corresponding standards were checked on the SSA-1569 and SSA-3070 as having been met.

There appears to be a lack of coordination between the division of health facilities standards and licensing and the medical review and nursing evaluation staff

MRNE staffs are charged with the responsibility of reviewing the level of care of all Medicaid patients; obviously, information derived from level of care evaluation can be helpful in determining compliance with applicable nursing home standards, and, in fact, must be considered in the making of certification decisions, 45 CFR 249. 33 (a) (5) (i). However, it does not appear as if the Department is making optimal use of that information. In August of 1976, Charles Truscon, D.O., and Mary Covert, R.N., of the Wayne County Health Department, performed level of care evaluations at Friendship Manor.

Both Dr. Truscon and Ms Covert wrote reports, dated August 17, 1976, documenting serious nursing care deficiencies at Friendship Manor. Dr. Truscon's report was sent to the Bureau of Health Care Administration and Mary Covert's to Dorothy Chapple. It does not appear as if either of these reports had been forwarded to Mary Alice White for her use in performing the nursing survey of Friendship Manor, as both reports would have called her attention to serious nursing deficiencies which she simply overlooked.

Moreover, effective use seems not to have been made of the September 17 report of Dr. Willoughby and Dorothy Chapple. On November 9, 1976, John Laing, Administrator of Friendship Manor, submitted a plan of correction which responded to the deficiencies noted by the Department's survey team. However, the plan of correction did not address most of the deficiencies noted on the report prepared by Dr Willoughby and Ms Chapple.

Documentation of surveys has been inadequate

CBC has, on several occasions brought to the attention of you and your staff the fact that documentation of surveys is often inadequate. Obviously, informed licensing and certification decisions cannot be made unless the decision makers have all necessary information.

Let me cite but one example of poor documentation. The FER prepared by Mary Alice White, dated September 21, 1976, lists four rule violations. The accompanying FR, however, notes other deficiencies which are not reflected on the FER. For example, on page two of her FR, Ms White notes that "closed clinical records lack a physician's discharge summary, and nurses (sic) notes in some records were incomplete." Although an apparent violation of Rule 102, appropriate notation was not made by Ms White on the FER. Again, although an apparent violation of federal certification standards, the relevant standard is checked as having been met in box F346 on the SSA-1569.

Those individuals with responsibility for licensing and certification decisions have failed to exercise careful judgment and have failed to take firm action when required

Friendship Manor has been in operation for approximately three years. In a report on Form SSA-1539 to HEW, dated June 28, 1976, James Claucherty and Robert Laraway of your staff noted that "the performance record (of Friendship Manor) has been marginal over the past three years"; despite this assessment, the Department has never taken the firm action necessary to assure that Friendship Manor meets applicable standards. At best, the Department has been a paper tiger. In a conference memorandum dated October 22, 1974, Mr C. K. Lewis noted that "the principals of the home . . . were admonished that positive steps must be taken in the immediate future to eliminate the items noted so as not to jeopardize future licensure." In late 1975, an automatic cancellation date for certification was set. In a memorandum dated November 17, 1975, to Curtis Wolf, Mr. Claucherty noted that "an automatic cancellation date of April 20, 1976 (sic) will be established and some time in late February or early March we will make a 2567B follow-up visit. If the facility is not in compliance at that time it will not be certified." Mr Wolf, a sanitarian, re-visited the facility on April 7, 1976, and although he found that Friendship Manor had not corrected all of the deficiencies he had cited, Mr Claucherty and Mr Laraway recommended to HEW that the automatic cancellation date be waived.

Two problems are apparent. First, the Department has made ineffective use of the sanctions at its disposal. As far as I know, never has Friendship Manor been served with a letter of intent to deny its license, nor has its provider agreement been terminated. While revocation is a harsh remedy, as

a practical matter, the delays in the appeals process often give a nursing home a long period of time in which to bring its facility into compliance. Thus, there is no reason not to issue an intent-to-deny letter to a nursing home when deficiencies are initially identified. In fact, it is my impression that many nursing homes fail to take corrective action until the intent-to-deny letter has been issued.

Secondly, the Department has failed to follow up on its surveys and complaint investigations. The Department has been all too willing to rely on assurances by Friendship Manor that violations and deficiencies would be corrected; unfortunately for the patients, those assurances have frequently not been realized. See, for example, the plan of correction submitted May 4, 1976, by Louis Johnson, administrator of Friendship Manor and compare it with the latest survey and MRNE Report. In particular, the Department seems to treat plans of correction as corrections in fact. It further appeals that the Department has been overly optimistic when told by Friendship Manor that personnel changes will result in corrective measures.

The Department has failed to comply with Federal certification procedures.

Federal Medicaid regulations require the Department of Public Health to comply with specified procedures in making certification decisions or recommendations. Those regulations are found at 45 CFR 249.33a(a)(4)-(6) and elsewhere as to Medicaid certification and 20 CFR 1901 et seq as to Medicare certification recommendations to HEW.

The Department is failing to comply with Medicaid regulations in numerous important respects. First, 45 CFR 249.33(4)(ii)(A) permits certification of a nursing home not in full compliance with applicable standards, but only if "the deficiencies noted, individually or in combination, neither jeopardize the health and safety of patients nor are of such character as to seriously limit the provider's capacity to render adequate care." Although admittedly a matter of judgement, I am dismayed that the Department has not, for example, regarded the deficiencies noted on the SSA-1569 and SSA-3070 prepared after the September, 1975, survey as deficiencies which jeopardize the health and safety of patients or are of such character as to seriously limit Friendship Manor's capacity to render adequate care. The deficiencies noted include failure to review or revise patient care plans, failure to document medication and failure to administer medication as ordered by the attending physicians.

Secondly, 45 CFR 249.33(a)(4)(ii)(A) requires the Department to prepare a written justification in the event a home is certified notwithstanding noncompliance with applicable standards. To my knowledge, the Department has routinely failed to prepare such written justifications.

Thirdly, 45 CFR 249.33(4)(iii)(B) requires the Department to set an automatic cancellation date of the provider agreement as a deadline for the correction of deficiencies. However, despite Friendship Manor's long history of deficiencies, to my knowledge, only one automatic cancellation date has ever been set and, as noted above, your Department recommended to HEW that that ACD be waived, even though not all of the cited deficiencies had been corrected. Furthermore, as noted above, the Department's follow-up monitoring has often been inadequate.

Fourth, 45 CFR 249.33(4)(iv)(B) limits the conditions under which a second certification may be given following certification despite deficiencies. This provision seems to have been completely ignored by your Department.

Fifth, 45 CFR 249.33(6) provides that provider agreements may not be more than a year in duration and further provides that the certification period may be extended for not more than two months, provided the health and safety of the patients are not jeopardized thereby and provided certain other conditions are met. I am informed that Friendship Manor's provider agreement expired November 30, 1976, and that the Department has delayed a decision on certification for the period beginning December 1. After having read the MRNE reports of last August and September, the Department is certainly hard-pressed to justify this apparent extension of Friendship Manor's provider agreement.

Sixth, in April 1976, Mr Claucherty and Mr Laraway recommended to HEW that the third floor, a skilled floor, not be certified as provider under the Medicare program. I am therefore dismayed that the third floor has been certified for skilled nursing facility services under the Medicaid program when the standards for skilled certification are identical under the Medicare and Medicaid programs.

Although I do not believe it is necessary to elaborate, I must also note that to the extent the Department has corresponding responsibilities under 20 CFR 1901 et seq, the Department's record is likewise poor.

In view of the conditions at Friendship Manor and in view of its marginal performance over the last several years, I believe that the Department has no alternative but to take the strongest of action against Friendship Manor at this time. I believ that the facts can not be evaluated in any way as to justify continued licensure or certification. I trust you will immediately take appropriate action against Friendship Manor and that it will not be necessary for CBC and I to bring this matter to the attention of the courts.

I have also written this letter to you because the Department's sorry record in regard to Friendship Manor is not an isolated example of regulatory paralysis. As counsel to CBC, I have seen other examples of each and every action and inaction by the Department which I have reviewed in this letter. I believe that a review and evaluation of the nursing home regulatory process of your Department is immediately in order. Citizens for Better Care and I are both willing to assist you and your staff in so doing.

Sincerely,

HENRY LANGBERG.

ADDENDUM

In a memorandum dated November 3, 1976, James Claugherty identified five "major" deficiencies at Friendship Manor from the latest field reports: 1) infection control; 2) in-service training; 3) housekeeping; 4) maintenance; and 5) nursing care. None of these deficiences are of recent origin.

I. Infection control

Deficiencies regarding infection control were cited as a violation of federal certification standards two years in a row. SNF (Skilled Nursing Facility) standard 405.1135(a) was cited on September 3, 1975 and again on September 10, 1976. SNFF Standard 405.1135(b) was cited on three occasions: September 3, 1975; April 7, 1976; and September 10, 1976.

II. In-service training

On six separate occasions, Michigan Department of Public Health personnel cited in-service training as a problem or recommended that it be conducted: April 12, 1974; January 6, 1975; September 2, 1975; September 3, 1975; September 7–8, 1976; and September 17, 1976.

In addition, SNF standard 405.1121(h) was cited on June 20 and/or August 8–9, 1974, according to the plan of correction, as well as on January 6, 1975. ICF (Intermediate Care Facility) standard 249.12(1)(a)(vi) was cited four times: on April 12, 1974; June 20 and/or August 8-9, 1974; January 6, 1975; and September 2, 1975.

III. Housekeeping

Friendship Manor has been found out of compliance with each of the following state regulations on more than one occasion:

1. Rule 35(1), referring to cleanliness and sanitation, was cited on December 18, 1974, September 3, 1975, and September 10, 1976.
2. Rule 131(1), regarding soiled linen handling, was cited on September 3, 1975, and September 10, 1976.

In addition, violations of SNF standard 405.1135(c), regarding lack of housekeeping staff, were cited on April 8, 1975; September 3, 1975; and September 10, 1976.

IV. Maintenance

In the area of maintenance, Friendship Manor has again repeatedly fallen short of state licensure requirements. The following regulations have been cited more than once:

1. Rule 114(6), referring to maintenance of the ventilation systems, was cited on June 20, 1974 and September 3, 1975;
2. Rule 114(9), referring to maintenance of floors, walls and ceiling was cited on June 20, 1974, and December 18, 1974; and
3. Rule 135(1), assessing adequacy of maintenance, was cited on September 3, 1975, and September 10, 1976.

Violations of skilled certification maintenance, standards were cited as follows:

1. 405.1134(i), regarding preventative maintenance of equipment, building and grounds, was cited on April 8, 1975, September 3, 1975, April 7, 1976, and September 10, 1976;

2. 405.1134(1), was not met on September 3, 1975. On September 10, 1976, the standard was checked as "met", even though the consultant indicated that the facility did not provide a "functional, sanitary, comfortable environment."

V. Nursing care

Nursing care has consistently been the most serious problem at Friendship Manor. The following state regulations governing nursing care have been violated more than once:

1. Rule 41, which mandates that feelings, attitudes and comfort of each resident be meticulously respected at all times, was cited on March 19, 1976, September 7–8, 1976 and September 17, 1976;

2. Rule 64(1)(a), covering the care of skin, mouth, teeth, hands, feet and hair, was cited on March 19, 1976, and September 17, 1976;

3. Rule 64(1)(b), regarding prevention of skin irritation and decubiti, was cited on March 19, 1976 and September 17, 1976;

4. Rule 65(13), which prescribes mattress pads, was cited April 8, 1975; September 2, 1975, and September 7–8, 1976;

5. Rule 83(2), which requires the recording of medication doses, was cited on January 6, 1975, and September 17, 1976;

6. Rule 86(1), requiring disposal of discontinued medication, was cited on September 2, 1975 and March 19, 1976;

7. Rule 97, governing activities programs, was cited on April 12, 1974 and August 8–9, 1974;

8. Rule 155(2), which requires a full-time R.N. in pediatrics, was cited on April 12, 1974 and August 8–9, 1974.

In addition, SNF standard 405.1124(c), requiring each patient to receive prescribed treatment, medications, diet and restorative nursing care, was cited on June 20 and/or August 8–9, 1974, as well as on January 6, 1976.

Violations of the following ICF standards have been repeatedly cited:

1. 249.12(b)(4)(ii), referring to the plan of care for social needs, on April 12, 1974; April 8, 1975, and January 6, 1975;

2. 249.12(b)(5)(ii), requiring a plan of care for activities, on April 12, 1974; and June 20, and/or August 8–9, 1974. In addition, the consultant noted a lack of plans on September 7–8, 1976, though she cited the violation under 249.12(b)(5)(iii);

3. 249.12(a)(1)(i), regarding adequacy of staffing, on April 12, 1974, June 20, and/or August 8–9, 1974;

4. 249.12(a)(4)(i)(C), regarding discharge summaries or plans of care in patient records, on April 12, 1974, June 20 and/or August 8–9, 1974 and September 7–9, 1976;

5. 249.12(a)(9)(i), requiring a full-time health services supervisor, on April 12, 1974 and June 20, and/or August 8–9, 1974; and

6. 249.12(a)(9)(iv), referring to written health care plans, on April 12, 1974 and June 20 and/or August 8–9, 1974.

Examining only cited violations of state regulations or of federal certification standards tends to seriously understate the extent and duration of problems at Friendship Manor. First, as noted above, deficiencies may be noted on Field Reports in narrative form, but not cited on the checklist used by your department, the FER, SSA–1569 and SSA–3070. Second, since it is possible to assign a variety of rule or standard numbers to a particular deficiency, rarely is a single rule or standard cited more than once—even though deficiencies remain uncorrected. As an example of these two patterns, CBC has documented, from the material in the Department's licensing file, all instances in which the problem of medications administration are mentioned. Although this problem is mentioned at least 22 times in the licensing file, only one rule repeat is involved:

1. Mary Covert, R.N., Wayne County Health Department, memo, February 28–March 1, 1974: medications not documented.

2. Dorothy Chapple, R.N., memo, March 26, 1974: medications not documented or given as ordered.

3. Wayne County Health Department nurse's memo, August 28-30, 1974: medications not given as documented; medications out of stock; medications not given because keys unavailable.

4. Field Report (FR), December 16, 1974: medications not recorded as ordered.
5. SSA-3070, Intermediate Care Facility Survey Report, January 6, 1975: 249.12(a)(4)(D): medications not recorded as ordered.
6. SSA-1569 (Skilled Nursing Facility Survey Reports), January 6, 1976:
405.1124(c)—each patient not receiving prescribed treatments, medications, diet and restorative nursing care; medications not always recorded;
405.1124(h)—drugs frequently not recorded.
7. Facility Evaluation Report (FER), January 6, 1975: Rule 83(2)—medications not recorded as ordered.
8. Dr Harrington, WCHD, memo, February 14, 1975: medications errors.
9. FR, April 8-9, 1975: medications improperly stored.
10. FER, April 8, 1975, Rule 82(3)—medications improperly recorded.
11. SSA-1569, April 8, 1975: 405.1124(i)—no thermometer in medications refrigerator.
12. Jeannette Fromm, R.N., Detroit Health Department, memo, May 12-13, 1975: medications errors.
13. Covert, memo, WCHD, June 2, 1975: haphazard drug documentation, slow re-orders.
14. Covert/Chapple memo, August 25, 1975: medications errors.
15. Dr Truscon, WCHD, memo, August 22, 1975: medications dispensing poor, drug room keys in lock while room unattended.
16. FER, September 2, 1975: Rule 82(2)—medications not recorded; Rule 86(1)—discontinued medications not destroyed.
17. FR, September 2, 1975: medications disposal.
18. Covert, memo, February 6, 9, 10, 1976: medications not given as ordered.
19. Chapple, memo, June 10, 1976: outdated medications on shelf.
20. Covert, memo, August 17, 1976: medications or treatments not documented as ordered.
21. Chapple, FR, September 17, 1976: discontinued medications on shelf, medications not given as ordered; medications on cart after patient died.
22. Chapple, FER, September 17, 1976: Rule 102(h)—medications and treatment records not in record; Rule 84—medications errors not reported; Rule 83(3)—medications not checked against doctor's orders.

[Exhibit No. 48]

Citizens for Better Care,
Detroit, Mich., January 6, 1977.

Congressman Claude Pepper,
Chairman, Subcommittee on Long Term Care,
U.S. House Committee on Aging, U.S. House of Representatives,
Washington, D.C.

Dear Congressman Pepper: Knowing of your interest in learning whether the Medicare, Medicaid and State licensing programs are achieving success in insuring decent care for nursing home patients, I am sending you information about one dramatic example of failure. The enclosed lengthy letters written by Citizens for Better Care (CBC) and our legal counsel to the Michigan Department of Public Health (MDPH) and a short response received from that agency—document ongoing and glaring violations of State and Federal rules affecting senior citizens and children in the 170-bed Friendship Manor Nursing Home in Detroit. The enclosed also documents a sorry record of backsliding and "wishiwashiness" by the Michigan Health Department—which, in this case, has turned its back on its responsibility for requiring compliance with State and Federal nursing home standards.

Since the nursing home opened in 1974, Friendship Manor has exhibited chronic and horrendous deficiencies in such areas as nursing care, housekeeping, medical care, administration of drugs, and maintenance. Yet, the State Health Department, which is responsible for enforcing State and Federal nursing home standards, has failed to conduct thorough surveys, has neglected to cite as violations problems which have been brought to its attention, and has been unable to coordinate its licensing/certification and Medical Review Nursing Evaluation staff. Most important, the MDPH granted State licensure and Federal Medicaid/Medicare certification for a nursing home which obviously does not meet the standards of these programs. In one instance, the

MDPH recommended waiver of the "automatic cancellation date" upon finding that deficiencies had not been corrected. In another instance, despite recommendations to the contrary by its own sanitarian and utilization review specialist, the MDPH proposed that the fifth floor of the facility be certified for Medicare. Obviously, to the extent that Federal laws and regulations have been ignored or violated, the U.S. Department of Health, Education and Welfare also bears responsibility for this mess. Since the nursing home opened, millions of dollars in Federal and State Medicaid and Medicare funds have been used to pay for substandard patient care. For example, a March 1974 inspection report by a public health nurse found the facility "quivering from lack of staffing, lack of in-service or proper orientation, and general lack of nursing and administrative know-how." A May, 1974 inspection survey identified urine odor, dirty floors and no full-time R.N. on the child care unit, as problems. In October, 1974, a 10 year old boy died following a six-day stay in the nursing home after receiving shockingly absent medical and nursing care in the facility. (See enclosed newspaper article.) In August, 1975, a survey of the facility by a physician reported haphazard medication dispensing, "many patients found to be unkempt, unshaven and slovenly" among other problems. The same month a nurses inspection noted that two patients had been treated for lice in the past two months (both patients had been in the home for about one year) and also found much teasing and agitating of confused patients on the fourth floor by aides and attendants. A September, 1975 inspection report prepared by a sanitation noted two flooding toilet rooms, an accumulation of "gross fecal material" on walls, floor, and furniture. The same report describes a facility staff member "sitting in the dining room in full view of a patient sitting with his feet in a pool of urine."

A March, 1976 nurses report describes one patient with uncovered stage four bed sores on both feet—with no documentation of any treatment for the previous six days. A report prepared after a 1976 visit to the home by a nurse found no evidence—either in the records or in the care being provided—that nursing staff had been trained in rehabilitation care. That report also stated that "some (children) were being bathed in an area that was unsafe due to carelessness of personnel." A sanitation report for September, 1976 found that "strong urine and feces odors were detected in many of the patient rooms."

In view of the above problems, you may be interested in conducting an investigation of this matter.

Sincerely,

CHARLES CHOMET,
Executive Director.

Enclosures.

[EXHIBIT NO. 49]

Detroit, Mich., January 6, 1977.

MR. RICHARD FRIEDMAN,
Director, HEW Region V
Chicago, Ill.

DEAR MR. FRIEDMAN: Knowing of your interest in learning whether the Medicare, Medicaid and State licensing programs are achieving success in insuring decent care for nursing home patients, I am sending you information about one dramatic example of failure. The enclosed lengthy letters written by Citizens for Better Care (CBC) and our legal counsel to the Michigan Department of Public Health (MDPH) and a short response received from that agency—document on-going and glaring violations of State and Federal rules affecting senior citizens and children in the 170-bed Friendship Manor Nursing Home in Detroit. The enclosed also documents a sorry record of back-sliding and "wishiwashiness" by the Michigan Health Department—which, in this case, has turned its back on its responsibility for requiring compliance with State and Federal nursing home standards.

I would ask that your office conduct an investigation to determine whether the MDPH has carried out its Federally mandated responsibilities.

Sincerely,

CHARLES CHOMET,
Executive Director.

Enclosures.

[Exhibit No. 50]

State of Michigan,
Department of Public Health,
Lansing, Mich., January 6, 1977.

Re Notice of Intent to Deny Licensure and Certification.
Mr. John A. Laing,
Administrator, Friendship Manor Nursing Home,
Detroit, Mich.

Dear Mr. Laing: You are hereby notified that I have received staff reports and recommendations to deny the application for licensure and certification filed on behalf of Friendship Manor, 3950 Beaubien Avenue, Detroit, Michigan received in the Department on August 31, 1976.

I intend to deny the licensure and certification of the above facility within 30 days from the receipt of this letter. This action is justified on the basis of the Field Reports of Dorothy E. Chapple, R.N., dated September 17, 1976; Darwin Root, R.S., dated December 21, 1976; Mary Alice White, R.N., dated December 22, 1976; Facility Evaluation Reports of Edward Willoughby, M.D. and Dorothy E. Chapple, R.N., dated September 17, 1976; Darwin Root, R.E., dated December 21, 1976; Mary Alice White, R.N., dated December 22, 1976; Federal Survey Report form SSA 1569 dated December 1 & 3, 1976; Federal Survey Report form SSA 3070 dated December 1 & 3, 1976. The Department's licensure and certification repords for the facility are on file at the Offices of the Bureau of Health Care Administration, 3500 N. Logan, Lansing, Michigan.

This notice and information is provided to assist you in maintaining your facility in accordance with licensure and certification standards contained in Rule R325.1901 through R325.2068 of the Administrative Code of 1954, Supplement 60 and to comply with the provisions of Section 92, P.A. 306 of 1969, as amended.

I wish to advise you that you may appeal from this Administrative Decision in which case you may have an administrative hearing. Your appeal should comply with the requirements of Rule R325.1915 of the Administrative Code of 1954, Supplement 60 (copy of the Rule is attached hereto). If such an appeal is not filed, a final order will be entered in accordance with procedures set forth in P.A. 306 of 1969, as amended.

However, prior to the notice of an administrative hearing being issued, you will be provided with an opportunity, at an informal conference, to demonstrate compliance with nursing home rules and laws and/or Medicare/Medicaid certification standards, violations of which have been alleged in the above mentioned reports. Mr. James Claucherty will be available at 10 a.m. on January 14, 1977 at the Department offices, 3500 North Logan, Lansing, Michigan to participate in this informal conference. If after completion of the informal conference satisfactory evidence of compliance is not forthcoming, or if you do not appear, a notice of administrative hearing will be issued in accordance with Section 71, P.A. 306 of 1969, as amended.

Please be advised that until I am in receipt of satisfactory evidence of compliance, you are advised of my intent to proceed with the licensure/certification action proposed in this letter.

Sincerely,

Maurice S. Reizen, M.D.,
Director.

[EXHIBIT No. 51]

Michigan Department of Public Health
BUREAU OF HEALTH FACILITIES
Division of Standards and Licensing

FACILITY EVALUATION REPORT

Facility: Friendship Manor Nursing Home
City: Detroit County Wayne
Administrator: John A. Laing
Date of Visit: March 23, 1977

Visit to:
( ) Hospital
(x) Nursing Home
( ) Home for Aged
( ) Med. Care Fac.

By:
(X) Nurse
( ) Engineer
( ) Sanitarian
( ) Physician
( ) Dietitian
( ) Administration

For consultant's use on next visit . . . . .

MICH. PUBLIC HEALTH Rule No.	SOCIAL SECURITY ADMIN'N Cond-ition	Std	Items of Non-Compliance	Improved	No Change	Corrected
41			Comfort of patients was not always respected by all personnel. (e.g. Foot-stools for swollen, dangling feet and call lights not within reach of chair-restrained patients.)			
64(1)			Personal care and services were not evident as part of nursing care.			
65(10)			Supply of linen not sufficient.			
68(1)			Personnel not skilled in techniques of restorative nursing.			
83(2)			Medications and treatments not always recorded.			
(3)			No procedure for checking order for medicine against administration.			
86(1)			Outdated medicines not disposed of.			
97			Diversional activities not provided.			

MAW/RW/ars
3/28/77

Submitted by: [signatures]
Mary Alice White, R.N., Rita White, R.N.
Health Dept.: Michigan Department of Public Health
Date: 3-28-77

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Consultant

Michigan Department of Public Health
BUREAU OF HEALTH FACILITIES
Division of Standards and Licensing

FIELD REPORT

Visit to:
( ) Hospital
(x) Nursing Home
( ) Home for Aged
( ) Med. Care Fac.
( ) Ambulance Serv.

By:
(x) Nurse
( ) Engineer
( ) Sanitarian
( ) Physician
( ) Dietitian
( ) Administration

Type of Visit:
(x) Evaluation
( ) Consultation

Program:
(x) Lic/Certif.
( ) Medicare

Facility: Friendship Manor Nursing Home
City: Detroit County: Wayne
Administrator: John A. Laing
Date of Visit: March 23, 1977

PARTICIPANTS: John A. Laing, Administrator
Edith M. Barnes, R.N., Director of Nursing
M. Ware, L.P.N., Inservice Education Director
J. Clark, Director Maintenance
Almeda Steemer, R.R.A.
Donald Kristola, A.C.S.W. Region V H.E.W.
Joy McGath, R.Ph.
Ann Hains, R.D., Chief, Dietary Division, MDPH
Carlean Williams, R.D., Consultant, MDPH
Darwin Root, R.S., Consultant, MDPH

The facility was toured with Mrs. Barnes and Mrs. Ware. All patient areas were visited, selected patients interviewed and clinical records reviewed.

OBSERVATIONS AND RECOMMENDATIONS

General appearance of the patient units showed evidence improved housekeeping procedures have been implemented. Day room clean and orderly, corridors and utility rooms tidy, waste material bagged and floors clean. Immediate environment of patient's bedside was in need of attention. Food and milk cartons should be removed after meals rather than be allowed to be stored in bedside table drawer. Most patients were up and seated in chairs. Many were appropriately dressed in clean clothing, leg and foot covering. Some were still in night clothes, wearing soiled trousers, no foot or leg covering. Overall grooming of fingernails, hair, skin was lacking. Frequent bathing, hand washing, shampoo, skin lotion or oil is needed to provide comfort for the patient. Personnel were observed assisting patients to tub room for bathing, into wheelchair and administering treatments. Observation would indicate personnel were in need of instruction on transfer technique, range of motion and general body mechanics.

Many patients were observed sitting in chairs with feet dangling, without supportative foot stools or padded chairs to relieve swelling.

Signal lights were not always in reach of patients who depended on them, especially noticed were chair-restrained patients.

Three-fourths (3/4) of patients on 4th floor intermediate care were left to dress themselves and provide own personal hygiene. Many of them were still unkempt, including men who in the late afternoon were still unshaven. Some men and women were dressed in dirty, torn clothing and one man was noticed with dirty clothing, unmatched stockings with holes in toes and heels

Distribution: Facility Administrator
Local Health Officer
MDPH Lic/Cert. Folder*
MDPH Medicare Folder
Consultant

MAW/RW/ars
3/28/77

Submitted by: Mary Alice White, Rita White, R.N.
Mary Alice White, R.N., Rita White, R.N.
Health Dept.: Michigan Department of Public Health

Date: 3-28-77

a strong foot and body odor at three p.m. in the afternoon.

One patient on the 4th floor observed with broken bleeding wound on finger, blood on clothing and patient walking about unit. No attention paid to her need until called to their attention by nurse consultant.

Chair confined patients needed support of pillows, foot-stools for foot elevations.

Linen was available for bedmaking, however, there was no additional supply on the shelves for use later in the day. Mrs. Ware stated clean laundry would be delivered later in the day.

Pharmacy policy is review of medicare orders every thirty (30) days with unit dose system and delivery of 24 hour supply made daily. On review of the medicine records approximately twenty patients had no recording of receiving their medication during the day tour of duty March 16 & 19, 1977. Another record reflected patient received medicine daily during February and March, 1977, however, clinical record did not contain a signed physicians order for this medicine, yet the pharmacy sent the prescribed dosage for an order dated 12/30/76 daily and nursing administered it. There is no apparent procedure for checking physician orders against unit dosage sent by pharmacy. Another patient stated she was not receiving her eye drops. Medicine as prescribed was available, medicine record indicated during January and February that patient received eye drops at 12:00 noon and 6 p.m. instead of every six (6) hours as ordered. No explanation was made in nurses notes why two doses were omitted.

Treatments not always followed. On 5th floor there were three (3) patients with edematous legs and order was written on record to elevate legs. No evidence in nurses notes that order was followed.

Blood pressure was ordered daily by physician; but recorded only on Mondays on chart and then not recorded consistently.

A treatment cart is supplied with dressings, tape, bandages, and ointments prescribed. A treatment aide follows the physicians orders for treatments. Check of a treatment cart and the treatment room, as well as conversation with the relief treatment aide indicated a need for specific instruction and a procedure for setting up treatment routines. A box on the bottom shelf of the treatment cart contained many tubes of ointments of discharged patients, tubes unlabeled and outdated.

Care Plans were available for all patients, but lacked the interdisciplinary approach which would allow for specific goals and approaches to meet the patients needs. Nurses notes were descriptive as to specific observation, however, they did not correlate with the plan of care.

Since the last visit there has been a change in the social worker. A staff member with little experience has been designated. It is felt she would be able to function well if consultation were provided. The social work consultant indicated in her January, 1977 report that she would no longer be providing consultation. To date there has been no agreement with another social work consultant. Patient request for eyeglasses, clothing, physician orders for dental and podiatry consultation are not being met. The designee needs assistance and relief from the extraneous duties she is presently assigned.

No evidence in patient record of social service needs for one (1) patient needing glasses repaired. One (1) patient had concerns about his monies.

Diversional activities seem to have been curtailed with change in personnel. A new activities director assumed responsibility February 15, 1977. A volunteer consultant offered some consultation March 10, 1977. There were no planned activities on any floor visited. On interview, several patients stated there was "nothing to do" outside of bingo and church.

INSERVICE

Nursing meetings have been held weekly since January 5, 1977. Pirmary focus has been on review, discussion, and demonstration of nursing procedures.

It is still most evident while touring the patient units that supervision and nursing management is non-existent. Inservice has attempted to provide the what and how of nursing procedure but the licensed personnel need to be taught nursing management, their responsibilities and continuous supervision of non-licensed personnel. The licensed personnel with the exception of the child care unit, could not answer questions relating to patient care policy; ignored nurse aide inquiry and/or observations.

CHILD CARE UNIT

This is a twenty-five bed unit. Census on day of visit was eighteen (18). Several children were out of unit attending school. Others were being cared for. Five children were in wheelchairs, two in the day room and three with a nurse aide in the bathing area. All were properly restrained for safety.

The interaction between nursing supervisor, nurse aides and patients was warm and friendly.

The patient rooms were bright and cheerful in decoration. Housekeeping personnel were engaged in routine cleaning.

All other observations were in compliance.

MAW/RW/ars

3/28/77

Michigan Department of Public Health
BUREAU OF HEALTH FACILITIES
Division of Standards and Licensing

FACILITY EVALUATION REPORT

Visit to:
( ) Hospital
(X) Nursing Home
( ) Home for Aged
( ) Med. Care Fac.

By:
( ) Nurse
( ) Engineer
(X) Sanitarian
( ) Physician
( ) Dietition
( ) Administration

Facility: Friendship Manor Nursing Home
City: Detroit County: Wayne
Administrator: Jack Laing
Date of Visit: March 23, 1977

MICH. PUBLIC HEALTH Rule No.	SOCIAL SECURITY ADMIN'N Condition	Std	Items of Non-Compliance	Improved	No Change	Corrected
65 (11)			An adequate supply of linen is not provided in the facility with linen supplies being depleated on the 3rd, 4th, and 5th floors.			
65 (13)			Mattress pads or their equivalent are not provided on all of the patient beds in the facility.			
132 (5)			Covers are not provided for all of the water carafes which results in subjecting the water for consumption to potential contamination.			
132 (13)			1. Employees do not wash their hands between handling soiled and clean dishes.			
			2. Dishes and utensils are not being sanitized due to low final rinse water temperatures.			
135 (1)			The facility is not being maintained adequately as evidenced by the following maintenance problems:			
			1. Unit ventilators are not maintained in a clean and operable condition.			
			2. Wall damage is present as exemplified by a large hole in the wall in the anti-room leading to patient room #414.			
			3. Ceiling tile damage including stained ceiling tile was noted in various areas of the facility.			
			4. Light bulb globes or diffusers were missing in three different areas.			
			5. Bedside stands were not maintained in good repair.			

For consultant's use on next visit . . . .

Submitted by: [signature]
Darwin Root, R.S.
Health Dept.: Physical Plant Section
Date: March 25, 1977 kb

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Consultant

6. Handwash lavatories were loose from the wall in at least four different areas.

7. A junction box was noted to be torn from the wall on the 5th floor dining room.

8. The exhaust ventilation for the entire west wing on 2nd, 3rd, 4th, and 5th floors was not operating. (Repaired and placed back into operation during my visit.)

9. Unsecured oxygen tanks were noted in the general storage room in the basement creating an immediate safety hazard.

10. Grab bars were missing at the attendants bath on the 4th floor.

11. Paint was spalling from the ceiling in two of the attendant baths and also the treatment room.

12. Quarry floor tile was missing on the 4th floor attendant bath and grouting around some of the floor tile was missing in the 5th floor attendant bath.

13. Cubicle curtains were noted to be missing in at least two patient rooms.

14. The locking mechanism was malfunctioning serving the door to the janitor's closet on the 4th floor near room #422. Entrance to the room was not able to be gained.

15. The refrigerator in the medicine preparation room was 55°F., well into the danger zone for refrigerated medication storage.

16. A leaking sewer line was noted in the mechanical room in the basement.

135 (1) The facility is not maintained in a <u>clean</u> and <u>sanitary</u> condition as evidenced by the following:

1. The floors were dirty as evidenced by urine puddles, dust and dirt accumulations and "sticky" to the touch.

2. A yellowed, excessive wax build-up was noted on the floors, in the corners, and in the doorways.

3. Strong urine odors were prevalent throughout the 3rd, 4th, and 5th floors.

4. Window tracks were filled with dust and dirt in various areas of the facility.

5. Furniture, including over bed tables, bedside stands, and tops of unit ventilators were dirty.

6. Exhaust vents in the janitors closets and in the corridors of the facility were clogged with dust and dirt accumulations.

7. Bath tubs were noted to be dirty in bathing room #2 on the 4th floor, and in bathing room #1 on the 3rd floor.

8. Toilet seats were dirty with dried-on urine and feces noted in room #520.

9. Smeared, dried-on feces were noted on the waste containers in the toilet rooms serving patient rooms #413, and #520.

DR/kb

Michigan Department of Public Health
BUREAU OF HEALTH CARE ADMINISTRATION
Division of Standards and Licensing

FACILITY EVALUATION REPORT

Facility: Friendship Manor Nursing Home
City: Detroit County: Wayne
Administrator: Mr. John Laing
Date of Visit: 3/23/77

Visit to:
( ) Hospital
(X) Nursing Home
( ) Home for Aged
) Med. Care Fac.
( )

By:
( ) Nurse
( ) Engineer
( ) Sanitarian
( ) Physician
(X) Dietitian
( ) Administration

MICH. PUBLIC HEALTH Rule No.	SOCIAL SECURITY ADMIN'N Cond-ition	Std	For consultant's use on next visit . . . . Items of Non-Compliance	Improved	No Change	Corrected
72 (2)			A low potassium diet ordered 12/3/76 had been served as a soft diet over the past 3 + months.			
			There was no policy on interpretation of the low salt diet orders. In practice all food was cooked without salt. The menu pattern included salt free bread and butter but regular bread and butter were served.			
			The same menu plan was used for fat free and diabetic diets. No exchange food values were noted.			
73			The posted menus consisted of the re-used three week cycle. The daily sheets were separated so there was no way to determine which day was being used.			
			The dated menu as actually served was not on file.			
74			The record of kinds and amounts of food used for the preceeding three months was not available.			
132-5			In patient areas some trays were removed from the carts and placed on the counter at the nursing station.			
			On the serving line the temperature of roast beef and mashed potatoes was 120°F.			
132-6			In 4th and 5th floor pantries some employee lunches were stored.			
132-8			In above pantries there was no thermometer in the refrigerators.			
132-12			The canopy hood over the cooking equipment was soiled and had black greasy lint particles.			

Submitted by: Ann J. Hains R.D. Carlean Williams R.D.
Ann J. Hains, R.D. - Carlean Williams, R.
Health Dept.: Michigan Department of Public Health
Date: 3/25/77

DISTRIBUTION:
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MICH. PUBLIC HEALTH	SOCIAL SECURITY ADMIN'N.					
Rule No.	Condi-tion	Std:	For consultant's use on next visit .... Items of Non-Compliance	Improved	No Change	Corrected
132-13			Forty-one patient trays and 12 utility trays had cracked and chipped edges.			
			Stainless steel plate covers were overlapped in the dishwashing machine racks.			
			The disposable flatware was emptied from bulk boxes and eating ends finger handled. It was not washed and sanitized before using.			
			An employee unracked clean dishes after handling and racking items on the soiled end. The final rinse temperature in the dishwashing machine was 160°F. although the gauge registered 180°F. to 200°F. Many of the rinse jets were clogged with lime deposits.			
AH:CW/dw						

Michigan Department of Public Health
BUREAU OF HEALTH CARE ADMINISTRATION
Division of Standards and Licensing

FIELD REPORT

Visit to:	By:
( ) Hospital	( ) Nurse
(X) Nursing Home	( ) Engineer
( ) Home for Aged	( ) Sanitarian
( ) Med. Care Fac.	( ) Physician
( )	(X) Dietitian
	( ) Administration

Type of Visit:	Program:
(X) Evaluation	(X) Lic/Certif.
( ) Consultation	( ) Medicare

Facility: Friendship Manor Nursing Home
City: Detroit County: Wayne
Administrator: Mr. John Laing
Date of Visit: March 23, 1977

PARTICIPANTS: John Laing, Administrator
Thelma Hightower, Food Service Supervisor
Fredrick Traill, Chief, Division of Health Facility, Standards and Licensing
Ronald Knistala, A.C.S.W., Social Work Consultant, H.E.W.
Jay McGath, R. Ph., Pharmacy Consultant, H.E.W.
Alemeda Stumer, R.R.A., Consultant, H.E.W.
Rita White, R.N., Nurse Consultant, Michigan Department of Public Health
Mary Alice White, R.N., Nurse Consultant, Michigan Department of Public Health

ITEMS OF NON-COMPLIANCE - CERTIFICATION

1. There was no policy and procedure for providing appropriate substitutes.

   One untouched breakfast tray was returned to the dishwashing room on the soiled cart. The identification had been removed. There was no way for dietary personnel to check on this and there was no message from nursing related to it.

   One patient on a diabetic diet did not eat her mashed potatoes. Nothing was done a[illegible] this. The situation was further complicated by the fact that the medication had been placed on the potato but the patient said she did not like white potatoes so never ate them. Nursing service did not seem to be aware of this situation.

   Charting related to dietary service has been infrequent and only states appetite is fair, poor or good. This is unacceptable as it provides no specific information.

2. The dietetic service does not participate in patient assessment and care planning. On visitation of patients, the consultant dietitian seems to identify lengthy lists of dislikes which do not get transferred to the tray card and cannot be taken care of on a regular basis.

ITEMS OF NON-COMPLIANCE LICENSURE AND CERTIFICATION

1. A low potassium diet ordered 12/3/76 had been served as a soft diet over the past 3 months.

   The original laboratory test showed a high potassium level. The repeat of the test had just been ordered so no report was available. In order for a physician to evaluate reports it is necessary to serve diets as they are ordered.

Distribution: Facility Administrator
Local Health Officer
MDPH Lic/Cert. Folder
MDPH Medicare Folder
Consultant

Submitted by: Ann J. Hains R.D. Carlean Williams R.D.
Ann J. Hains, R.D. - Carlean Williams, R.D.
Health Dept.: Michigan Department of Public Health
Date: 3/25/77

2. Sodium restrictions are ordered as "low salt" diets. However there is no policy on how such an indefinite order is to be filled. All food has been cooked without salt. The daily menu includes salt free bread and butter but the regular bread and butter were been served. There must be a policy of interpretation signed by the medical director and it must be implemented in the meal plan.

3. The same daily menu was planned for low fat and diabetic diets. Foods for each are not necessarily the same so separate menus should be written.

4. The menu for the diabetic diets did not include food exchange equivalents. For accuracy in following the individual meal patterns, the exchanges must be written on the daily menu.

5. The posted menu consisted of a three week cycle. The sheets were separated so it was difficult to determine which Wednesday was being used. Dated menus showing the changes which had been made were not on file.

   In order to review menus it is necessary to have the past menus as actually served.

6. In patient areas some trays were removed from the cart to the counter at the nursing station to add medications to food. This not only affects the food temperatures but is poor practice as the counter cannot be maintained in a sanitary condition. If necessary to add medications to food it should be done on individual trays as they are being removed from the cart.

7. The temperature of both roast beef and mashed potatoes on the serving line was 120°F. Temperatures of hot food must be maintained at 140°F. or above.

   Even though hot/cold carts are used they are not intended to change temperatures in holding. Also, there is only one wall outlet in the patient corridor and the cart was not plugged in on arrival. Also the second and third carts had arrived before the first one was half empty.

   To maintain temperatures and facilitate serving, the dietary department should be supplied a list of the patients who will eat in the dining room. If an occasional patient changes his mind it should be no problem to carry a tray or two to a room.

   Also, carts should be staggered to all floors so service occurs at the same time, patients get ample time to eat, and some carts can be returned as soon as filled to speed up dishwashing.

8. In the 4th and 5th floor pantries there were no thermometers in the refrigerators. These are necessary to determine safe holding temperatures.

9. In the above pantries some employee lunches were stored. This is unsanitary practice as there is no way to determine the cleanliness of the packages.

10. The canopy hood over the cooking equipment was soiled and had black, greasy lint particles. These can contaminate food by falling into pans. Also this can be a safety hazard. All equipment must be cleaned on a regularly scheduled basis.

11. Forty-one patient and 12 utility trays had cracked and chipped edges. These can no longer be maintained in a sanitary condition so must be replaced.

12. Stainless steel plate covers were overlapped in the dishwashing machine racks.

    Since water spray cannot reach all surfaces it is necessary to rack them flat for washing and sanitizing.

13. The disposable flatware was emptied from a bulk box for wrapping.

    These items cannot be maintained sanitary in open boxes and there was too much finger handling of eating edges.

    Before use, these items should be placed in cylinders with the eating end up, washed and sanitized in the dishwashing machine, and inverted over previously sanitized cylinders for storage with the handles up.

14. An employee removed clean items from dishwashing machine racks after racking soiled dishes without washing her hands each time.

    The hand washing lavatory is at the end of the clean dish table but was inaccessible because dish holding equipment was stored in front of it. This equipment should be moved so the lavatory can be used as needed.

15. The final rinse gauge on the dish washing machine registered 180°F. to 200°F. Several checks of water temperature with a maximum recording thermometer showed a temperature of 160°F. It was noted that most of the final rinse jets were clogged with lime deposits. These must be cleaned and be kept open. If after this is done, the water temperature on the dish surface is not within 10°F. less than the gauge shows, the gauge must be checked for accuracy.

NON-COMPLIANCE - LICENSURE

There were no adequate records of kinds and amounts of foods used. This record is needed to be able to evaluate the nutritional adequacy of meals served.

AH:CW/dw

Michigan Department of Public Health
BUREAU OF HEALTH FACILITIES
Division of Standards and Licensing

FIELD REPORT

Visit to:
( ) Hospital
(X) Nursing Home
( ) Home for Aged
( ) Med. Care Fac.
( )

By:
( ) Nurse
( ) Engineer
(X) Sanitarian
( ) Physician
( ) Dietition
( ) Administration

Type of Visit:
(X) Evaluation
( ) Consultation

Program:
(X) Lic/Certif.
( ) Medicare

Facility: Friendship Manor Nursing Home
City: Detroit County Wayne
Administrator: Jack Laing
Date of Visit: March 23, 1977

PARTICIPANTS: Jack Laing, Administrator
Rev. Louis Johnson, Executive Director
Joseph Clark, Maintenance Supervisor
Alcmeda Steamer, RRA, H.E.W.
Jay McCath, R. Ph., Pharmacy Consultant, H.E.W.
Donald Kristola, ACSW, H.E.W.
Frederick A. Traill, Division Chief, MDPH
Ann J. Mains, R.D., Section Chief, MDPH
Carlean Williams, R.D., MDPH
Mary Alice White, R.N., MDPH
Rita White, R.N., MDPH
Darwin Root, R.S., MDPH

PURPOSE

Pursuant to the request made by the hearing officer on the February 16, 1977 administrative hearing, this follow-up survey was initiated to assess whether or not deficiencies previously sited during my December 1, 1976 survey have been corrected.

General information for this facility including the basic construction, mechanical systems, bed compliment, etc., remain unchanged from the prior survey.

MAINTENANCE PROBLEMS

According to the maintenance supervisor the facility provides a maintenance staff of four men plus the supervisor; however, the maintenance supervisor and one of his men (in a trainee position) actually perform all maintenance activities while the other three men are considered porters and work primarily at heavy housekeeping tasks. Although marked improvement of the maintenance aspects were noted during the date of this visit as opposed to the December 1, 1976 visit, there still continues to be serious maintenance problems. The following are examples of maintenance concerns noted on the date of this visit:

1. The through-wall heating and ventilating units located in every patient room in the facility and many of the service areas and corridors are not being properly maintained as evidenced by accumulations of dust, dirt, cigarette butts, paper, spoons, and in many instances, medication (tablets, capsules, etc.,) in the mechanical compartments of these unit ventilators. Several of these unit ventilators were not operating at all; as noted in patient room #319, which is a four-bed room and contains two unit ventilators with neither of these ventilators operating. Also a unit ventilator in

Distribution: Facility Administrator
Local Health Officer
MDPH Lic/Cert. Folder*
MDPH Medicare Folder
Consultant

Submitted by: [signature]
Darwin Root, R.S.
Health Dept.: Physical Plant Section
Date: March 25, 1977 ,kb

room #211 was also not operating. Immediately following my visit of December 1, 1976 the unit ventilators were cleaned and filters replaced; however, as noted during the date of this visit, the filters were again clogged with dust and dirt accumulations on the mechanical parts noted. It is obvious that these heating and ventilating units are not maintained regularly.

2. The heating problem (wide differential in room temperatures) experienced during the December 1, 1976 visit has been resolved with the exception of patient room #319 where the heating and ventilating units for that room were not functioning and a temperature of 60°F., as recorded at the three foot level, was observed. This problem especially within this room may be attributed to the lack of maintenance on these heating and ventilating units and the fact that many of these heating and ventilating units are not in operable condition, as referred to above.

3. Wall damage as noted on the December 1, 1976 field visit has essentially been corrected throughout the facility with the exception that a large hole measuring 10" x 10" in the ante-room leading to patient room #614 was noted.

4. Stained ceiling tile was noted in the corridor near patient room #502 and in patient rooms #320 and #393.

5. The general room light serving patient room #616 was not operating.

6. Light bulb globes or protectors for incandescent fixtures were noted to be missing in the following areas; the janitor's closet near patient room #317, in the penthouse, and in the 3rd floor pantry.

7. Bedside stands in various areas of the facility were in disrepair with hinges being broken off the doors as noted in room #515, and one of the legs to the bedside stands missing, as noted in patient rooms #420, #305, and #303 as well as other areas of the facility.

8. Loose handwash lavatories were noted in various areas of the building, but especially noted in patient rooms #320, #522, and #611.

9. Junction boxes were still noted to be torn loose from the wall as noted in such areas as the day room on the 5th floor.

10. No air movement was detected through the exhaust vents in all of the patient rooms on the east wing including all four patient floors. The problem was traced to an exhaust fan located on the roof which was not properly functioning. The exhaust fan was then repaired, placed back into operation prior to my leaving of the facility; however, this points out a need for regular maintenance checks on such mechanical equipment.

11. Three oxygen cylinders, located in the bulk storage room in the basement, were not secured to prevent overturning as required.

12. Grab bars were missing at the attendant bath on the 4th floor.

13. Paint was spalling on the ceiling in the attendants bath on the 4th floor, the ceiling on the attendants bath on the 3rd floor, and the ceiling in the treatment room on the 3rd floor.

14. Floor tile was missing or broken in the attendants bath on the 4th floor and the grouting between the tiles were missing in an area near the shower in the 5th floor attendants bath.

15. Cubicle curtains were missing in patient rooms #510 and #505.

16. The thermometer in the refrigerator in the medicine preparation room near the nurses station on the 3rd floor indicated an inside temperature reading of 55°F. Premature deterioration of medications stored in this refrigerator could result. These refrigerators should be maintained between 35°F. and 40°F.

17. The dishwasher in the kitchen was not functioning properly with a final rinse temperature noted on the dishwasher as recorded by passing a maximum recording thermometer through the dishwasher was 150°F. Manifold temperature gauges located on the dishwash machine indicated temperatures near 200°F. Closer investigation revealed that the spray rinse jets on the final rinse section of the dishwasher were apparently clogged as minimal water flow was noted through the spray rinse jets which would explain why adequate final rinse temperatures are not being reached on the final rinse section of the dish machine. In order to adequately sanitize dishes and other utensils passing through the dishwasher, a minimum of 170°F. final rinse temperature at the dish surface must be achieved.

18. The door latch hardware to the janitor's closet on the 4th floor near room #422 apparently was broke as the maintenance man could not unlock the door.

19. Leaking sewer line was noted in the mechanical room in the basement.

20. Night-lights were burned out in rooms #501 and #317.

21. A window in the dietary service near the kitchen range was broken and in need of replacement.

22. The ice machine located in the pantry on the 4th floor was not operating resulting in the necessity to transport ice from other areas of the facility. Steps should be taken to replace this ice machine back into proper operation.

Federal certification standards require a formalized written preventive maintenance program for the facility to insure that the building is maintained and that all mechanical, electrical, and patient care equipment is maintained in a safe operating condition. Certain attempts have been made by the maintenance supervisor to develop some type of preventive maintenance program. Mr. Clark has developed an inventory which encompasses the major mechanical and electrical equipment within the facility and has started writing preventive maintenance procedures on each of the equipment. The facility does not have a <u>complete</u> formalized written preventive maintenance program as exemplified by the following:

a. A system of scheduling the maintenance activities has not been developed.

b. Maintenance procedures on all of the equipment indicating step-by-step methods of how to perform the maintenance on the equipment or building has not been provided.

c. Not all of the equipment manuals, (i.e., the manual for the emergency power generator) are present within the facility.

d. A system of logging maintenance activities is not complete for all equipment.

<u>CONCLUSION - Maintenance Problems</u>

The maintenance deficiencies listed above are indicators of a poor preventive maintenance program. Improvement as compared to the conditions noted during my December 1, 1976 visit was noted; however, there are still severe maintenance problems which must be addressed by the facility. Mr. Clark indicated a frustration in recruiting and retaining qualified maintenance personnel to assist him in resolving the maintenance deficiencies. This undoubtedly will require strong supervision, good administrative support, and adequate maintenance personnel to perform the tasks and the development and implementation of an organized system of performing maintenance.

<u>HOUSEKEEPING PROBLEMS</u>

Reportedly staffing patterns for the housekeeping department consist of a ratio of one housekeeper per floor. This has resulted in certain housekeeping problems due to insufficient staffing of these areas. Severe housekeeping problems have been a chronic condition at this facility as documented in detail on Mr. Wolf's September 25, 1975 field report and also documented on subsequent evaluations. The following are examples of severe housekeeping problems that existed on the date of the visit:

1. The floors were dirty as evidenced by spilled food, cigarette butts, ashes, spent matches, and urine puddles on the floors, primarily noted on the 3rd, 4th, and 5th patient floors. The floors were also "dingy" and "sticky" to the touch indicating a lack of proper floor care techniques being used especially in the patient room areas. Thick, dirt, and grime accumulations were noted especially at the floor/wall junctures completely surrounding the room, behind furniture, and in the corners.

2. A wax and grime build-up especially around the floor/wall junctures in the doorways and in the corridors were noted throughout the facility. Cleaning and stripping of the floors should include thorough cleaning of these floor/wall junctures.

3. Floor tile stains were noted in patient rooms #510 and #303, and in the corridor near room #517.

4. "Stale" urine odors were prevalent throughout the facility but particularly pungent in patient rooms #505, #505, #422, #515, #415, #411, #406, #302, #313, #316, and the attendants bath on the 3rd floor.

5. Window tracks in many areas of the facility were not clean as evidenced by dust, dirt, and grime accumulations in the track especially noted on the 3rd, 4th, and 5th floors.

6. Furniture such as bedside stands and over-the-bed tables were dirty and in need of a thorough cleaning as noted in patient rooms #515, #422, #405, #309, and #316.

7. The exhaust vents in such areas as janitor's closets, soiled utility rooms and the exhaust vents near all of the smoke barrier doors on 3rd, 4th, and 5th floors were dirty with dust and lint accumulations.

8. The towel dispensers in the patient rooms were empty in many areas such as those serving patient toilet rooms off patient rooms #520, #413, #415, and #403.

9. Housekeeping supplies and equipment were noted to be stored in the soiled utility rooms. The janitor's closet on the patient units are not being utilized.

10. Toilet seats and bathing tubs were noted to be dirty as evidenced by the toilet seat in patient room #520 and the bath tubs in bathing room #2 on the 4th floor, in bathing room #1 on the 3rd floor.

11. Smeared feces was noted on the tops of the "flip-top" type waste receptacles in toilet rooms such as the ones' serving patient room #413, and #520.

CONCLUSION - Housekeeping Problems

There do not appear to be any specific housekeeping procedures followed with different procedures apparently being followed on each floor. The housekeeping supervisor was not available for detailed questioning as to what procedures were being utilized. From previous conversations with the administrator, the housekeeping supervisor actually does not supervise or evaluate the housekeeping staff's performance, but rather just keeps track of the scheduling of personnel for that department. Considering the housekeeping ratio and the chronic condition of the building, it is obvious that sufficient housekeeping staff is not being provided to adequately maintain the facility. Also definitive policies and procedures must be developed and followed by housekeeping staff. Direct supervision and training is also needed in order to resolve some of the poor housekeeping performance as now exists.

DIETARY CONCERNS

The dietary service is located in the basement of the facility. The following concerns were noted on the date of this visit:

1. The exhaust hood is not thoroughly cleaned as evidenced by dust accumulations at the exhaust ports.

2. The lowerator utilized for dispensing of glasses is not cleaned out regularly as evidenced by an accumulation of plastic spoons, individually wrapped salt and pepper, individual packets of sugar, etc., accumulated in the bottom.

3. Dishwashing procedures were questioned on the date of the visit with the following concerns noted:

   a. The method of stacking plate covers in the dish racks as they pass through the dishwasher results in incomplete washing and sanitizing of these plate covers. These plate covers should be stacked or placed on the trays in such a manner that complete exposure to the wash and rinse water can be achieved. This may mean that only four plate covers would be contained in one dish rack at a time.

   b. The handwash lavatory is provided near the dishwasher. However, personnel were noted stacking of soiled dishes in the dish racks and then moving directly to the other side of the dishwasher and pulling out clean dishes and stacking these in dish carts, without benefit of washing their hands between stacking of soiled dishes and unloading of the clean dishes; therefore, subjecting the dishes to contamination.

OTHER CONCERNS

1. Mattress pads or their equivalent are not provided on patient beds in a few areas of the facility. A spot check for the presence of mattress pads was made on the date of this visit with the following rooms containing beds without mattress pads, patient rooms #505, #523, #411, and #403.

2. An adequate supply of linen is not provided for within the facility as evidenced by several beds on the 4th and 5th floors not being made by 10:30 or 11:00 a.m. and the complete absence of clean linen in linen closets or the clean linen carts on these floors. At approximately 12:00 noon a clean linen shipment was noted at the facility and it is not known as to what time this linen was distributed to the patient floors for use. Minimum rules and regulations require an adequate amount of linen of at least two complete bed changes available on-site for use.

3. Previous concerns regarding medication control as documented on my December 21, 1976 field report again are expressed by the presence of medications such as capsules and tablets and liquid medications being found in the mechanical compartment of the unit ventilators. Better control to make sure that the patients are actually taking their medications is apparently needed.

4. The interior surfaces of bedside stands were dirty in patient areas encompassing all of the 3rd, 4th, and 5th floors. A question is raised regarding whether or not the responsibility for keeping the patients bedside stand clean has been delineated and appropriately assigned.

5. Water carafes generally were noted to be covered throughout the facility with the exception of a few instances noted on the date of the visit as exemplified by the uncovered water carafes noted in patient room #316. Covers are needed for these water carafes in order to protect the water from contamination.

6. Refuse cans were noted to be left uncovered in the soiled utility room on the 4th floor. A strong pungent urine and feces odor was detected within the room. Covers over these refuse cans are needed in an effort to contain odors.

7. The bedside stand was still noted to be missing in patient room #414. A bedside stand is required in each patient room.

8. Bed spreads were noted to be in various stages of deterioration with "tears" and "thread bear" conditions noted on many of these bed spreads as noted by a spot check in patient rooms #318, #302, #411, #403, #502, #504, #501, and #505. Bed spreads when they become torn should either be repaired or replaced - worn bed spreads should be replaced.

INFECTION CONTROL

Federal certification criteria requires conformance with a standard relative to a functioning infection control committee and program. Reviewing the homes infection control committee minutes of March 21, 1977 along with other minutes and other information included in the policies and procedures manual revealed the following:

1. The facility does have elements relating to the following:

   a. The facility does have a committee which is composed of appropriate membership including a chairman, a secretary, and a surveillance officer.

   b. The committee has met at least at the required frequency with the last meeting on March 21, 1977.

   c. The facility does have isolation policies and procedures.

[illegible]. The facility does not have information relative to the following:

a. The committee has not defined the responsibilities of each of the committee members [illegible] what their duties are in relationship to the infection control program.

b. The committee has not implemented a system for detection and reporting of infections. An infection reporting mechanism is needed which would indicate people who have, or are suspected of having infections, what symptoms are present, and what action is needed to be taken. There should be evidence of a surveillance program including a definition of the program and how the program is to be implemented. Implementation of the program should include a system of monitoring infections, a mechanism of reporting diseases and conditions, to whom these diseases or conditions should be reported to, and when these diseases or conditions are to be reported. A key point in developing this system for monitoring infections would include defining of infections as to the signs and symptoms used to discover these infections.

c. The infection control committee has not developed a system of monitoring the performance of the staff to insure that the policies and procedures established by the home, and approved by the infection control committee, are indeed being followed. Evidence is needed which can be found in the minutes of the committee meetings, surveillance reports, and in in-service training records.

d. Employee health policies are not present.

e. Existing policies and procedures are not reviewed by the infection control committee and are not updated and revised as indicated. Existing policies and procedures must be reviewed at least annually.

SUMMARY

This field report indicates examples of maintenance and severe housekeeping problems existing at Friendship Manor Nursing Home. These problems have been documented in almost identical form since Mr. Wolf's field report of September 25, 1975. During this timeframe and especially during the last three months, there has been some improvement in the maintenance of the mechanical and electrical aspects of the building, but little improvement in the housekeeping aspects.

Major problems seem to stem from the lack of adequate staff to perform the functions, a lack of adequate training of this staff in the facility, and a lack of good supervision of the employees.

DR/kb

[EXHIBIT NO. 52]

STATE OF MICHIGAN,
DEPARTMENT OF PUBLIC HEALTH,
Lansing, Mich., April 7, 1977.

Re Amended Notice of Intent to deny licensure/certification.

Mr. JOHN A. LAING, *Administrator,*
Friendship Manor Nursing Home,
3950 Beaubien Avenue,
Detroit, Mich.

DEAR MR. LAING: The notice of intent to deny licensure/certification, dated January 6, 1977, is hereby amended to include the following: Facility Evaluation Reports of Ann J. Hains, R.D. and Carlean Williams, R.D., dated March 25, 1977; Darwin Root, R.S. dated March 25, 1977; Mary Alice White, R.N. and Rita White, R.N. dated March 28, 1977; Field Reports of Ann J. Hains, R.D. and Carlean Williams, R.D., dated March 25, 1977; Darwin Root, R.S., dated March 25, 1977; Mary Alice White, R.N. and Rita White, R.N., dated March 28, 1977; Federal Survey Report Forms SSA 1569 dated March 23, 1977 and SSA 3070 dated March 23, 1977 prepared by Almeta Steemer, R.R.A., Ronald Kristola, A.C.S.W. and Jay McGath, R.Ph. all from the Office of Long Term Care of H.E.W.; and Ann J. Hains, R.D., Carlean Williams, R.D., Darwin Root, RS., Mary Alice White, R.N. and Rita White, R.N. all from the Michigan Department of Public Health.

The above listed Field Reports, Facility Evaluation Reports, and Federal Survey Report Forms are added to and made part of the January 6, 1977 Notice of Intent to Deny Licensure and Certification.

I wish to advise you that you will be given an opportunity at a continuation of the administrative hearing scheduled for May 11 and 12, 1977, at 10 AM to show compliance with all lawful requirements for retention of Nursing Home Licensure and Certification.

Sincerely,

MAURICE S. REIZEN, *M.D., Director.*

Senator BAYH. Mr. King?

TESTIMONY OF EDWARD C. KING, DIRECTING ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER, WASHINGTON, D.C.

Mr. KING. I am Edward King. I am directing attorney of the National Senior Citizens Law Center in the Washington, D.C. office. We felt in presenting the case for nursing home inclusion within Senate bill 1393 that it was advisable to bring forward people who could document the conditions that exist in nursing homes. We wanted to emphasize to this committee that some nursing homes have earned the same notoriety that other institutions you are considering, such as those for the mentally handicapped, and prisons, have become more well known for.

Today you have heard the President of an active citizens coalition which has worked vigorously trying to bring about nursing home reform. You have also heard a para-legal who works with a legal services program and devotes all of her time to trying to bring about reform in nursing homes. Both have indicated to you that the tools available to them at the present time are woefully inadequate.

Their testimony has also established that in nursing homes, as in the other institutions, basically the same conditions exist. There is negligence or affirmative abuse. This is not an isolated instance or two. There is a continuing pattern of negligence or abuse in many nursing homes. This results in great physical and mental harm to large numbers of nursing home residents and even, on frequent occasions, the death of those persons.

In other ways nursing homes are similar to the other institutions that are covered under the bill. First, they are federally and State funded with over one-half of the revenue of nursing homes coming from such public sources.

Second, enormous numbers of people are affected and are residents of nursing homes. Mr. Friedman testified as to the number of persons who are receiving mental health care there are in excess of 1 million persons confined in nursing homes today in the United States, and more than 23,000 nursing homes.

Third, it is too obvious to require emphasis that there is a great public interest in the care of the elderly people of this Nation; in particular in the care of the more enfeebled, that part of the elderly which finds itself in nursing homes.

Lastly, Mr. Friedman emphasized the economic interest in effective mental health care. Similarly, the Government of the United States has an enormous economic interest in nursing homes which is comparable to that of mental health care and other institutions covered by S. 1393. Some $7.5 billion are in Federal funds devoted to long-term care annually.

Thus the need for protection in nursing homes under Senate Bill 1393 is parallel to that of other institutions.

There are presently numerous obstacles to efforts to bring about nursing home reform.

Ms. Gorrecht has mentioned the difficulty of getting action from State officials. Often they are without the means and the knowledge to move, or without the resources. Sometimes State officials are also without the desire to move forward as nursing homes constitute a very important part of the local political influence.

HEW has not shown appreciable vigor and desire to enforce the laws that presently exist concerning nursing homes. However, Secretary Califano is indicating more interest in doing that these days.

As for court action, we regret to say that we cannot, as have the preceding witnesses, to tell this committee of the landmark decisions that have been won for our clientele. Such decisions do not exist in the nursing home area.

The fact of the matter is that the courts have been reluctant to define rights for nursing home residents for reasons that are not altogether discernible to me. There seems to be a substantial amount of sympathy for the fact that nursing home proprietors in many instances are either ostensibly private operators or are nonprofit or church institutions. This seems to have resulted in nursing homes being treated as though they were in fact private institutions, although they are, in point of fact, carrying out the governmental function of caring for the Nation's elderly, and doing so with federal money, by and large.

It is no overstatement to say that the present lack of enforcement of the rights of the enfeebled elderly in nursing homes in the United States is a national disgrace.

So, Senate bill 1393 in our estimation is badly needed. It recognizes the public interest in enforcing rights in nursing homes. It recognizes specifically that nursing homes are within the public purview and that nursing home operators must observe the civil rights of their residents.

It recognizes the need for enforcement of rights of nursing home residents in courts. Through this bill the U.S. Congress would be expressing its will that the Attorney General's office should devote resources to the enforcement of rights of nursing home residents. All of these aspects, of course, are extremely laudable.

For several reasons S. 1393—and we would like to reaffirm the statements made by the witnesses who preceded us here this morning—is superior to bills on the House side, H.R. 2439 and 5791, which address the rights of institutionalized persons.

For example, this bill contains no provisions for exhaustion of remedies. We believe the exhaustion of remedies requirements would introduce confusion in the nursing home area. Ms. Gorrecht has plainly illustrated the kinds of difficulties that exist if nursing home residents are relegated to administrative remedies.

Attempts to employ administrative remedies by and large have been unsuccessful. The overpowering point, however, is that people in nursing homes have extremely limited energy and extremely limited resources and should not be required to take any steps that in their own and their counsels' judgment are not the most efficient steps for obtaining redress. There is no question in my judgment that nursing home residents and those people who represent them will employ any effective administrative remedies that exist.

If none do exist or if there is substantial doubt that there is utility in exploring those administrative remedies, then no exhaustion attempts should be required. We certainly commend S. 1393 in making this entirely clear.

Senator BAYH. It sounds to me as if the kinds of conditions we're talking about are such that if we require exhaustion, the plaintiffs may literally run out of breath in the process. The only thing exhausted will be the energy of those whom this bill is designed to help.

Mr. KING. That's exactly true.

The absence of a "reasonable time" requirement, in our view, is also an excellent feature of this bill. S. 1393 tries to get at the same issue as do the House bills, but the House bills say that after a notice goes to the State officials there has to be a reasonable time for them to respond.

S. 1393 does require the protection for State officials and says there must be notice. It requires also certification by the Attorney General that immediate action will materially further the vindication of rights. In making such a certification, the Attorney General will have to find that those rights are not going to be carried out elsewhere, that there is need for the Attorney General to be involved.

This provides flexibility for the Attorney General and at the same time gives the protection and opportunity for action that State officials legitimately can demand.

S. 1393 also eschews any voluntary/involuntary distinction. This is particularly important in the nursing home area. You asked earlier about how people get into nursing homes, whether they do so voluntarily or not.

There are essentially three types of persons in nursing homes: There are those who have been declared incompetent and have been committed to nursing homes by their guardians. They in no sense enter voluntarily. Secondly, there are people who have entered "vol-

untarily" but who have subsequently become incompetent. They are extremely vulnerable, of course, just as the first group, is and equally unable to defend themselves; and the third group, should be recognized, do not enter voluntarily in any real sense. Such persons in the last group are invariably persons who are alone in the world and who do not have resources or places to live. They have had heart attacks or something of that sort and are unable to care for themselves. There are no reasons that I can discern why a person who enters under those circumstances should be considered "voluntary" in any sense which would logically dictate that he should be deprived of rights that might exist if he were involuntarily confined.

The distinction simply makes no sense in the nursing home area. We commend S. 1393 for not attempting to maintain such a distinction.

Speaking specifically with respect to nursing homes, it is our view that S. 1393, as you said, Senator Bayh, in your introductory statement in the Congressional Record, would grant no new substantive rights. It provides specifically that in order for action to be taken by the Attorney General there must be actions by the State or the agent of the State. Under S. 1393, there must be deprivation of existing Federal laws on constitutional rights and be a showing of a pattern of practice.

Passage of S. 1393 would, however, confirm congressional recognition that nursing home patients are entitled to the protection of the Federal Government. In our view it would impliedly confirm that nursing home patients are entitled to enforce the kinds of rights that are covered under this bill.

Because the Attorney General's office in the past has not blazed a trail of litigative activity in the nursing home area, it is, as we have suggested in our written statement, important that a private right be established for nursing home residents.

In our view there is a substantial possibility that the bill, as it presently exists, would establish an implied right on the part of nursing home residents under the circumstances that are outlined to enforce their own rights even if the Attorney General did not feel that it was appropriate to devote his resources in that direction at a given time. This is not the establishment of a new substantive right in our judgment but instead it's a confirmation, a statement by the U.S. Congress that such rights are important, that existing rights are enforceable in courts and that the rights of nursing home patients should be observed.

We do, however, at the same time note that in your introductory statement in the Congressional Record on April 26, you indicated that it does not give rise to new litigants proceeding to court. That gives us a small amount of concern because it could be used as legislative history contrary to the position that there is an implied right. We would simply ask this: that consideration be given as to whether there is indeed an implied right available to nursing home residents to bring direct actions under this bill.

If there is determined to be such an implied right, legislative history to that effect would be extremely helpful to support the view we have taken. If it is determined that there would not be such an implied private right of action under this bill, I hope that the testi-

mony that has been given today can be faced squarely and that this committee will face squarely the issue as to whether there should be such a private right of action. Of course, we urge the private right of action section somewhat similar to that in Representative Kastenmeier's bill be included in S. 1393, if the committee determines that that would not be an implied private right of action under this bill.

We do not believe that the nursing home residents, who may obtain fewer tangible results as a result of this bill than would confinees of other institutions, should be ignored in this situation. We think it's important that the committee simply face the issue as to how far it is willing to go to protect nursing home residents.

The other technical point that I would like to stress is this. The definition of nursing home may raise some questions because it is so simple.

Nursing homes have a number of different forms. Technically there are skilled nursing facilities, intermediate care facilities, and custodial care facilities. All of these have basically the same problems. They have different characteristics. To some extent some homes have elements of some and elements of others, but opinions might differ as to which of these institutions are covered by the term "nursing homes."

We have suggested the use of those three terms as being an all-embracing method of assuring that all nursing home residents would be covered. We commend that to the consideration of the committee.

In summing up, I want to say that S. 1393 in our view is an excellent bill. We want to make no mistake about it. We would like for our suggestions to be considered, but in any event, we commend the bill and we support it fervently.

Thank you very much for giving us the opportunity to come before you and express our comments concerning this bill.

Senator BAYH. Thank you, Mr. King. Your prepared statement will be inserted in the record.

[The prepared statement of Edward C. King follows:]

PREPARED STATEMENT BY EDWARD C. KING AND TOBY SAMBOL EDELMAN

We are Edward C. King and Toby Sambol Edelman, attorneys with the Washington, D.C., office of the National Senior Citizens Law Center.

The National Senior Citizens Law Center is a national support center, with offices in Los Angeles and Washington, D.C., specializing in the legal problems of the elderly poor. We are funded by the Legal Service Corporation and the Administration on Aging of the Department of Health, Education, and Welfare. Pursuant to the Center's Administration on Aging grant, we provide technical assistance to state and local offices on aging, with a view toward expanding the delivery of legal services to the elderly.

Under our Legal Services Corporation grant, our principal functions is to provide support service to legal service attorneys throughout the country on the legal problems of their elderly clients. In this connection, we respond to requests from legal service attorneys for assistance in areas of the law which substantially affect the elderly. One of these areas, of course, is nursing homes. Since S.1393 defines "institutions" as including nursing homes, the bill is of potential importance to present and future nursing home residents and we are pleased to have this opportunity to comment upon it. In testifying here today, we are also aware of two similar bills recently under consideration in the Judiciary Committee on the House of Representatives, H.R. 2439 and H.R. 5791, and from time to time we shall refer to provisions in those bills for purposes of comparison or illustration.

SUMMARY OF CONCLUSIONS

Briefly, our conclusions are that:

(1) Confirmation of the authority of the Attorney General to initiate and intervene in litigation aimed at preventing deprivation of rights, privileges and immunities of institutionalized persons is needed and should be enacted.

(2) Shocking violations of rights, privileges and immunities of nursing home residents occur with frequency, but in contrast to actions with respect to other institutions affected by these bills (e.g., prisons and mental health institutions), no effective or widespread litigative campaigns have been mounted by federal officials or by public interest or private advocates to uphold the rights of nursing home residents.

(3) For nursing home residents, an effective private right of action is crucial to furnish effective protection against abuses. It seems clear that S.1393 implies a private right which would enable nursing home residents to rely on the legislation as a basis for direct court action. If members of this Subcommittee have doubt that S.1343 creates such a private right of action, however, consideration should be given to adding a section comparable to Section 3 in H.R. 2439, to confirm the right of institutionalized persons to litigate in federal court in order to assert the rights enforceable under this bill.

(4) The term "nursing home," at Section 4(3) of S.1393, is insufficiently precise and could be construed as excluding residents of custodial care facilities from coverage, although such persons have as great a need for such legislation as do residents of skilled nursing facilities and intermediate care facilities. This problem could be solved by adding substantially the following language after the words, nursing home: "including skilled nursing facilities, intermediate care facilities and custodial care facilities."

(5) The jurisdiction of Federal District Courts to hear actions brought under this bill could be clarified by deleting the word "such" from Section 1, at page 2, line 5 of the bill.

DESCRIPTION OF NURSING HOME INSTITUTIONS

We are here today to speak concerning the largest group of institutionalized persons in the United States, elderly persons residing in nursing homes.

A. Large numbers

This group, consisting of more than 1 million persons, contains nearly twice the number of all other institutionalized persons, including federal and state prisoners, detained juveniles, state and county mental hospital patients and persons confined to various public institutions for the mentally retarded.

On any given day, more than 1 million older persons reside in the country's more than 23,000 nursing homes.[1] While 1 million people represent only 5 percent of the country's elderly population, studies reported by the Subcommittee on Long-Term Care of the Senate Special Committee on Aging indicate that approximately one out of five persons will live some part of his or her life in a nursing home. The institutionalization of persons in nursing homes is therefore neither rare nor avoidable for a large number of American citizens.

B. Public funding.

Institutionalization in a nursing home typically means confinement in an ostensibly "private" profit-making institution, but one actually financed in great part by public funds. In contrast to most other institutionalized persons who are confined in facilities owned and operated directly by some instrument of government, most nursing home residents are confined in institutions owned and operated by profit-making corporations. More than three-quarters of the country's 23,000 nursing home facilities, containing more than two-thirds of the country's nursing home beds, are operated on a for-profit basis.[2]

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[1] There are approximately 9,000 skilled nursing facilities, with 650,000 beds; 4,500 intermediate care facilities with 650,000 beds; 4,500 intermediate care facilities with 220,000 beds; and 9,000 custodial care facilities, with 250,000 beds. Subcommittee on Long-Term Care of the Senate Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy, Introductory Report, S.Rep. No. 93–1420, 93d Cong., 2d Sess. (1974) (hereinafter cited as Introductory Rep.).

[2] Fifteen percent of the facilities, containing one-quarter of hte beds, are operated by philanthropic organizations; and a mere eight percent of the homes and beds are government-owned. Introductory Rep., *supra* note 1, at 22.

At the same time that most nursing home facilities are operated on a for-profit basis, they rely heavily on government dollars for income. Fully half the revenues directly received by nursing homes for patient care come from public sources.[3]

In fact, the exponential growth of the industry followed quickly and directly from the enactment of medicaid and medicare in the mid-1960's. Between 1960 and 1970, the number of nursing homes increased by 140 percent; the number of beds, by 232 percent; the number of patients, by 210 percent; and the number of employees, by 405 percent.[4] The increases in federal expenditures, however, was largest of all: between 1960 and 1974, federal expenditures for long-term care increased from $500 million to $7.5 billion, an increase of 1,400 percent.[5] It is perhaps superfluous to point out that without the massive infusion of government money, the nursing home industry would not have experienced such astronomical growth.

C. No effective enforcement of rights

Yet, despite the enormous numbers of people involved, the massive government commitment of funds to the industry, and the great public interest in the care of the nation's elderly, the nursing home population has been largely unaffected and unprotected by the public interest litigation that has developed on behalf of other institutionalized persons. While numerous and significant cases have been litigated by the Department of Justice, public interest lawyers and legal services attorneys on behalf of other institutionalized persons, there has been no similar litigation effort on behalf of nursing home residents.[6]

The law regarding nursing home residents' right to care and treatment remains undeveloped and only in its beginning stages of legal theorizing. A recent article by Prof. John J. Regan, of the University of Maryland School of Law, highlights this point. In "When Nursing Home Patients Complain: The Ombudsman or the Patient Advocate," 65 Geo.L.J.691(1977), Professor Regan reviews possible private causes of action which could be raised by nursing home residents seeking to enforce their rights in court. While the theories cover a broad spectrum of legal areas—and include tort, contract, federal civil rights actions and implied private rights of actions—Professor Regan does not cite any nursing home cases where these theories have been successfully litigated.

D. Conditions in the institutions

Nursing home residents are no less susceptible to mistreatment and abuse than other institutionalized persons. Like other persons confined to institutions, nursing home residents are dependent on their institutions for the necessities of life. In fact, their dependency may be even more acute than that of other institutionalized persons.

Many nursing home residents have virtually no human contacts outside the facility, more than half having no close family ties at all.[7]

In addition, many nursing home residents must depend on the facilities for assistance in activities of daily life—more than half need help in walking and bathing; nearly half need help in dressing; and more than one in ten needs help in eating.[8] This lack of independent human support, combined with extreme dependance on the facility for daily life functions, makes the nursing home population extremely vulnerable.

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[3] Introductory Rep., *supra* note 1, at 21–22.

[4] Introductory Rep., *supra* note 1, at 21.

[5] Introductory Rep., *supra* note 1, at 20.

[6] Although the Department of Health, Education and Welfare is the source of so much of the funds flowing into the industry and could undoubtedly have great impact on the standards of care provided, the Department's performance has been disappointing. HEW has adopted regulations which point the way toward effective enforcement and maintenance of standards. See, for example, 20 C.F.R. § 405.1101 (1976) (conditions of participation for intermediate-care facilities). See also the statutory provisions at 42 U.S.C. §§ 1395–1395u (Medicare) and id. §§ 1396–1396 (Medicaid). Despite these tools, there is general agreement that HEW's enforcement efforts have been ineffectual. See Regan, "When Nursing Home Patients Complain: The Ombudsman or the Patient Advocate," 65 Geo.L.J. 619 (1977); Comment, "Regulation of Nursing Homes—Adequate Protection for the Nation's Elderly," 8 St. Mary's L.J. 309 (1977); Brown, "An Appraisal of the Nursing Home Enforcement Process," 17 Ariz. L. Rev. 304 (1974); Murray & Glassberg, "Long-Term Health Care for the Elderly: The Challenge of the Next Decade," 39 Alb.L. Rev. 617 (1975).

[7] Introductory Rep., *supra* note 1, at 16.

[8] Introductory Rep., *supra* note 1, at 17.

The problems of nursing home residents have been documented and discussed extensively, as we are sure the members of this Subcommittee are fully awar. It is a rare week that passes without some public attention being focused on the abuses of the nursing home industry. While much of the recent attention has stressed the financial abuses by the industry—the medicaid fraud and the efforts of the New York State Special Prosecutor, for example—the personal abuses endured by some nursing home residents themselves have also been repeatedly documented.

The litany of abuses was chronicled by the former Subcommittee on Long-Aerm Care of the Senate Special Committee on Aging in its comprehensive series of reports under the tittle "Nursing Home Care in the United States: Failure in Public Policy."[9]

The Senate Subcommittee recited the following "most important nursing home abuses" in its litany of abuses:

Negligence leading to death and injury;
Unsanitary conditions;
Poor food or poor preparation;
Hazards to life or limb;
Lack of dental care, eye care or podiatry;
Misappropriation and theft;
Inadequate control of drugs;
Reprisals against those who complain;
Assault on human dignity; and
Profiteering and cheating the system.[10]

After documenting in painful detail the extensive abusees in the nursing home industry, the Subcommittee concluded that more than 50 percent of the country's nursing homes are substandard, in the sense of having serious and life-threatening conditions.[11]

Other witnesses on the nursing home panel before you today will relate specific instances of life-threatening abuses such as those reported by the Senate Subcommittee. Our point of course is that the personal abuses suffered by many nursing home residents are in great part of the same nature, frequency and gravity as those suffered by other institutionalized persons.

CONFIRMATION OF AUTHORITY OF ATTORNEY GENERAL TO LITIGATE TO UPHOLD FEDERAL RIGHTS OF INSTITUTIONALIZED PERSONS IS NEEDED

As the members of this Subcommittee are aware, the United States, acting through the Department of Justice, has participated in many of the major cases litigated across the country to protect the rights of institutionalized persons. Assistant Attorney General Drew S. Days III testified before this Subcommittee on June 17, 1977, about the Department's active participation in litigation upholding the rights of prisoners, mentally ill and mentally retarded institutionalized persons, and institutionalized juveniles. While we note that none of the cases cited by Mr. Days specifically involves nursing home facilities, we would encourage the Justice Department's participation in litigative efforts to protect the rights of nursing home residents.

Recent court decisions have raised considerable doubt as to the power of the Attorney General to initiate or intervene in litigation aimed at upholding the federal constitutional and statutory rights of institutionalized persons; *United States* v. *Solomon* 419 F.Supp. 358(D.Md. 1976), appeal pending, No. 76–2184(4th Cir.); *United States v. Mattson*, appeal pending, No. 77–3568 (9th Cir.) *In Re Estelle*, 526 U.S. 925, 938 (1976) Rehnquist J. dissenting).

Other witnesses before this Subcommittee have previously emphasized the dearth of resources available to assist confined persons in the assertion of their federal rights. The Department of Justice has played a useful and essential role in the efforts to uphold fundamental federal constitutional principals in prisons and mental institutions. It would be tragic indeed if the United States were to acquiesce in the maintenance of inhuman and unlawful conditions in any of the institutions identified in this bill.

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[9] Other sources of nursing home abuse reports include the book written by the present Director of the National Institute of Aging, Robert N. Butler, M.D., "Why Survive? Being Old in America." pp. 260–99 (1975). Also see the Ralph Nader Task Force Report, "Old Age: The Last Segregation" (1971); and John Hess' 1974 series in The New York Times.

[10] Subcommittee on Long-Term Care of the Senate Special Committee on Aging, Rept. No. ——, 94th Cong. 1st Sess., Supporting Paper No. 1. The Litany of Nursing Home Abuses and An Examination of the Roots of Controversy (December 1974), at x.

[11] Supporting Paper No. 1, *supra* note 10, at 205.

Senate Bill 1393 provides assurance against unnecessary encroachment upon State prerogatives by requiring, as a condition to institution of a civil action, that the Attorney General certify that he has notified appropriate officials of the deprivation of rights, that he is satisfied that instituion of an action will materially further the vindication of such rights, and that institution of a sui by the United States will be in the public interest. In this respect S.1393 is superior to the approach of H.R.2439 and 5791 which require that the Attorney General wait a "reasonable time" after notice to officials before instituting court action. Such a provision introduces confusion and may reduce the ability of the Attorney General to act quickly when immediate action is crucial.

Congressional confirmation of the authority of the Attorney General to initiate and intervene in litigation involving federal constitutional and statutory rights of institutionalized persons would be an appropriate manifestation of the will of the Congress that the federal rights of those members of our society who are most defenseless and vulnerable must be upheld.

It must be fully understood that nursing home residents at the present time are an isolated and abandoned population.[12] While their deprivations are in many instances severe, no broad litigative effort addresses their problems. The participation of the United States in litigation on their behalf would be most helpful.

PRIVATE RIGHTS OF ACTION NEEDED

The efforts of the Department of Justice have been instrumental in asserting rights of persons in prisons and mental institutions. We are hopeful that, with explicit recognition by the Congress that nursing homes and facilities for the chronically physically ill or handicapped are also institutions where Federal rights are of great importance, the Attorney General will devote greater attention and resources to these institutions.

However, it must be recognized that the Department of Justice has limited resources and cannot hope by itself to vindicate all Federal rights of all institutionalized persons. This fact is especially pronounced in the nursing home area, which has received little emphasis from previous Attorney Generals. Althought prior to the *Solomon* and *Mattson* cases the power of the Attorney General to litigate to assure compliance with Federal law protecting nursing home residents was generally assumed, we are aware of only one reported case involving action by the Department of Justice aimed at affecting nursing homes. See *United States* v. *Commonwealth of Pennsylvania*, 533 F.2d 107 (3rd Cir. 1976), involving alleged failure by State officials to enforce required fire-safety guidelines applicable to nursing homes.

Thus, the authority of the Attorney General to assert rights of nursing home residents and other institutionalized persons could not be seen as sufficient, somehow obviating the necessity of assuring that institutionalized persons have the opportunity to vindicate their rights on their own behalf. Also, nursing homes as we know them today as a relatively new development and the law has not yet developed adequately to permit reasonable access to the courts to protect the rights of nursing home residents. In his article surveying the legally enforceable rights of nursing home residents, Professor Regan finds some traditional tort and contract theories usable by residents, but does not find tort and contract law sufficient for the protection of nursing home residents. Regan, *supra*, 65 Geo. L.J. at 711–16. Thus the importance to nursing home residents of a private right of action under this bill is apparent.

In our view, S.1393 would, in its present form, confirm the right of nursing home residents to bring actions on their own behalf to enforce the rights covered by the bill. Patently, S.1393 is aimed at protecting the institutionalized persons against abuse, and a direct right of action on behalf of these persons is created by implication.

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[12] The isolation of the nursing home population from the traditional advocacy was commented upon by the United States District Court in New Jersey in a recent case:

"Considering the massive impact termination of a facility's provider statute has upon the well being of Medicaid patients and their right to receive benefits under Title XIX, it is surprising that more case law dealing with these issues has not developed. Perhaps it is a function of the nursing home patients' isolation from the services of lawyers, lay advocates, family and friends. That is not to say no law has developed, but simply that there is a paucity of opinions exploring what the court considers difficult and important issues which affect the lives of many. Klein v. Mathews, —— F. Supp. ——" (C.A. No. 76–1197) (D.N.J. March 31, 1977).

In, however, any member of the Subcommittee doubts that such a private right of action would exist under S.1393 in its present form, we urge that consideration be given to insertion of a section similar to Section 3 of H.R. 2439, in order to confirm the existence of a private right of action.

CLARIFICATION OF JURISDICTION

Similarly, there remains some ambiguity concerning jurisdiction of Federal District Courts to hear cases under S.1393 without the necessity of establishing a separate basis for jurisdiction over the action. Section 1 suggests that jurisdiction would exist under S.1393, saying: ". . . The district courts shall exercise such jurisdiction without regard to whether the aggrieved party or parties shall have exhausted any administrative or other remedies provided by law . . ."

However, the present language may offer sufficient ambiguity to permit an argument that an independent basis of jurisdiction must be established. We suggest deletion of the word "such" from Section 1, page 2, line 5, to avoid any such ambiguity.

THE BILL PROPERLY PREVENTS DISMISSAL FOR FAILURE TO EXHAUST ADMINISTRATIVE REMEDIES

The vast majority of nursing home residents would prefer to use the simplest possible method of obtaining their remedies. They, and those who help them, have extremely limited resources and would be unlikely indeed to bypass available administrative remedies before instituting a lawsuit in Federal courts.

Today, there are few, if any, administrative remedies in existence for nursing home residents. We are therefore especially pleased to note the Section 1 provision confirming that cases brought in existence for nursing home residents. We are therefore especially pleased to note the Section 1 provision confirming that cases brought under S.1393 should not be dismissed on grounds that administrative remedies have not been exhausted.

CONCLUSION

There is a great need for careful Congressional attention to be given to the inadequate protection now available to persons institutionalized in nursing homes, which the Federal government supplies with $7.5 billion annually. By making explicit the right of the Attorney General to act on behalf of nursing homes residents, S.1393 would provide greatly needed assistance.

S.1393 is an excellent bill. While we believe implementation of the suggestions set out in this statement would improve the bill, and we hope the suggestions will be carefully considered, we wish it to be understood that enactment of the bill even in its present form, could be of great benefit to nursing home residents.

Senator BAYH. We thank you for giving us your expert testimony. We're thankful for the suggestions about the language. I hope we can work with you to deal with the double problem of State action and individual rights. Personally, I would be very much in favor of doing whatever we can to prevent the kind of abuse we've been talking about and to make it possible for individuals who are subjected to that kind of abuse to get their grievances redressed. We will do our best. These are two troublesome matters and I support your contention that we should deal with them. We appreciate your contribution very much and look forward to working with you.

Mr. KING. We thank you very much. We'll be pleased to do anything we can to be of assistance.

Senator BAYH. At this point, we will adjourn our hearings.

[Whereupon, at 12:05 p.m., the subcommittee stood in adjournment.]

APPENDIXES

PART 1.—STATEMENTS AND CORRESPONDENCE

[APPENDIX 1]

NARRATIVE SUMMARY, SITE VISIT, FARVIEW STATE HOSPITAL—JULY 20–22, 1976, BY MARSHALL D. FITZ, M.D., MARY ROSE MARTINELLI, MSN, JUNE M'LAUGHLIN, R.D.

I. Introduction

The hospital is located in a rural section of northeast Pennsylvania and provides services for a catchment area that includes the entire state of Pennsylvania. The catchment area is more specifically defined as the justice system of the state as well as other state hospitals. The hospital receives patients for evaluation prior to standing trial, patients committed to the hospital in lieu of sentencing, patients from correctional institutions who have psychiatric difficulties in those institutions, patients from other state mental hospitals who are difficult to manage in those hospitals and patients who are acquitted by the judicial system but felt to be in need of psychiatric care. The hospital presently has a census of 348 patients—this is a reduction in the number of patients from approximately 1,400 several years ago.

The hospital is a large prison-like institution that presents itself both internally and externally as a stark, cold, uninviting, nonprivate environment (redeemed only in its view which is relatively inaccessible to the patient population). The hospital has a basic philosophy of security first and other considerations second; this philosophy is evidenced by the prysical nature of walking through the hospital as well as by certain practices which basically rest upon whether or not security can be provided as opposed to whether clinical necessity demands it. Services provided in general are those of most psychiatric hospitals although it is quite clear that there is a paucity of active psychiatric treatment at the present time and this will be discussed in detail in the following sections. Presently the hospital is certified for Title XVIII. The hospital is non-JCAH accredited and includes a distinct part which is defined as R–1, R–2, S–1 and S–2. These four wards are four of the twelve wards which make up the hospital and these four wards have a total census of 64. These wards are mixed and include geriatric patients, new admissions, some minor medical and surgical problems and a variety of difficult-to-manage patients. These wards are in the same physical state as the rest of the hospital allowing for little patient privacy, allowing little sense for the uniqueness of the individual and providing a stark, sterile environment. One of these wards, R–2, serves as the admissions unit and all admissions that come into the hospital come through this ward unless they are deemed to be behaviorally disturbed. Then they go to CC–1 which is a cell block of 42 cells.

The Admissions Unit keeps patients for approximately 15 to 30 days and attempts to get the initial evaluation started. Rarely are patients ever discharged directly out of the hospital from the Admissions Unit, although in cases looked at on the Admissions Unit it did not seem that would be an impossibility given certain administrative and management initiatives. The unit feels at the mercy of the court system and this is a theme that pervades the entire hospital and one which will be discussed more fully later in the Narrative Summary. Services provided in this distinct part are those of a typical inpatient unit again suffering from the deficiencies mentioned above—a lack of quality and a lack of quantity of staff.

II. Medical records

In the area of medical records there is considerable improvement noted in the records of the survey of 1974. Predominantly this improvement is manifested both by the presence of discharge summaries and in almost all cases of treatment

plans. The records also indicate a marked increase in note making by the psychiatric security aides who have functioned in the capacity of guards primarily in the past and are making a slow but steady transition into becoming agents in the therapeutic process. Even with these marked strides there is considerable indication of failure to comply with the standards in medical records. This is primarily tied to the staffing deficiencies that will be discussed in section III. The results of the staffing deficiencies that make the medical records situation out of compliance primarily rest upon the fact that the medical record does not reflect a process of planning and treatment given that is adequate to give the hospital the status of a psychiatric hospital. There are obviously attempts to change this but as of yet they still have not come to fruition and may not be able to given the present level of staffing.

Treatment plans attempt to mention the patients' strengths, however, these are not included in the overall assessment that is given when goals both short- and long-term are stated and when specific and individual steps to achieve these goals are articulated. Long- and short-term goals of the treatment plans often are not in any way shape or form goals and even when they are they are never in any specific or behaviorally defined objective statements but rather vague words such as increased self-esteem or improved interpersonal relationships. Treatment plans have a certain stereotype which probably reflects the lack of therapeutic resources available to the staff. Furthermore the treatment plans often reflect treatments planned and orders written for these treatments but no indication in the progress notes what one might call therapeutic reports. Trere is an exception to this and that is in certain cases in the use of psychopharmacological drugs. However, in this situation given the fact that the major direction for the use of antipsychotic agents is given by the clinical director, it is obviously quite impossible for him to closely follow 348 patients. Therefore, the failure to meet the standard in the medical records is the failure to have adequate and extensive professional input into the treatment planning process. This is evidenced in the review of patients' charts on the wards and in talking with staff who seem to be concerned with patients but who seemed also to be somewhat bewildered by the process of need assessment, individualized goals and individualized steps to get there. However, the administration is quite cognizant of this and consultation was provided to them as to sources they might obtain in helping them reach this kind of level of medical record. One of the things that the treatment plan most indicated was that there is some lack of clarity as to who the clinically responsible person for the treatment plan is. The term concept is a new one at Farview and one to be much encouraged as it at least brings into focus the need for therapy as well as security. However, at this point the extent of clinical delegation below the clinical director is very unclear and this makes for ambiguity as to roles as well as leadership in the treatment of patients. There is of course the split in security and clinical which is being bridged hopefully by the hiring of more nurses and by the treatment team concept but it is still quite present and it is quite clear that security is the primary task of most of the operating units.

II. Staffing

There is absolutely no way in which the Farview State Hospital meets even minimum requirements for staffing which is necessary to provide for active psychiatric treatment. Of the three professions, psychiatry, psychiatric nursing and psychology, there can only be said to be one fully trained person, the chief of psychology in those three professions who presently works at the hospital. This is a rather stark and dramatic indication of the failure for the governing body to provide the appropriate resources to provide adequate psychiatric treatment. There are many reasons given for this primarily which includes the inability and difficulty in recruiting professionals. However, that of course is an old, old reason and one which has never been adequately addressed either by recruiting some persons or by reducing the patient load so that active treatment can be given. The question of professional leadership is most dramatically exhibited in the area of physicians. In this area there is little direction except that which the clinical director is able to give. The three general practitioners who man the wards are described by the clinical director as not particularly interested in psychiatry or experienced in it and there is little evidence of their experience or interest in the discussions with them or in the charts nor is there any evidence of their attempting to obtain any continuing education in psychiatry. This lack of leadership in the medical area is by the dramatically visual failure to provide active treatment, patients sleeping in the dayroom,

patients standing around, security aides standing around, and no evidence that any kind of active therapeutic intervention with the exception of some shop activity which is limited to a few patients. The clinical director who has a good grasp of pharmacological therapy is often unable to carry through on cases because general practitioners who work on them are unable to grasp the complexity of these issues and therefore are unable to follow through on his recommendations. This was discussed frankly with him and several cases were discussed in which therapeutic activity had to be changed due to the inexperience of the general practitioners in charge of the case. There is clearly an analogy here which I think is worth mentioning—if 350 patients with acute abdomens, all of which are both diagnostic and therapeutic problems—if these patients were placed in a hospital and the hospital was directed by a general practitioner who had one year of internship in a rotating internship and had worked in this hospital for 10 years or 20 years and there were three other physicians present all of whom are psychiatrists, I think the analogy then is accurate to Farview State Hospital.

Farview State Hospital has received the most difficult psychiatric and behavioral problems of the state and has been staffed almost exactly the opposite of the way it should be to treat these people. At the time of the previous surveys there were just four nurses available. That number has presently risen to 30, however, of these 30 nurses none is a fully trained psychiatric nurse and only two or three actually have bachelor degrees. This means that those persons on the wards, for the most part, are unable to exert the professional leadership need d to change the pattern of activities from custodial and security to therapeutic. This situation is readily recognized by the senior staff of the hospital and they have made efforts to recruit as well as efforts to increase the therapeutic efficacy of the hospital, but it is clear that there is a critical mass of staff needed in order to change this and that critical mass has not yet been obtained.

There is an attempt to train psychiatric security aides in medication giving and an attempt on the clinical level to supervise them as members of the team. However, both these efforts albeit welcome are inadequate in the face of the situation. The director of the psychology department has been designated as the person to develop a treatment program for the hospital and on paper this program looks good, but due to the difficult situation the decision has been made to direct this effort first of all to one ward, training staff on that ward particularly in behavior-oriented observations and interventions as well as goal planning on that ward. Even if this process works it will be a number of years before this is able to have any impact on the whole hospital.

IV. Utilization review

There is active utilization review in the hospital as well as active medical audit. The utilization review however, could focus more and more on patients who are not appropriate for Farview, patients who are said by other state hospitals to be too sick for them and patients who remain at Farview at the court's discretion but who do not need that and who could more properly be in prison. The utilization review activity should focus more on this, documenting these cases and attempting to use whatever administrative or political means that are available to them to have these patients discharged which will of course help the staff-patient ratio. The audits done up to this point, the first two were on the use of psychotropic drugs and the general medical record itself, both of which resulted in action. The present audit being used is under the JCAH format and relates to the use of CC–1 the maximum security area. These are appropriate areas and this activity is to be commended.

V. Farview State Hospital today is the result of a complex number of factors which include societal, management, and clinical areas. The hospital has been set up and functioned as the last stop for the most difficult persons living in Pennsylvania—those who are poor, criminal, and psychotic. The hospital has been used by the Department of Corrections, Department of Justice and by the rest of the mental health system as a way of punishing patients or as a way of relieving these other institutions of difficult management problems. On the other hand, the hospital has been managed by essentially untrained, unqualified persons for dealing with these severe behavioral disorders and has been run under the philosophy of security as the primary and ultimately over the years the only reason for the hospital. It is no wonder that the present allegations made toward the hospital concerning patient brutality come up if one realizes that the setting is such that if brutality does not come up it would be rather surprising. How-

ever, we must point out in our survey we saw no evidence of brutality; charts reviewed of three of the patients who are being presently investigated for sudden and unexpected deaths revealed no exceptional difficulties in clinical management or no failure in clinical management beyond those manifested for every other patient in the overall sense that there is simply not enough professional supervision, guidance, and treatment provided. The largest single group in the hospital, the psychiatric security aides, have a long history of which their efforts have been directed toward security, maintaining it and who have in a sense been responsible for the hospital.

The above mentioned factors therefore clearly point not to individual malfeasance within the hospital nor even individual apathy in the hospital but rather to an overall failure of the governing process—a failure to provide adequate resources, adequate administrative and managerial support, dequate monitoring and ultimately having failed to be accountable for the institution called Farview State Hospital. The issues at Farview are not those that are being played up in allegations or brutality, the issue at Farview is whether or not any institution of this kind can or should exist and if it does, how to monitor it, manage it, and staff it so that there is adequate treatment provided to those patients who are in it. Internally it seems that the management of Farview could be and should be more aggressive in defining itself more clearly in attacking those practices which leaves it as a dumping ground and which keeps its population at a level which makes active treatment for anyone highly unlikely. This really refers to the need for Farview and its governing body insofar as the Department of Welfare is considered to be the governing body to address issues with the corrections department as well as to address the issue of other state hospitals learning to manage their own difficulties. But even beyond this there is clearly a need for the governor and the legislature not to investigate Farview, not to castigate it but rather to address themselves and the people of the state as to whether or not the people of the state wish to continue to treat criminal, poor, and psychoic persons in this manner or whether they wish to address their mental health needs in a different way. Certainly by these findings not being in compliance it is clear that medicare recertification is not possible and there is a good chance obviously that the governing body will decide that there is no other way, nothing else they can do and therefore at least the pretense of providing psychiatric treatment can be dropped and the state can face the fact that what they are providing is relief for the rest of the community.

The present hospital administration at the top is realistic, idealistic, aware and forward looking; however, immediately below the top there is an enormous paucity of clinical management persons and above the top there is little indication from our stay that there is any activity constructively aimed towards either changing Farview or addressing the needs of these persons who are incarcerated there in a different way. Therefore, it seems likely that this administration will be left with a near impossible task.

RECOMMENDATIONS

1. The Hospital should begin extensive inservice training for its staff, especially in the areas of treatment planning, behavioral therapy techniques, group principles and techniques, and basic psychiatry. This training should be directed at all staff, especially including nursing and the psychiatric security aides.

The hospital does not have the internal capacity to conduct such an extensive program and therefore should use outside consultation and services in this area. Moneys for this should be made available by the governing body.

2. The Utilization Review Committee should actively document cases where more appropriate placement is indicated. This information should be routinely supplied to senior management and to the governing body.

3. All attempts to continue the movement for closer clinical supervision of the psychiatric security aides by the professional staff should be encouraged.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved.
OMB No. 72-RO824

PSYCHIATRIC HOSPITAL SURVEY REPORT

PROVIDER NUMBER: 39-4029

NAME OF HOSPITAL: Farview State Hospital

SURVEYED BY: June McLaughlin

SURVEYOR'S PROFESSIONAL TITLE: Medicare Certification Team Coordinator

ADDRESS: P.O. Box 128 Waymart, Pennsylvania 18472

DATE SURVEYED: 7-20-22-76

1) [ ] INITIAL SURVEY
2) [X] RESURVEY

LIST ADDITIONAL SURVEYORS:

NAME	TITLE
Marshall Fitz, M.D.	Psychiatric Consultant, NIMH
Mary Rose Martinelli	Psychiatric Nurse Consultant

	YES	NO	N/A		EXPLANATORY STATEMENTS
B6				[ ] MET [X] NOT MET XVII. Special Medical Record Requirement (405.1037) The medical records maintained by a psychiatric hospital permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.	
B7				[ ] MET [X] NOT MET (a) *Standard: Medical Records* — Medical records stress the psychiatric components of the record including history of findings and treatment rendered for the psychiatric condition for which the patient is hospitalized.	
B8	X			(1) The identification data includes the patient's legal status.	
B9	X			(2) A provisional or admitting diagnosis is made on every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.	B9-Although in 10 out of 11 records reviewed there were admitting diagnoses; 1 record had no diagnosis and 2 records had two or more diagnosis and it was unclear as to which diagnosis was operational.
B10	X			(3) The complaint of others regarding the patient is included as well as the patient's comments.	B10-Complaints of others as well as patients complaints were court related rather than behaviorally oriented
B11			X	(4) The psychiatric evaluation, including a medical history, contains a record of mental status and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functions, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretive, fashion.	B11-A form is used for the initial evaluation. The content of the form gives little guidance to treatment. The psychiatric evaluations done by non staff psychiatrists are good. Given the paucity of psychiatric staff at the hospital, it is impossible to expect adequate psychiatric evaluation on admission.

Form SSA-1537A (11-74)

NAME OF FACILITY
Farview State Hospital — 39-4029

	YES	NO	N/A		EXPLANATORY STATEMENTS
B12	X			(5) A complete neurological examination is recorded at the time of the admission physical examination, when indicated.	B12-Neurological examinations and consultation are done at Scranton State General Hospital as needed
B13		X		(6) The social service records, including reports of interviews with patients, family members and others, provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.	B13-Only 19 out of 30 records contained some evidence of social work activity.
B14	X			(7) Reports of consultations, psychological evaluations, reports of electroencephalograms, dental records and reports of special studies are included in the record.	
B15		X		(8) The individual comprehensive treatment plan is recorded, based on an inventory of the patient's strengths as well as his disabilities, and includes a substantiated diagnosis in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual; short-term and long-range goals, and the specific treatment modalities utilized as well as the responsibilities of each member of the treatment team in such a manner that it provides adequate justification and documentation for the diagnoses and for the treatment and rehabilitation activities carried out.	B15-The marked increased in the number of treatment plans since the previous survey is impressive. However, the lack of sophistication is evidenced by stereotypy the lack of continuity between specific steps and goals. There is an attempt to list patient's assets but these are no integrated into the treatment plans. The treatment plans do not clearly indicate who is clinically responsible for the treatment.
B16		X		(9) The treatment received by the patient is documented in such a manner and with such frequency as to assure that all active therapeutic efforts such as individual and group psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, industrial or work therapy, nursing care and other therapeutic interventions are included.	B16-Although the treatment plans indicate a variety of treatment modalities and there are specific orders for these therapies there is evidence concerning only the efficacy of pharmacological therapy.
B17	X			(10) Progress notes are recorded by the physician, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. Their frequency is determined by the condition of the patient but should be recorded at least weekly for the first 2 months and at least once a month thereafter and should contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.	B17-There has been a marked increase in writing of progress notes by psychiatric security aides. These notes often give clear indication of the patients behavior. However, there is a need for increase in professional supervision in this area. as the notes are blunt and do not perserve the patients dignity.

FORM SSA-1537A (11-74)

NAME OF FACILITY

Farview State Hospital — 39-4029

	YES	NO	N/A	
B18		X		(11) The discharge summary includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning followup or aftercare as well as a brief summary of the patient's condition or discharge.

B19

SUMMARIES INCLUDE	ALWAYS(1)	OFTEN(2)	SELDOM(3)	NEVER(4)
a) Chief Complaint			X	
b) Diagnostic procedures		X		
c) Diagnosis	X			
d) Treatment			X	
e) Progress reports			X	
f) After care plan		X		

	YES	NO	N/A	
B20	X			(12) The psychiatric diagnoses contained in the final diagnoses are written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual.

NUMBER OF MEDICAL RECORDS REVIEWED

B21 A) NEW ADMISSIONS 11 B) STAY OVER 90 DAYS 10 C) DISCHARGES 8

NUMBER CONTAINING FOLLOWING INFORMATION

	INFORMATION	NEW ADMISSIONS (A)	STAY OVER 90 DAYS (B)	DISCHARGES (C)
B22	Legal status	11	10	8
B23	Admitting diagnosis	10	10	8
B24	Intercurrent diagnosis	1	3	4
B25	Patient's complaint	7	3	7
B26	Complaint of others	8	8	8
B27	Psychiatric evaluation	10	9	8
B28	Neurological examination	3	2	2
B29	Social Service reports	6	8	5
B30	Consultations	2	4	2
B31	Laboratory reports	11	9	7
B32	Other diagnostic reports	7	6	8
B33	Treatment plan	10	10	8
B34	Therapeutic reports	10	10	8
B35	Progress notes	10	10	8
B36	Discharge summaries			7
B37	Final diagnosis			7

EXPLANATORY STATEMENTS

B18-Chief complaints present, but often court committment related rather than in behaviora terminology. It is recognized that discharg summaries are now on the patient's record as compared to previous survey, but do not adequately describe the hospital course. This is a result of inadequate number of physicians.

FORM SSA-1537A (11 75)

NAME OF FACILITY
Farview State Hospital — 39-4029

	YES	NO	N/A		EXPLANATORY STATEMENTS
B38				☐ MET ☒ NOT MET **XVIII. Special Staff Requirements (405.1038)** The hospital has staff adequate in number and qualifications to carry out an active program of treatment for individuals who are furnished services in the institution.	
B39				☐ MET ☒ NOT MET (a) *Standard: Personnel; Facilities* — Inpatient psychiatric facilities (psychiatric hospitals, distinct parts of psychiatric hospitals or inpatient components of community mental health centers) are staffed with the number of qualified professional, technical and supporting personnel, and consultants required to carry out an intensive and comprehensive treatment program that includes evaluation of individual needs, establishment of treatment and rehabilitation goals, and implementation, directly or by arrangement, of a broad range therapeutic program including, at least, professional psychiatric, medical surgical, nursing, social work, psychological and activity therapies as required to carry out an individual treatment plan for each patient.	
B40		X		(1) Qualified professional, technical, and consultant personnel are available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for such evaluation include laboratory, radiological and other diagnostic tests, obtaining psychosocial data, carrying out psychiatric and psychological evaluations, and completing a physical examination, including a complete neurological examination when indicated, shortly after admission.	B40-B44-There is an inadequate number of psychiatrists to provide immediate thorough evaluation of patients at the time of admission. Although there has been progress in the area of active psychiatric treatment, there is simply not enough professional staff with the necessary qualifications to provide the pharmacological, psychological or sociological interventions that are needed by this particularly difficult patient population.
B41		X		(2) The number of qualified professional personnel, including consultants and technical and supporting personnel, is adequate to assure representation of the disciplines necessary to establish short-range and long-term goals; and to plan, carry out, and periodically revise a written individualized treatment program for each patient based on scientific interpretation of:	

FORM SSA-1537A (11-74)

NAME OF FACILITY

Farview State Hospital — 39-4029

	YES	NO	N/A		EXPLANATORY STATEMENTS
B42		X		(i) Degree of physical disability and indicated remedial or restorative measures, including nutrition, nursing, physical medicine, and pharmacological therapeutic interventions;	
B43		X		(ii) Degree of psychological impairment and appropriate measures to be taken to relieve treatable distress and to compensate for nonreversible impairments where found;	
B44		X		(iii) Capacity for social interaction and appropriate nursing measures and milieu therapy to be undertaken, including group living experiences, occupational and recreational therapy, and other prescribed rehabilitative activities to maintain or increase the individual's capacity to manage activities of daily living;	
B45		X		(iv) Environmental and physical limitations required to safeguard the individual's health and safety with a plan to compensate for these deficiencies and to develop the individual's potential for return to their own home, a foster home, an extended care facility, a community mental health center, or another alternative facility to full-time hospitalization.	B45-The gross lack of patient privacy is not only an issue in the area of basic human dignity, but in the area of therapeutic milieu management. For example - increased tension due to the lack of privacy which leads to increased acting out. This may delay the patients potential for alternative care.
B46				☐ MET ☒ NOT MET (b) *Standard: Director of Inpatient Psychiatric Services; Medical Staff* — Inpatient psychiatric services are under the supervision of a clinical director, service chief or equivalent who is qualified to provide the leadership required for an intensive treatment program, and the number and qualifications of physicians are adequate to provide essential psychiatric services.	
				DIRECTORS QUALIFICATIONS	B47,48-The Clinical Director has no formal training in psychiatry; he has a solid grasp of basic hospital psychiatry and is recognized by the courts in Pennsylvania and the State Civil Service Commission as a psychiatrist.
B47				A) BOARD CERTIFIED ____ B) BOARD ELIGIBLE ____	
B48				A) PSYCHIATRY ____ B) NEUROLOGY ____ C) BOTH ____	

FORM SSA-1537A (11-74)

94-420 O - 77 - 59

NAME OF FACILITY
Farview State Hospital 39-4029

	YES	NO	N/A	
B49		X		(1) The clinical director, service chief or equivalent is certified by the American Board of Psychiatry and Neurology, or meets the training and experience requirements for examination by the Board ("Board eligible"). In the event the psychiatrist in charge of the clinical program is Board eligible, there is evidence of consultation given to the clinical program on a continuing basis from a psychiatrist certified by the American Board of Psychiatry and Neurology.
				QUALIFIED CONSULTANTS
B50				1. YES ___ 2. NO _X_ FREQUENCY OF VISITS ______
B51	X			(2) The medical staff is qualified legally, professionally and ethically for the positions to which they are appointed.
B52		X		(3) The number of physicians is commensurate with the size and scope of the treatment program.
B53				(4) Residency training is under the direction of a properly qualified psychiatrist.

NUMBER OF PHYSICIANS

	SPECIALTY	FULL-TIME (A) DP	FULL-TIME (A) TH	PART-TIME (B) DP	PART-TIME (B) TH	CONSULTING (C) DP	CONSULTING (C) TH
B54	Psychiatry		1	1	4	0	0
B55	Neurology	0	0	0	0	0	0
B56	Other* GP	1	3	0	0	0	0
B57	Other*						

* Specify
1 Full time Dentist
1 Part time Dentist
1 Part time Surgeon
1 Part time Ophthamologist
2 Part time Podiatrists
1 Contract Psychiatrist and 3 psychiatrists from Clarks Summit State Hospital

EXPLANATORY STATEMENTS

B49-There is no evidence of consultation to the clinical program by a psychiatrist. Occasional visits by the state psychiatrists do not meet this requirement. The content of the medical records, the indisciplinary team approach and staff development reflect the lack of consultation to the clinical program.

B52-The hospital has effective use of one psychiatri the Clinical Director. The other psychiatrists listed below. (B54)-Provide no ongoing treatment for the hospital population and no psychiatric direction of staff leaving one psychiatrist who i not formally trained for a current census 348 patients. This is in addition to his role of Clinical Director. The General Practioners liste below, (B56)-Provide the only medical direction for the psychiatric evaluation and treatment. They show little expertise in psychiatry. There is no evidence of ongoing psychiatric inservice for medical staff. Three psychiatrists listed, under part time are from Clarks Summit State Hospital. Each of the three spends one half day per week at Farview State Hospital doing evaluations of new patients. There is one other psychiatrist who does evaluations on a constant basis.

FORM SSA-1537A (11-74)

NAME OF FACILITY

Farview State Hospital 39-4029

	YES	NO	N/A		EXPLANATORY STATEMENTS
B58				[X] MET [ ] NOT MET (c) *Standard: Availability of Physicians and Other Personnel* — Physicians and other appropriate professional personnel are available at all times to provide necessary medical and surgical diagnostic and treatment services, including specialized services. If medical and surgical diagnostic and treatment services are not available within the institution, qualified consultants or attending physicians are immediately available or a satisfactory arrangement has been established for transferring patients to a general hospital certified under the Health Insurance for the Aged Program.	
B59				MEDICAL-SURGICAL UNIT ON PREMISES 1) YES ___ 2) NO X NUMBER OF BEDS ___	B59-Patients are transferred to Scranton State General Hospital.
B60				NUMBER OF NURSING PERSONNEL ASSIGNED TO UNIT (FULL-TIME EQUIVALENTS) A) RN'S ___ B) LPN'S ___ C) AIDES ___	
B61				[ ] MET [X] NOT MET (d) *Standard: Nursing Services* — Nursing services are under the direct supervision of a registered professional nurse who is qualified by education and experience for the position; and the number of registered professional nurses, licensed practical nurses, and other nursing personnel are adequate to formulate and carry out the nursing components of the individual treatment plan for each patient.	B61-There are 8 registered nurses and 1 licensed practical nurse assigned to the distinct part for all three shifts for direct patient care. There is one supervisor for the entire hospital on the day, evening, and night shift.

NUMBER OF NURSING PERSONNEL (FULL-TIME EQUIVALENTS)

	SHIFT	R.N.'S	L.P.N.'S	AIDE	ORDERLIES
B62	DAY	*17	1	110	
B63	EVENING	6	0	101	
B64	NIGHT	5	0	83	
	Other			21	

*Includes Director of Nursing, 2 Assistants Dirs and 3 Supervisors. Includes guard service, escort and Switchboard services to cover all three shifts.

B62-64-The aides are psychiatric security aides who report to a psychiatric security aide supervisor who reports to the Clinical Director. There is clear deleneation as to the security and medical and psychiatric nursing duties of the psychiatric security aides. (See A214)

FORM SSA-1537A (11-74)

NAME OF FACILITY
Farview State Hospital

39-4029

	YES	NO	N/A		EXPLANATORY STATEMENTS
B65		X		(1) The registered professional nurse supervising the nursing program has a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or is qualified by education, experience in the care of the mentally ill, and demonstrated competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, supervise and train others who assist in implementing and carrying out the nursing components of each patient's treatment plan.	B65-The Director of Nursing has a M.S. in Industrial psychology and has been in this position for 20 years. The department is well run administratively i.e. scheduling, staff and supervisory meetings, review of nursing procedures, etc. However, there is no direct supervision and training by a nurse with a masters degree in psychiatric or Mental Health Nursing.
				QUALIFICATIONS OF NURSE-SUPERVISOR MS in Industrial Psychology	
B66		X		(2) The staffing pattern insures the availability of a registered professional nurse 24 hours each day for direct care; for supervising care performed by other nursing personnel; and for assigning nursing care activities not requiring the services of a professional nurse to other nursing service personnel according to the patient's needs and the preparation and competence of the nursing staff available.	B66-There is an insufficient number of registered nurses to perform and supervise the psychiatric security aides in the medical and psychiatric nursing techniques. (See A195, A211 through A214)
B67				Average bed-size of adult patient ward 12-55 beds	B67-(See attached sheet) RI Geriatrics - Bed Capacity 15 RII Admission Unit - 12 Bed Capacity SI Medical Surgical Unit - 31 Bed Capacity SII Chronic patients - 34 Bed Capacity CCI Hyperactive patients/maximum security - 41 Bed capacity

R N Duty Roster (Full-time Equivalent)

	SHIFT	SUN.	MON.	TUES.	WED.	THURS.	FRI.	SAT.
B68	Day							
B69	Evening							
B70	Night							
B71	Relief							

Form SSA-1537A (11-74)

NAME OF FACILITY

Farview State Hospital 39-4029

	YES	NO	N/A	
B72		X		(3) The number of registered professional nurses, including nurse consultants, is adequate to formulate in writing and assure that a nursing care plan for each patient is carried out.
B73				Written nursing care plans prepared for all patients 1) YES X 2) NO ____
B74		X		(4) Registered professional nurses and other nursing personnel are prepared by continuing in-service and staff development programs for active participation in interdisciplinary meetings affecting the planning or implementation of nursing care plans for patients including diagnostic conferences, treatment planning sessions, and meetings held to consider alternative facilities and community resources.
B75				[ ] MET [X] NOT MET (c) *Standard: Psychological Services* — The psychological services are under the supervision of a qualified psychologist and the psychology staff, including consultants, is adequate in numbers and by qualifications to plan and carry out assigned responsibilities.
B76				A) Full Time DP 2 TH 8 B) Part-Time 0 C) Consulting 0
B77	X			(1) The psychology department or service is under the supervision of a psychologist with a doctoral degree in psychology from an American Psychological Association approved program in clinical psychology or its adjudged equivalent. Where a psychologist who does not hold the doctoral degree directs the program, the individual has attained recognition of competency through the American Board of Examiners for Professional Psychology, State certification or licensing, or through endorsement by the State psychological association.
				QUALIFICATIONS OF SUPERVISING PSYCHOLOGIST The Director has a PhD in psychology and is licensed by the State

EXPLANATORY STATEMENTS

B72-Nursing care plans are not updated frequently enough to provide direction for nursing personnel to carry out active psychiatric nursing techniques. The approaches to goals or problems are not specific as to nursing techniques.

B74-Due to the limited number of registered nurses with degrees and limited training of psychiatric security aides there is a critical need for continuing inservice and staff development programs. However due to the number of registered nurses available, the intensity and frequency of these programs are limited and inadequate as evidenced by the patient treatment plans, nursing care plans and nursing notes.

NAME OF FACILITY

Farview State Hospital 39-4029

	YES	NO	N/A		EXPLANATORY STATEMENTS
B78		X		(2) Psychologists, consultants and supporting personnel are adequate in number and by qualifications to assist in essential diagnostic formulations, and to participate in program development and evaluation of program effectiveness, in training and research activities, in therapeutic interventions such as milieu, individual or group therapy, and in interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs.	B78-Besides the Director, there are 7 other persons functioning as psychologists. However, none of these meet the qualifications of the institutions governing body as a psychologist as none of them have advanced past the masters level. These staff members are assigned to treatment teams and assist in diagnostic formulations and treatment planning. However, they have limited training and skills needed to provide leadership in these areas and the overal treatment program reflects these limitations.
B79				[X] MET [ ] NOT MET (f) *Standard: Social Work Services and Staff*—Social work services are under the supervision of a qualified social worker, and the social work staff is adequate in numbers and by qualifications to fulfill responsibilities related to the specific needs of individual patients and their families, the development of community resources, and consultation to other staff and community agencies. (The factors explaining the standard are as follows:)	
B80	X			(1) The director of the social work department or service has a master's degree from an accredited school of social work and meets the experience requirements for certification by the Academy of Certified Social Workers.	B80-The director of the department has a MSW and meets the experience requirements for certification by ACSW.
B81	X			(2) Social work staff, including other social workers, consultants and other assistants or case aides, is qualified and numerically adequate to conduct prehospitalization studies; to provide psychosocial data for diagnosis and treatment planning, direct therapeutic services to patients, patient groups or families, to develop community resources, including family or foster care programs; to conduct appropriate social work research and training activities; and to participate in interdisciplinary conferences and meetings concerning diagnostic formulation and treatment planning, including identification and utilization of other facilities and alternative forms of care and treatment.	B81-Social work staff is adequate in number and qualifications to provide traditional social work services in particular handling the complex legal issues concerning patient committments. Although a social worker is assigned to treatment teams, department wide duties inhibit their active participation in the treatment teams.

NUMBER OF SOCIAL SERVICES STAFF

	QUALIFICATIONS	FULL-TIME (A)	PART-TIME (B)	CONSULTING (C)
B82	Master's degree	5		
B83	Baccalaureate	3		
B84	Other (Specify)	1 (education and experience)		

FORM SSA-1537A (11-74)

NAME OF FACILITY

Farview State Hospital — 39-4029

	YES	NO	N/A		EXPLANATORY STATEMENTS
B85				☐ MET ☒ NOT MET	
				(g) *Standard: Qualified Therapists, Consultants, Volunteers, Assistants, Aides* — Qualified therapists, consultants, volunteers, assistants or aides are sufficient in number to provide comprehensive therapeutic activities, including at least occupational, recreational and physical therapy, as needed, to assure that appropriate treatment is rendered for each patient, and to establish and maintain a therapeutic milieu.	

NUMBER OF THERAPISTS

	TYPE	OCCUPATIONAL (A)	PHYSICAL (B)	RECREATIONAL (C)
B86	Professional		1	
B87	Assistants			2
B88	Aides	4		4

VAS
1 Assistant
5 Aides

	YES	NO	N/A		EXPLANATORY STATEMENTS
B89		X		(1) Occupational therapy services are preferably under the supervision of a graduate of an occupational therapy program approved by the Council on Education of the American Medical Association who has passed or is eligible for the National Registration Examination of the American Occupational Therapy Association. In the absence of a full-time, fully qualified occupational therapist, an occupational therapy assistant who is certified by the American Occupational Therapy Association may function as the director of the activities program with consultation from a fully qualified occupational therapist.	B89-The Director of occupational therapy does not have education or training in occupational therapy. The Director does not receive any consultation from a qualified occupational therapist.
B90	X			(2) When physical therapy services are offered, the services are given by or under the supervision of a qualified physical therapist who is a graduate of a physical therapy program approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association or its equivalent. In the absence of a full-time, fully qualified physical therapist, physical therapy services are available by arrangement with a certified local hospital or by consultation or part-time services furnished by a fully qualified physical therapist.	B90-Although a qualified physical therapist is available to the staff, he is underutilized as evidenced by the number of patients seen per month. There is need to orient the medical and nursing staff as to the effective utilization of physical therapy services within the total treatment process. The hospital does not provide adequate equipment. The physical therapist is currently providing his own equipment. (See A102 and B90)
B91	X			(3) Recreational or activity therapy services are available under the direct supervision of a member of the staff who has demonstrated competence in therapeutic recreation programs.	

FORM SSA-1537A (11-74)

SCHEDULES

**

S I	6-21 MONDAY		6-22 TUESDAY		6-23 WEDNESDAY		6-24 THURSDAY		6-25 FRIDAY		6-26 SATURDAY		6-27 SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Day	½		½		½		1/3		1/3		¼		¼	
Evening	½		½		½		½		½		½		½	
Night	¼		¼		¼		¼		¼		¼		¼	

**

S II	6-21 MONDAY		6-22 TUESDAY		6-23 WEDNESDAY		6-24 THURSDAY		6-25 FRIDAY		6-26 SATURDAY		6-27 SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Day	½		⅓		½		1/3		1/3		¼		¼	
Evening	½		½		½		½		½		½		½	
Night	¼		¼		¼		¼		¼		¼		¼	

AA I	6-21 MONDAY		6-22 TUESDAY		6-23 WEDNESDAY		6-24 THURSDAY		6-25 FRIDAY		6-26 SATURDAY		6-27 SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Day	*1		*1		*1		½		¼		¼		1/3	
Evening	¼		¼		½		½		¼		*1/6		*1/6	
Night	*1/6		*1/6		*1/6		*1/6		*1/6		*1/6		*1/6	

AA II	6-21 MONDAY		6-22 TUESDAY		6-23 WEDNESDAY		6-24 THURSDAY		6-25 FRIDAY		6-26 SATURDAY		6-27 SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Day	1		1		1		½		¼		¼		1/3	
Evening	¼		¼		½		½		¼		*1/6		*1/6	
Night	*1/6		*1/6		*1/6		*1/6		*1/6		*1/6		*1/6	

* Also Is Supervisor
** Distinct Part

SCHEDULES

CCII	6-21		6-22		6-23		6-24		6-25		6-26		6-27	
Date	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Day	½		½		1		½		½		1		½	
Evening	½		½		½		½		½		½		½	
Night	½		½		½		½		½		½		½	

P	6-21		6-22		6-23		6-24		6-25		6-26		6-27	
Date	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Day	½		½		1		1		½		1		½	
Evening	*½		½		½		½		½		*1/6		*1/6	
Night	*1/6		*1/6		*1/6		*1/6		*1/6		*1/6		*1/6	

Q	6-21		6-22		6-23		6-24		6-25		6-26		6-27	
Date	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Day	½		½		½		1		½		*1		½	
Evening	*½		½		½		½		½		*1/6		*1/6	
Night	*1/6		*1/6		*1/6		*1/6		*1/6		*1/6		*1/6	

CCI	6-21		6-22		6-23		6-24		6-25		6-26		6-27	
Date	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Day	½		½		1		½		½		1		½	
Evening	½		½		½		½		½		½		½	
Night	½		½		½		½		½		½		½	

*Also is supervisor
**Distinct Part

[illegible]

BBI	6-21		6-22		6-23		6-24		6-25		6-26		6-27	
DATE	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Day	½		½		½		½		½		½		½	
Evening	½		½		½		½		½		*1/6		*1/6	
Night	*1/6		*1/6		*1/6		*1/6		*1/6		*1/6		*1/6	

BBII	6-21		6-22		6-23		6-24		6-25		6-26		6-27	
DATE	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Day	½		½		½		½		½		½		½	
Evening	½		½		½		½		½		*1/6		*1/6	
Night	*1/6		*1/6		*1/6		*1/6		*1/6		*1/6		*1/6	

RI	6-21		6-22		6-23		6-24		6-25		6-26		6-27	
DATE	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
** Day	½		½		½		1/3		1/3		½		½	
Evening	½		½		½		½		½		½		½	
Night	½		½		½		½		½		½		½	

RII	6-21		6-22		6-23		6-24		6-25		6-26		6-27	
DATE	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
Nurses	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN	RN	LPN
** Day	1		1		1		1		1		½		½	
Evening	½		½		½		½		½		½		½	
Night	½		½		½		½		½		½		½	

*Also Is Supervisor
**Distinct Part

NAME OF FACILITY

Fairview State Hospital — 39-4029

	YES	NO	N/A		EXPLANATORY STATEMENTS
B92		X		(4) Other occupational therapy, recreational therapy, activity therapy and physical therapy assistants or aides are directly responsible to qualified supervisors and are provided special on-the-job training to fulfill assigned functions.	B92- (See B89)
B93		X		(5) The total number of rehabilitation personnel, including consultants, is sufficient to permit adequate representation and participation in interdisciplinary conferences and meetings affecting the planning and implementation of activity and rehabilitation programs, including diagnostic conferences; and to maintain all daily scheduled and prescribed activities including maintenance of appropriate progress records for individual patients.	B93-The patient population in this institution needs an intensive and extensive rehabilitation program that is actively integrated with the total treatment program. The staff provided for these critical functions is inadequate in number and training. For example, 1 recreation worker is assigned 3 hours a day Monday through Friday to 3 out of 4 wards in the Distinct Part (RI, SI, and SII)
B94		X		(6) Voluntary service workers are under the direction of a paid professional supervisor of volunteers, are provided appropriate orientation and training, and are available daily in sufficient numbers to be of assistance to patients and their families in support of therapeutic activities.	B94-There is no volunteer program at this hospital.

FORM SSA-1537A (11-74)

U.S. GOVERNMENT PRINTING OFFICE:

[APPENDIX 2]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COORDINATION OF STATE PROGRAMS FOR THE MENTALLY RETARDED, INC.

The National Association of Coordinators of State Programs for the Mentally Retarded is a non-profit organization consisting of the designated officials in the fifty states and territories who are directly responsible for the provision of residential and community services to a total of over ½ million mentally retarded children and adults. Since publicly operated institutions for the mentally retarded have been a major target of rights litigation in recent years, NACSPMR members have a vital stake in pending legislation (H.R. 2439; S. 1393) to grant the U.S. Attorney General satutory authority to file suits on behalf of mental patients, prisoners, juvenile delinquents and other persons confined in institutional settings.

In recent weeks both the House and Senate Subcommittees have heard extensive testimony on H.R. 2439 and S. 1393 from a wide range of witnesses. Many of the witnesses favoring the legislation emphasized the deplorable conditions which exist in some public facilities for the mentally ill and mentally retarded and argued that the Attorney General needs the authority contained in the pending bills to protect the constitutional rights of the residents in such facilities.

Other witnesses argued that involvement of the Justice Department does not result in benefits for all institutionalized persons but rather in massive consent decrees that set standards for a particular institution. These witnesses asserted that, in this way, the Justice Department has become inappropriately involved in making social and health policy judgments.

Although we believe that significant improvements have been made in public treatment facilities for the mentally retarded in recent years, we are not contending that all the problems have been eliminated or, indeed, that litigation is not a significant and sometimes necessary tool for inducing needed changes in such facilities. As program administrators we have struggled over the years to improve institutional programs, often against great odds because of public apathy, misunderstanding and neglect. Therefore, we welcome the spotlight of attention which has recently been focused on the substandard and sometimes inhumane conditions in public institutions. At the same time, as the defendents in many of the so-called "rights to treatment" suits which have been filed over the past five years, several of our members have had a first hand opportunity to observe the results—both positive and negative—of such litigation.

The purpose of this statement is to share with Subcommittee members our observations concerning the impact of recent rights litigation involving retarded institutional residents and the attendant implications for drafting legislation authorizing the Attorney General to file suits on behalf of such individuals. In our testimony we will argue that if the Attorney General is to have such authority there should be specific guidelines established by legislation specifying the conditions under which such authority may be exercised.

A. The administrative realities of litigation

One of the major lessons to be learned from the recent litigation is that the pursuit of broad social change through court action is an extremely complex undertaking. We are certain that various observers hold sharply differing perspectives on the overall impact of litigation on the field of mental retardation. From our vantage point, however, the suits have been a useful device for dramatizing societal neglect and abuse, which has gone on for far too long; on the other hand, litigation has not proven to be a particularly successful method for causing fundamental changes in the range, extent and quality of treatment and habilitative services delivered to mentally retarded citizens in institutional settings.

Searching for the elusive ingredients of a high quality program, federal judges have often found themselves becoming increasingly immersed in the day-to-day administrative affairs of the facility. Well meaning attempts to eliminate impediments to change have often led to further delays and inaction, which, in turn, have resulted in the issuance of even more detailed court edicts. The ensuing tug-of-war between plaintiff's, defendants and the court has led to lengthy impasses during which conditions in the facility stagnate, staff morale dips and all parties to the suit (including the top leadership personnel of the state agency and the facility) are forced to spend an inordinate portion of

their time responding to the litigation rather than developing and implementing more effective methods for delivering client services. In such situations the ultimate losers, of course, are the residents of the facility.

In considering the present legislation, one question which Congress should examine is: what are the appropriate roles of the U.S. Department of Justice and the federal courts in mandating administrative and legislative actions on the part of the sovereign states. Obviously, access to the courts is a fundamental right of any citizen and it would be contrary to our system of justice to deny this right to persons in institutional settings. And, as we learned during the civil rights movement of the 1950's and 1960's, there will be instances where the federal courts must intervene to protect the constitutional rights of citizens when recalcitrant state administrators and/or legislators fail to act. On the other hand, the courts are ill-equipped to assume de-facto operational authority for complex, multifaceted state programs. Certainly, our experience with right-to-treatment cases indicates that litigation is far from a cure-all for current program deficiencies and, in some instances, tends to exacerbate already difficult situations.

Another lession of the litigation is that changes in any particular institutional setting cannot be pursued without considering the overall impact on the state's system for delivering services to the mentally retarded. It is fruitless, for example, to force a state to reduce the population of an existing residential treatment center only to find that the "deinstitutionalized" residents end up in settings where they receive as bad or worse care and services. Similarly, it makes little sense to create a special class of beneficiaries of a particular suit only to discover the increased costs of care for such individuals is being achieved by denying similarly situated persons in the state access to even minimal services.

As attorneys for the plaintiffs have gained more experience, they have attempted to address problems by expanding the definition of the class. The problem is that the litigation becomes even more complex and time-consuming, again to the detriment of the facility's clients.

Finally, while litigation can induce change by forcing responsible state administrators and legislators to respond to an independent, external force, it can also obscure the need for legislative and administrative action and distort the internal allocation of scarce resources. For example, the energy and resources committed to engaging in the litigation often detract from the state's capability to commit time and resources to the improvement of other components of the state's system.

Dealing with a more immediate concern, the states need the help of Congress and the Administration in resolving the many funding dilemmas surrounding the establishment of alternative living environments for mentally retarded individuals. As the General Accounting Office pointed out in its recent report on deinstitutionalization of the mentally disabled, "in the absence of a national strategy or management system to implement deinstitutionalization federal officials responsible for other programs that affect deinstitutionalization generally (1) were not aware of the national goal or had not received instructions on implementation, (2) had not implemented their programs to help achieve the goal, (3) had not undertaken joint efforts directed at deinstitutionalization, or (4) had not monitored or evaluated their programs' impact on deinstitutionalization."[1] As a result, a number of key federal programs continue to contain provisions which encourage institutionalization of the mentally retarded.

One glaring illustration of the negative impact of these disjointures in federal policy can be found in the federal-state Medicaid program. Last year HEW reimbursed the states under Medicaid for some $750 million in intermediate care services to eligible recipients in public institutions for the mentally retarded. Despite the ongoing efforts of our Association, the National Governors' Conference and other interested groups, Departmental officials rave thus far refused to issue clear policies making residents in small, community based facilities (group homes, hostels, etc.) eligible for ICF/MR reimbursement. As a result, the program—the federal government's largest single source of support for mental retardation services—tends to reward the states for maintaining residents in large, isolated congregate care facilities—even though the Administration contends that it favors deinstitutionalization.

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[1] General Accounting Office, *Returning the Mentally Disabled to the Community: Government needs to do More* (Rept. No. 76–152) Jan. 1, 1977.

Solving such problems may not be as politically attractive as authorizing the Justice Department to sue the states, but from our perspective, it is a more essential component of a broad-gauged strategy for upgrading services to the mentally retarded.

B. The Justice Department's role in right-to-treatment litigation

If one accepts the limitations of litigation as a strategy for affectuating social change, the next logical question is: what role should the Justice Department play in future right-to-treatment suits.

An examination of the history of such cases indicates that the Department initially became involved in the *Wyatt* case at the request of the Federal District Court in Alabama rather than as part of a carefully planned strategy of litigation. Indeed, the primary impetus for identifying and seeking out new litigative targets in the field of mental health and mental retardation has come from a small cadre of private attorneys associated with public interest law firms. Up until this point, the Department's most important role in ground breaking litigation in this area has been in making available the FBI to collect extensive background information and data on the operation of the facility or facilities under investigation. In most instances, this service has been furnished either at the request of the court or when the Department was participating as an *amicus* in the suit.

It has been our observation that few, if any, new legal or constitutional arguments have been presented in those cases where the Department has filed as plaintiff. At least in suits against mental retardation facilities, the process of selecting the particular targets of litigation has been somewhat less than rigorous; in addition there has been a minimum of prior consultation with responsible state officials. (These points are aptly described in the testimony presented by Francis B. Burch, Maryland Attorney General, before the Senate Subcommittee on Constitution.)

The very fact that Justice officials found it necessary to file these suits at a time when literally scores of similar private suits were pending or in the process of development suggests something of a "me-too" response on the part of the Department to a popular new area of constitutional law.

Assistant Attorney General Drew S. Days, III suggested in testimony before both the House and the Senate Subcommittees that the Department needs the authority contained in H.R. 2439 and S. 1393 "to embark upon a coordinated program of litigation in this important area". He assured members that the Department intends to file suits only after carefully considering the facts of the case and giving appropriate officials a fair opportunity to correct existing deficiencies.

Given the Department's past track record in this area, however, we feel that Congress should include stronger safeguards in the legislation to protect the states against poorly thought-out suits which hinder rather than hasten program reforms in residential care for the mentally disabled.

In addition, we suggest that Subcommittee members carefully examine the "David vs. Goliath" image which usually surrounds suits filed by a small, underfunded, understaffed, public interest law firm against a powerful sovereign state. An examination of the record in many of the past right-to-treatment cases believes this popular image. The Justice Department, with all of the resources at the Government's disposal, can often tip the balance of justice significantly in favor of the plaintiffs.

But it is not simply a case of the relative numbers of attorneys assigned to a case; it is also a matter of experience in trying similar suits. The typical assistant state attorney general has had no training or experience with right-to-treatment cases and the emerging body of law surrounding this new area of litigation.

In addition, he or she rarely has the luxury of devoting full time to the case. It is not unusual to find a state attorney simultaneously involved in several other major cases while working on a right-to-treatment case. By comparison, attorneys for the plaintiffs can call upon the most experienced lawyers in the country in the area of mental health law and also have access to legal back-up centers to help in developing their cases.

If one of the hallmarks of the American system of justice is a reasonably balanced adversarial relationship, then we believe there is cause for concern about the drift of events in recent institutional rights cases. Although we recognize that the Justice Department has a responsibility for seeking appropriate

redress for incursions upon the rights of institutionalized persons, we also believe that Congress must consider the above facts in determining how the resources of the Justice Department should be deployed.

C. Proposed amendments to pending legislation

In view of the above observations, the Association wishes to offer the following specific proposals for amending H.R. 2439 and S. 1393:

1. *A new section should be added to the pending bills atuhorizing the establishment of a representative committee to advise the Attorney General on the Justice Department's role in suits involving institutional residents.*—The committee's mission should include: (a) assisting Departmental officials in the development of guidelines for the Government's involvement in institutional rights cases (both as plaintiff and in various supportive capacities); (b) advising the Attorney General on whether or not the Department should file or become a party to particular suits; and (c) advise the Attorney General on the development of a coordinated strategy for litigation in this area. Representatives of consumer and provider organizations and state elected officials (Governors, attorneys general and state legislators) should serve on the committee. To assure that a wide range of viewpoints are represented, the legislation should stipulate that specified organizations will be asked to nominate representatives to serve on the committee. In addition, to prevent the committee from becoming a useless appendage, the Attorney General should be forbidden from entering any case unless a majority of the advisory committee indicates its approval.

As currently drafted neither the House nor the Senate version of the bill places any restrictions on the Attorney General's authority to find that a "pattern or practice" of neglect or abuse exists which warrants Justice Department intervention. We have attempted to point out that the decision of whether changes can be efficaciously pursued through litigation involves weighing many different variables; therefore, the Association believes that the legislation should contain some safeguards against the filing of capricious and unwarranted federal suits which, on balance, impede rather than accelerate the process of change. The establishment of an advisory committee, with broad representation, is one way of assuring that the Attorney General has at his disposal all relevant opinions before reaching a decision on the appropriate role for the Department.

2. *Section 4 of H.R. 2439 should be amended to specify that the Attorney General must give at least 12 months advance notice to appropriate state or local officials prior to filing a suit against a particular institution or institutions*—Currently Section 4 of the House bill says only that the Attorney General must give officials advanced notice plus "reasonable time to correct such deprivations . . .". The Senate bill states that advanced notice must be provided but is silent on the matter of the time allowed for corrective actions.

If the Administration and Congress are serious about avoiding unnecessary litigation, it seems reasonable to suggest that responsible officials should be given an adequate advanced warning so that necesary corrective actions can be initiated. Given the complexity of the tasks involved, one year does not strike us as an inordinately long "probationary period" in which to assess a state facility's efforts to correct outstanding deficiencies.

3. *Finally, the Department of Justice should be specifically authorized to furnish technical assistance to any institution or institutional system which has been identified as a possible target for litigation*—If our mutual goal is to bring about needed reforms in institutional management, then the Department should be able to offer practical advice and assistance to state and local institutional officials as well as seek change through litigation. The types of assistance provided should not be limited to consultation on legal issues but rather should include advice on dealing with the underlying programatic deficiencies which plague the facility. Since the Civil Rights Division of the Justice Department possesses no special expertise in the latter area, Subcommittee members may wish to consider including appropriate requirements for interagency cooperation in the provision of such technical assistance—most notably between HEW and the Justice Department.

* * * * * * *

We appreciate this opportunity to share the Association's views with the Subcommittee. If the members and staff of the Association can be of further assistance on this matter, we hope that you will call upon us.

[APPENDIX 3]

PREPARED STATEMENT BY THE NATIONAL CENTER FOR LAW AND THE HANDICAPPED

Comments on S. 1393

The National Center for Law and the Handicapped, a project of national significance jointly funded by the Bureau of Education for the Handicapped, Office of Education, and Division of Development Disabilities, Office of Human Development within the United States Department of Health, Education, and Welfare, welcomes this opportunity to express its views in support of S. 1393.

The Center believes the bill, which would authorize the Attorney General to bring a civil action in Federal Court on behalf of institutionalized persons whose Constitutional or statutory rights are being deprived, is a positive step in the guarantee of equal rights to all handicapped individuals. Support of this bill is based upon our perception of Congressional intent in protecting the rights of the handicapped, our active experience in this area, and our evaluation of the work being done by the Attorney General's Office.

Congress has enunciated a national policy to guarantee the rights of handicapped and institutionalized individuals, promulgating an array of programs for the purpose of ensuring humane care and effective habilitation and treatment. At the core of this national policy is Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, which has been called the Civil Rights Act for the Handicapped. It provides that no handicapped person shall be discriminated against in any program or activity receiving federal financial assistance. Additionally, Congress stated in the passage of the Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. § 6010 *et seq.*, that persons with developmental disabilities are entitled to appropriate treatment services and habilitation for their disabilities. Many statutes and programs, too numerous to mention, echo these concerns.

That the ideals of such statutes are not being fulfilled today in numerous state institutions serving the handicapped needs no further elaboration. The members of the Senate Subcommittee are well aware of the grossly inhumane conditions that have existed and still exist in many of these institutions, conditions which once seen cannot be adequately described in words. Yet these facilities receive substantial sums of federal money, and states rely heavily upon federal funds to operate all aspects of their service systems. The federal government has a great interest in assuring that its funds are used in the best possible way, and that the rights of those receiving benefits have not been violated.

The Center is presently involved in litigation in several states concerning the conditions of state institutions for the handicapped. The Center has worked closely with groups and individuals in numerous other states in an attempt to improve institutional conditions and protect and guarantee the rights of handicapped individuals in these states. In the past and still unquestionably at present, this has been a very difficult task, involving a substantial commitment of time and effort.

Several times in litigation the Center has had an opportunity to work closely with the Attorney General's Office and observe its effectiveness. In these cases and in numerous others, in which the Attorney General has been involved, the positive benefits which have resulted on behalf of handicapped individuals cannot be questioned. Many extremely poor conditions have been improved significantly, legal precedents have been set, often resulting in new legislation and improvements absent the need for further litigation. Much more, however, needs to be done. The Attorney General has developed an expertise, and has the resources necessary to handle effectively, long and complex negotiations and litigation, involving extensive investigation and collation of facts and data.

One example from the Center's experiences with the power and effect of the Attorney General is worth noting here. The case of *Horacek v. Exon*, CV 72–L–299 (D, Nebr. 1972), was filed in the fall of 1972 by a very able private practitioner. The case concerns the conditions in a Nebraska institution for the retarded. The Center was admitted into the case as Amicus Curiae in the spring of 1973; the Attorney General was admitted as Amicus Curiae in the spring of 1974. As the case was proceeding very slowly, the Center in the fall of 1974 applied for the status of Amicus Curiae with rights of a party, in an attempt to take greater action to assist in the speedy resolution of the lawsuit. However, the Court in its discre-

tion denied such motion. A few months later a settlement agreement was attempted but failed.

Thus, in the spring of 1975 the Attorney General made a motion to intervene as a party plaintiff, based upon the protracted length of time the case had been pending as well as the inadequate discovery which had been accomplished by the plaintiff. The Attorney General acknowledged the ability and willingness of the existing plaintiff to pursue the case, but illustrated to the judge the great advantages of experience and resources which they could add to bring about a resolution of the case. This motion was granted by the court shortly thereafter, and the Attorney General proceeded to do a thorough process of discovery in preparation for trial. In the Center's perception, that was a key factor as the trial began, leading the state immediately to enter serious settlement discussions, resulting in a final court approved consent decree in the fall of 1975. Though there have been problems in its implementation, the presence of the Attorney General to reopen discovery and illustrate deficiencies has greatly aided the situation.

The states and their institutions have long had their own way in dealing with a powerless and voiceless group; adding a meaningful voice to the cause of the handicapped will pose no undue burden or hardships upon those states and institutions. All S.1393 will do is to provide a mechanism in support of rights and conditions which should already exist. The Federal Courts have had the opportunity to hear many of these suits; they have conducted themselves well in enforcing justice. Thus no great burden on the courts is foreseen. In fact the threat of increased litigation could well accelerate the improvement of conditions and the guarantee of equality without the necessity of such litigation.

The National Center for Law and the Handicapped appreciates this opportunity to present its view to the Senate and is available to provide any further input which will aid in the deliberation of this important matter.

[Appendix 4]

PREPARED STATEMENT OF THE NATIONAL COMMITTEE ON PATIENT RIGHTS, IN SUPPORT OF S. 1393, SUBMITTED BY JUDI CHAMBERLIN, CHAIRPERSON

The National Committee on Patient's Rights wholeheartedly supports S. 1393, which would grant standing to the Department of Justice to bring suits against institutions which deprive their inmates of their rights. This bill, by making it possible for inmate grievances to be heard, could make an important difference in the way psychiatric inmates (and other inmates who come within its scope) are treated in institutions that ostensibly exist to provide "care" and "treatment."

The National Committee on Patients' Right came into existence late in 1975, out of concerns about the rights of mental patients being expressed by individuals within the Mental Health Association, the National Institute of Mental Health, and the Mental Health Law Project (among others). The Committee also includes a number of representatives of ex-patient organizations, as well as other ex-patients. Because of its unusual composition, the Committee is in an excellent position to examine the status of patients' rights, not from a single point of view, but from the perspectives of service providers, lawyers, concerned citizens, and service recipients.

What we have seen gives us great cause for concern. We know that the mental hospital system often abuses its patients (and seldom helps them). We know that patients are over-drugged so that they will be docile and manageable, and that the system then justifies this procedure as "treatment." We know that patients who sit in idleness on the wards are listed as receiving "milieu therapy," while patients who labor (often unpaid) in the laundry and kitchen are said to be receiving "industrial therapy." We know that "accidents" to patients are often hidden assaults, and that physically ill patients sicken and die because the medical care in these "hospitals" is inadequate or non-existent. And we know that, as these abuses continue, states proclaim the excellence of their mental health care, and the adequacy of their procedures to protect the rights of inmates.

S. 1393 would allow the Department of Justice, a Federal department free from the political pressures that local officials often face, to investigate reported denials of inmates' rights within institutions. If the investigation indcates that

abuses of rights have occurred, the bill would allow the Department to bring suit. If this bill is passed, and if it is vigorously pursued by the Justice Department, it could shine the brilliant light of publicity onto condtions that most ctizens would prefer to believe have not existed for a hundred years.

As an ex-patient, as a member of various mental patients' liberation organizations over the past six years (currently with Mental Patients' Liberation Front in Boston), and as the Chairperson of the National Committee on Patients' Rights, I am personally familiar with numerous instances of violations of mental patients' rights. Let me enumerate several:

1. Over-drugging occurs so frequently in mental institutions that it has become accepted as therapeutic. While psychiatrists speak of the "anti-psychotic" effects of these drugs, patients complain of being stupefied and disoriented. Investigations would show that "medication" is prescribed with little regard for the individual patient's emotional status or physical health. When patients become aware that they are experiencing not "symptoms" (as the staff tells them) but side-effects, they often try to refuse the drugs, in which case they are forceably injected.

2. "Voluntary" patients, who are often assumed to need fewer protections, are often voluntary in name only. Most state laws provide that "voluntary" patients can leave institutions only after a waiting period, which allows the institution to begin commitment proceedings if it does not agree with the patient's judgment that he or she is ready to leave. In addition, "voluntary" patients often sign in only after they have been threatened with commitment by the hospital authorities, relatives, or police. These pratcices violate the common-sense meaning of the word voluntary. Investigations would show that patients who have been led to believe that they are free to leave have, in fact, been lied to and coerced.

3. The physical and mental abuse of patients permeates the mental health system. Practices that make for smooth institutional management—waking, feeding, and putting patients to bed en masse—continue a process of dehumanization that begins with the designation of a person as "mentally ill." Meaningful human contact within mental institutions is rare; interactions with staff are highly formalized, and patients are taught to fear and distrust one another. Some patients (only investigations will show how many) are systematically beaten, while many more are struck and pushed.

Even those procedures which appear to guarantee that patients' rights will be respected are twisted within mental institutions so that they provide no protection at all. Eleven years ago, when I was a patient in a New York state hospital, a state-mandated sheet of paper listing my rights and instructing me how to get in touch with a state-employed lawyer was handed to me immediately after I had been humiliatingly strip-searched. The unspoken message—that I could be brutalized at the staff's discretion—was far more powerful than the words on the form. And, just last year, a member of Mental Patient's Liberation Front, after a verbal disagreement with a staff member, asked to know the name of the "civil rights officer" that every Massachusetts state hospital is required by law to appoint. "You're not permitted to know that information," he was told by the staff member, making it impossible for him to pursue his grievance.

In the interest of providing independent investigations of the systematic denial of rights to inmates of mental institutions (as well as to the inmates of prisons, institutions for the retarded, juvenile facilities, and old age homes), and legal intervention to stop this denial of rights, the National Committee on Patients' Rights urges the swift passage and implementation of S. 1393.

[APPENDIX 4A]

PREPARED STATEMENT OF WILLIAM W. TREANOR, EXECUTIVE DIRECTOR, NATIONAL ALTERNATIVES PROJECT

My name is William W. Treanor. I've been executive director of National Youth Alternatives since its inception four years ago. NYAP is a public interest group serving the interests of youth and community-based youth service programs. We are pleased to respond to the subcommittee's request for comments on S. 1393 which would authorize the Attorney General to initiate actions in behalf of institutionalized persons.

In spite of a three year implementation of the progressive Juvenile Justice and Delinquency Prevention Act and the growing number of alternative programs in

the country, there is still widespread institutionalization of youth, including status offenders; (age-related crimes: truancy, runaways). In recent years, lawsuits around the country have shown that the treatment of these youths in institutions has been horrendous.[1] This subcommittee is aware of many horror stories about the conditions and procedures many youth must endure in these institutions.

It has been the court's unfortunate duty to become involved in the workings of institutions simply because the legislatures have neglected to provide strict laws that would guarantee humane treatment. For those who are incarcerated, their loss should only be of liberty, not of personal dignity. There are those who believe that, except for a few horror stories, conditions in youth institutions have been very adequate. However, the confinement of a youth in a 6′ by 8′ room, with no reading material, no place to sit, and no visitors, as was commonly practiced only a few years ago in generally progressive New York,[2] is a far cry from adequate. This bill is needed to insure that the humane treatment most Americans assume is practiced in youth institutions is always and everywhere a reality.

In theory, the children in institutions are not there for punishment, but for treatment. The parens patriae doctrine on which the juvenile court system is based, states that the state becomes the parent and will provide the care and support a child needs. Realistically, however, confinement in a youth institution is far from nurturing. Children in institutions are often not treated with care, often not provided with education and usually not provided with a sense of confidence necessary for a healthy, productive adult life.

Since the early seventies, the Justice Department has been involved, as intervenor, or litigating amicus curiae in many cases concerning the constitutional rights of institutionalized persons, including juveniles. It has been the skills, expertise and staying power of the Justice Department that brought these cases to the courtroom, and to the attention of the country. Many of these cases take up years in court: hardly any one attorney, or public interest group can sustain the economic burden of handling such a case. It has been the courts themselves that have asked the Justice Department to intervene, aware that the complexity of a right to treatment case, as well as the need for extensive discovery process, demands the capabilities and resources that only the Justice Department has.

It seems that the Organization of State Attorneys General is providing the main opposition to this bill. It is their contention that this bill interferes with the delicate federal-state balance of citizen protection. This important bill should be passed even if it is the case that this balance may be redefined somewhat. The prime function of the federal government is to carry out the Constitution, which includes protecting the constitutional rights of all citizens, in all states. State Attorneys General are often reluctant to bring their State to trial, especially when such action might include suing a Governor, a possible political ally.

What is most important to remember is that this bill is not written to provide access to the Justice Department for every institutionalized person. The bill is to authorize the Justice Department to instigate suits only when there are involved violations of constitutional rights on a systematic and widespread basis. States which have provided minimum care and treatment for their citizens should not be fearful of the passage of this bill. It is the State's strong opposition of the bill that causes one to wonder and worry about conditions in their various institutions.

Another charge by the State Attorneys General is that Section 2 of the bill provides that adequate notice be given to relevant State officials about the existence of violations of constitutional rights. This requirement, cautioned Attorney General Francis Burch in his statement before the committee, could be satisfied with a mere phone call before filing suit. We do not agree with the image of the Justice Department, ready to pounce on any state with a major suit without providing the state with a certain amount of time to correct its abuses, and avoid court action. However, we do feel that to insure that the im-

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[1] *Morales* v. *Turman*, 356 F. Supp. 166 (E.D. Tex. 1973) a class action suit in Texas recognizing a constitutional right to treatment suit in juvenile institutions. The Court ordered the closing of certain institutions, and minimum standards to be followed in remaining institutions.

Wyatt v. *Stickney*, 325 F. Supp. 701 (M.D. Ala. 1971), a right to treatment suit brought on behalf of mental patients in Alabama.

[2] See *Lollis* v. *New York Department of Social Services*, 322 T. Supp. 473 (S.D.N.Y., 1970). Evidence was presented that this manner of solitary confinement was commonly practiced.

portant responsibilities of the Justice Department will be carried out without conflicts in technical matters, the bill should be amended to set out specific procedures for notice and conciliation.

The bill is especially important to the youths in institutions, for they, more than most, are unable to speak up for their rights. There are many reasons why the juvenile justice system, as originally conceived, remained only a theory. Those reasons are unimportant now as we examine this bill. What is important is that the welfare of these young persons become the main concern, more important than budgets, jobs, expediency or political clout. This bill is necessary to provide that certain constitutional rights are always present for every person.

Again, NYAP commends Senator Bayh for his outstanding concern for the rights of children and other institutionalized persons, and for the opportunity to share our support of S. 1393.

[APPENDIX 5]

PREPARED STATEMENT OF HON. EDWARD I. KOCH, A U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I am very pleased to submit my prepared statement this morning in support of S. 1393, which would grant the Attorney General of the United States authority to institute civil actions on behalf of institutionalized persons who are being denied their constitutional rights. As a concerned citizen, and as a co-sponsor of the House version of this bill, I am pleased that the Senate has begun active consideration of this legislation. I want to commend the Subcommittee Chairman for his leadership in sponsoring these hearings and in focusing public attention on the critical need for addressing the problems of institutionalized Americans.

I am aware that the U.S. Department of Justice has endorsed this legislation, and I believe that in his testimony of June 17, Mr. Drew S. Days III, Assistant Attorney General for the Civil Rights Division, U.S. Department of Justice, detailed the current status of the Department's authority to initiate civil rights cases involving institutionalized persons which necessitates this legislation. Therefore, I will not elaborate on the legal issues involved, but I wish to address two basic concerns. The first area involves my own investigation and a state investigation of two separate New York City Psychiatric Hospitals. I will conclude with a response to the opposition of this bill.

Mr. Chairman, last November I was approached by families whose relatives were institutionalized at Manhattan State Psychiatric Center located on Wards Island in New York City. The relatives were concerned about the poor physical conditions, the lack of adequate medical care and the lack of protection afforded the patients at the facility.

As a result of those discussions, on November 4, 1976, my staff and I conducted an unannounced on-site inspection of the facility.[1] The conditions I found there were deplorable. The total lack of security complained of by the relatives was evidenced by my ability to enter the island and the facility without encountering a single security or staff person until I was actually on one of the wards. We were taken to where the patients slept. The floor was filthy with dust and ants. Mattresses were strewn about the room, most of them lacking sheets and blankets. It was clear that the patients were not provided any individual privacy. There was no privacy provided in the bathroom facilities. The three toilet stalls in the bathroom were used by both men and women waiting in the same lavatory, and two stalls did not even have any curtain or door. In addition, there was no soap available for washing. The staff informed us that there was a chronic shortage of clothing and that the patients received a change of clothing only once a week. Many of the pieces of clothing that were distributed were basically rags.

Following the visit, on November 8 I wrote a 6-page, 63 question letter to Dr. Lawrence Kolb, Commissioner of the Department of Mental Hygiene for the State of New York who is responsible for overseeing the facility. I am making available for the record a copy of that letter, the response and the attached memorandum which I received from Regional Director Alvin Mesnikoff dated

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[1] See Appendix 6, p. 942.

November 23, 1976.[2] Subsequently, I made his response available to the Manhattan State Citizen Group which had originally approached me and I asked them for their comments. The Citizens Group provided me with a detailed response, which I am also submitting for the record, outlining the many areas of the Director's response with which the group took strong exception.[3] I want to bring this citizen's group memorandum to your special attention because it highlights very basic problems at the institution. The New York State Department of Mental Hygiene has in effect admitted to the existence of several of those problems, including the fact that violent patients are not separated from other patients and the fact that patients are allowed to leave the hospital freely without significant attempts to stop them or subsequently locate them and return them to the institution. The citizens also raised some additional facts and questions concerning the facility which led me to the conclusion that the State was not willing to take action or to meaningfully confront the conditions existent at the facility.

Because I was so concerned with the situation, I then wrote to the Mental Health Administration within the Federal Department of Health, Education and Welfare and requested that they undertake an investigation of the facility. My letter to Administrator James D. Isbiter, the responses from H.E.W., and the reports which were the result of the H.E.W. investigation are also appended for the benefit of the Subcommittee.[4] Briefly, H.E.W.'s investigation confirmed my own findings. Their investigators also found the facility unclean and improperly supervised. It should be noted that even after the H.E.W. investigation, the conditions have not significantly improved. Evidence of that are the reports which appeared in the *New York Post* of Monday, May 16, 1977, and Tuesday, May 17, 1977, copies of which I am appending.[5] One graphic sentence from the May 16th article reads as follows:

"The 1500 mental patients at Manhattan State Hospital live under constant threat of murder, rape, assault and theft because of inadequate security."

The *Post* cited hospital records which show 3 rapes, 38 assaults, 42 patient fights, 24 injuries, and 93 patient escapes in the single month of April, 1977. Additionally, the paper went on to cite many specific incidents of violence and assaults which need not be spelled out here. The deplorable fact is that the inhumane conditions still exist.

Mr. Chairman, I am not a mental health expert, but one need not be a doctor to know that the basic purpose of an institution such as Manhattan State is that of providing the patients with treatment. The lack of cleanliness, the lack of adequate clothing and the lack of privacy all contribute to patient's problems not their treatment. Our institutions are in fact exacerbating the problems of their patients rather than treating them and making the patients better.

Furthermore, it is clear to me that the State of New York and the hospital itself were not responsive to the legitimate concerns of staff and of the relatives of the patients. These relatives then turned to their Congressman. Even the investigation of a U.S. Congressman did not alleviate or ameliorate the situation. I am providing this history to illustrate my concern that without passage of S. 1393 there are no meaningful options for persons seeking to enforce basic human rights of institutionalized citizens. If there is to be appreciable change in the conditions at Manhattan State Hospital and similar institutions, the patients and their relatives, the hospital staff and heir Representatives in Congress have to be able to turn to th U.S. Department of Justice.

Since the time of my investigation of the Manhattan State Psychiatric Center, another incredible situation at a New York City Institution has been brought to my attention. On June 9, 1977, the New York State Commission on Investigations completed a thorough inquiry into the deaths of five patients and the beating of a sixth at the Bronx Psychiatric Center (BPC).

In 1975, four patients died under questionable circumstances at BPC. Within a one-month period in 1976, two additional deaths occurred after an unusual sequence of events. As a result of these incidents, an investigation was called for by a citizen Board of Visitors. Let me cite some examples from the resulting

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[2] See Appendixes 7 and 8, pp. 962 and 964.
[3] See Appendix 9, p. 969.
[4] See Appendixes 10, 11, and 12, pp. 976 and 977.
[5] See Appendixes 18 and 19, pp. 993 and 994.

Commission report: One female patient had been forcibly beaten. Her injuries included four fractures of her right arm, the fracture or dislocation of six to eight ribs, as well as extensive lung and internal injuries.

Another patient was critically injured when a patient with a history of violent behavior struck him on the head with a broom obtained from a supposedly-locked supply closet. The injured patient was forced to wait, for a prolonged period after the ambulance had arrived, while paperwork for his transfer was being filled out. The report indicates that doctors stated that the man's life might have been saved had he received prompt treatment.

The report outlines case after case of patient abuse and neglect. One woman's record gave no evidence that she had ever received any appropriate psychiatric treatment before her reported suicide. Another young man, hospitalized from his youth because of epileptic seizures, received inappropriate medication for his condition. On June 24, 1976, this patient had a seizure which lasted for several hours. He was described as being " on the floor of his room, blue and sweating, incoherent and biting a rag." During this time no doctors were ever called nor was any attempt made to seek emergency aid. It was not until his mother came to visit him that evening, to find him unconscious on the floor, that a doctor was called. Attempts to revive him were futile. Autopsy reports showed that this patient had received medication, Haloperidol, which in the words of Dr. Michael M. Baden, Deputy Chief Medical Examiner of New York, "can precipitate this type of seizure." Dr. Baden stated "he would not have died," if he had not received Haloperidol which had not been prescribed for him.

This is not the only instance of misuse of drugs in the treatment of patients. Under questioning, Dr. Hugh F. Butts, Director of the hospital, admitted:

"We use medication rather extensively, but there again, I don't think we are using medications as appropriately as we might. I think in many instances we either overmedicate or undermedicate patients."

The Investigative Commission reporting on the deaths summarized:

"In each of the cases scrutinized, the Commission found that little had been done to prevent the incident and that after the incident, BPC (Bronx Psychiatric Center) failed to respond adequately and to take essential corrective measures. . . ."

It is discouraging and frustrating to all those involved that even when these facts are made known to hospital administrators and state officials, there is little effective action being taken. The situations described remain generally unchanged. Furthermore, I believe that the abuses outlined may indicate a pattern of patient abuse and lack of treatment in other New York City institutions run by the State of New York.

I would now like to address some of the arguments made against this bill. There are those who argue that this bill would result only in long and expensive litigation. I do not agree. In the first place, the bill would give the Attorney General authority to bring suit only in those situations where the violation of constitutional rights is definite and clear and where there exists a pattern and practice of deprivation of rights. This combined with the complexity of investigating and initiating cases would insure that lawsuits would not be initiated without substantial basis. Litigation might also be avoided in some situations where a state makes an appropriate response to the notice of the Justice Department that a pattern and practice of violation of constitutional rights exists at a state institution. Finally, the State may avoid the protracted procedures of trials and hearings by a "consent decree" at any point in the litigation process. This mutual agreement is not only a cooperative way of abbreviating the legal process, but is a desirable solution for states that are sincere about improving the conditions for institutionalized persons.

There are those who argue that Public Interest groups can sufficiently represent the interests of persons confined in institutions in which constitutional rights are being violated. However, while action taken by citizen groups on behalf of confined fellow citizens is highly commendable, there are far too few of these groups. Those advocate groups which do exist and may be very vocal, are lacking both in the resources and the authority to initiate and carry out effective investigations and litigation.

I ask of those people who are opposed to this bill . . . Why do we see no results from the non-litigative solutions we have pursued for so long? Why is it that those individuals who have the responsibility will not take appropriate action even when the conditions at these hospitals are made known to them?

Quite frankly, Mr. Chairman, I am unimpressed with the arguments of those who believe that the Attorney General of the United States does not have a basic obligation to intervene on behalf of individuals whose basic rights are being denied, even when they are being denied by one of the 50 states. It is central to my own conception of federal/state relations that one of the primary functions of federal government must be to insure that basic principles of human dignity and individual freedom embodied in the Federal Constitution are not restricted by any state or person. I do not believe that states rights include the right to run institutions which do not provide the institutionalized person with his or her basic constitutional rights.

I would like to believe that the Attorney General of each state has made every effort to assure that persons confined in state institutions are afforded the full panoply of state and federal statutory and constitutional rights. However, I must cite as an example to the contrary, my own state of New York where the State Attorney General has failed to take aggressive action to bring relief and where the deplorable conditions are permitted to continue. In addition to my own attempts to bring these matters to the attention of the State of New York, the investigations of H.E.W., the appeals by families of patients and the actions taken by citizen groups have all been consistently ignored by New York State authorities. And now, in the midst of this, the New York State Attorney General Louis Lefkowitz has taken it upon himself to lead the fight against this bill by saying that it is unnecessary. This is incredible to me. What hypocrisy it would be for this legislation to be defeated on the basis asserted by Mr. Lefkowitz when there has been no change in the deplorable conditions which I have outlined to you at two of New York State's own institutions despite appeals to the officials of the State.

I have requested by letter of June 16, 1977 to Assistant Attorney General Days that he undertake a thorough investigation of Manhattan Psychiatric Center, Bronx Psychiatric Center and Creedmore State Hospital which is under investigation by the Queens County, New York District Attorney because of allegations of patient abuse.[6] At present, Mr. Days on behalf of the Attorney General, can authorize an F.B.I. investigation into situations which present potential criminal violations of civil rights. However, the authority of the Justice Department to initiate civil litigation in situations involving gross denials of institutionalized persons civil rights has been successfully challenged in two cases. The Department's ability to intervene in actions filed by individual plaintiffs has also been under attack.

The passage of S. 1393 would clarify the Department of Justice's authority to intervene and more importantly it would give the Department the right to initiate its own suits where the Attorney deemed such action was required in situations which constitute a pattern and practice of deprivation of civil rights. I have outlined today why such statutory authority is essential and I trust the Congress will act expeditiously to guarantee confined persons basic human and constitutional rights.

Mr. Chairman, I appreciate the opportunity to testify this morning, and I urge the adoption of S. 1393. Thank you.

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[6] See Appendix 13, p. 978.

[APPENDIX 6]

U.S. GOVERNMENT PRINTING OFFICE 1975—

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved.
OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER NUMBER (X1)

FACILITY: Manhattan Psychiatric Center

DATE SURVEY COMPLETED (X2) 2-10-77

STREET ADDRESS, CITY, STATE, ZIP CODE: Meyer Building - Wards Island, N.Y. 10035

NOTE: This document contains a listing of the deficiencies cited by the surveying State Agency as requiring correction. This Summary Statement of Deficiencies is based on the surveyor's professional knowledge and interpretation of Medicare and/or Medicaid requirements. In the column Provider's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time for correction. Copies of this form will be kept on file at local Social Security and Public Assistance Offices, to be made available to the public, upon request.

(X3) SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	(X4) PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
J. Shuckerow - Sr. Hos. Admin. Consultant	
II Governing Body and Management 405.1021 (g)Standard: Administrator Duties 148 Due to the number and nature of the deficiencies found on this survey the means of accountability established by the administrator on the part of his subordinates are either ineffective or non-existant.	RECEIVED APR 8 1977 MEDICARE PROGRAM COORDINATION
IV Medical Staff 405.1023 (a)Standard: Responsibilities Toward Policies 106 Medical staff by-laws are not being adhered to as designated committees are not functioning or functioning without required medical and/or other professional staff representation. Some committee records do not verify that committee meetings are attended by the majority of committee members.	
(n)Standard: Medical Records Committee 173 There is no documentation that medical records personnel are doing on-the-spot scanning on the patient units of current inpatient records for completeness.	
176 There is no documentation, with confirmation by the Deputy Director, that the committee is making recommendations to the medical staff for the approval of, use of, and any changes in form or format of the medical record.	
	PROVIDER REPRESENTATIVE'S SIGNATURE — DATE (X5)

Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. The asterisk means that the surveying State Agency has recommended that the deficiency be waived for this reason. If the State Agency recommendation has been [illegible]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Continuation Sheet

DATE SURVEY COMPLETED: 2-10-77

NAME OF FACILITY AND PROVIDER NUMBER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manhattan Psychiatric Center	Meyer Building - Wards Island, N.Y. 10035

Item	SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
	Several coed wards do not have adequate signs differentiating male and female bathrooms.	
	There is a total compliment of 43 security officers plus 3 vacant positions. This includes 5 supervisory personnel, 3 officers on children's Hospital payroll and 4 stationed in the outpatient clinics, with the balance of 31 officers covering the entire hospital complex. There is no control as to who may enter the grounds. The security booth at the main entrance is unmanned. Although wards are locked and require a pass key, anyone may enter the buildings and walk around unescorted, posing a hazard to the safety and well-being of all persons at the facility.	
A73	Adequate floor space per bed is not provided. According to the engineer's plans, dorms provide less than 42 sq. feet per bed and side rooms provide 80 sq. feet bed for single rooms, and approx. 40 sq. feet 1 bed for doubles.	
A74	The emergency generator covers only half of each building plus elevators. There is no emergency lighting in stairwells that are in half of each building not serviced by the generator.	
A79	Although needles and syringes are clipped and returned to Central Supply, they are disposed of	

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10 OF 12

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OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 2-10-77

NAME OF FACILITY AND PROVIDER NUMBER: Manhattan Psychiatric Center

STREET ADDRESS, CITY, STATE, ZIP CODE: Meyer Building - Wards Island, N.Y. 10035

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION		PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
Item	along with other garbage. All infectious wastes must be incinerated.	
A82	Responsibility for supervision and training of housekeeping personnel has not been designated to one person. Ward aides are responsible for cleaning on their own wards and are under that ward's unit chief's direction, resulting in inadequate supervision and training.	
	(c)Standard: Sanitary Environment	
A93	The infection control committee does not review such procedures as food handling, laundry practices, disposal of environmental and patient wastes, routine culturing of autoclaves and sterilizers, etc. No minutes for meetings are available. The "Infection Control and Prevention Manual" has not been reviewed since 12/75 and contains many non-applicable and out-dated procedures. (e.g. it includes areas no longer in existence).	
A94	Although sterile supplies are supposedly reprocessed at the end of each month, there is no such written policy.	
A97	The continuing education program is very fragmented. Although recently centralized, in-service education is still performed (though not consistently documented) by unit chiefs, by department heads and by the Central Education Training Dept. As a result, ward housekeeping personnel are inadequately trained, as evidenced by poor cleaning techniques	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 2-10-77

NAME OF FACILITY AND PROVIDER NUMBER: Manhattan Psychiatric Center

STREET ADDRESS, CITY, STATE, ZIP CODE: Meyer Building - Wards Island, N.Y. 10035

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION		PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
Item		
	and poor conditions on many wards. More control and interdepartmental planning and coordination is necessary to ensure adequate and appropriate training, and the continuing education of all personnel, but particularly of housekeeping.	
A98	As far as can be determined by the surveyor, the only hospital employees monitored for infections are the dietary personnel. There does not appear to be any such process for those employees in contact with patients or their laundry.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 2-10-77

NAME OF FACILITY AND PROVIDER NUMBER: Manhattan Psychiatric Center

STREET ADDRESS, CITY, STATE, ZIP CODE: Meyer Building - Wards Island, N.Y. 10035

Item	SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
A218	(f)Standard: Qualifications not met	
A219	Promotions are determined through personnel at the recommendation of the unit chief. The Director of Nursing service has no authority to evaluate personnel or recommend promotion.	
A221	Functions of nursing personnel are not clearly defined and differ from unit to unit.	
A224	RN's are oriented only if time is made available by the unit chief. (g)Standard Working Relationships	
A227	Interdepartmental policies affecting nursing are not made jointly with the direction of nursing service. There is no committee structure to provide formal nursing input. The DNS can only recommend and suggest.	
A229	(h)Standard: Evaluation and Review of Nursing Care. not met	
A230	Nursing Policies and procedures are written, however, they are only recommendations. Unit chiefs enforce their own policies.	
A231	Nursing care is not planned or supervised by RN's in many instances.	

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NAME OF FACILITY AND PROVIDER NUMBER: Manhattan Psychiatric Center

STREET ADDRESS, CITY, STATE, ZIP CODE: Meyer Building - Wards Island, N.Y. 10035

Item	SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
A232	Nursing care plans lack sufficient professional nursing input.	
A233	Nursing notes are primarily written by mental health therapy aides and do not reflect significant observations.	
III	Physical Environment (405.1022) (a)Standard: Buildings.	
A70	Housekeeping throughout the building is poor. Floors are not swept prior to mopping, resulting in dirt being mopped back and forth, leaving streaks. Mops are left in buckets of dirty water and several push brooms are very dusty. Floors under beds and recessed radiators have heavy accumulations of dust. Many window screens are dusty or missing; many light covers are missing; many window curtains are torn, dirty or missing entirely. Bathroom sinks, stalls, cubicle curtains and toilet bowls are dirty and in many instances a curtain or stall door is completely missing or does not latch properly. Many stalls are missing toilet tissue and toilet seats. Several seclusion rooms contain uncovered foam mattresses, which are stained and odorous. Fans and exhaust vents throughout are dusty. Treatment rooms and utility rooms are dusty. Several refrigerators in treatment rooms need a thorough cleaning.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 2-10-77

NAME OF FACILITY AND PROVIDER NUMBER: Manhattan Psychiatric Center

STREET ADDRESS, CITY, STATE, ZIP CODE: Meyer Building - Wards Island, N.Y. 10035

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION		PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
	VII Medical Records Department 405.1026	
	(c) Standard: Personnel	
A281	The facility does not employ a full-time registered records administrator nor a qualified ART. The consultant from central office is not visiting frequently enough to organize the department, train personnel, and evaluate the records and the operation of the department.	
A305	All definitive final diagnosis are not being recorded in terminology of a recognized system of disease nomenclature.	
A192	V Nursing Department (405.1024) not met.	
A194	a) Standard: Organization not met.	

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SOCIAL SECURITY ADMINISTRATION

Form Approved.
OMB No. 72-R0931.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Continuation Sheet

DATE SURVEY COMPLETED: 2-10-77

NAME OF FACILITY AND PROVIDER NUMBER: Manhattan Psychiatric Center

STREET ADDRESS, CITY, STATE, ZIP CODE: Meyer Building - Wards Island, N. Y. 10035

Item	SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
	There is no administrative delineation of authority The direction of Nursing Services functions in a staff position with no control over staffing.	
A195	b)Standard: Licensed Registered Professional Nurse: not met Registered professional nurses are not available on a 24 hour basis for all patients. Time sheets show uneven distribution and deployment of personnel in nursing.	
A209	a)Statutory requirement not met There are periods without an RN or LPN on duty in various units.	
A210	Staffing patterns show uneven distribution of personnel with many days of inadequate coverage.	
A212	The ratio of registered professional nurses to patients indicates lack of supervision as evidenced by day rooms left without staff supervision.	
A213	Care is assigned by the unit chief or deputy unit chief. Assignments are made unevenly with varying numbers of personnel available from day to day.	
A214	(d)Standard: Other nursing personnel not met Nursing personnel daily assignment varies from 4 RN's and 31 aides for the entire facility (2/6/77) to 14 RN's and 92 therapy aides (2/10/77). This deployment leaves many wards uncovered.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER NUMBER (X1) 33-4018

FACILITY: Manhattan Psychiatric Center

DATE SURVEY COMPLET (X2) 2/10 - 3/18/7

STREET ADDRESS, CITY, STATE, ZIP CODE: Dunlap Building - Wards Island, New York

NOTE: This document contains a listing of the deficiencies cited by the surveying State Agency as requiring correction. This Summary Statement of Deficiencies is based on the surveyor's professional knowledge and interpretation of Medicare and/or Medicaid requirements. In the column Provider's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time for correction. Copies of this form will be kept on file at local Social Security and Public Assistance Offices, to be made available to the public, upon request.

(X3) SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	(X4) PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
Team Members:	

J. Shuckerow, Sr. Hospital Administrator
Marianne Carrera, Hospital Nursing Services Consultant
Irene E. Atwell, Public Health Social Work Consultant
Sheri Samuels, Environmentalist

II. Governing Body & Management - 405.1021

(g) Standard: Administrator Duties

1. A48 Due to the number and nature of the deficiencies found on this survey, the means of accountability established by the administrator on the part of his subordinates are either ineffective or nonexistant.

IV. Medical Staff 405.1023

(a) Standard: Responsibilities Toward Policies

2. A106 Medical staff by-laws are not being adhered to as designated committees are not functioning or functioning without required medical and/or other professional staff representation. Some committee records do not verify that committee meetings are attended by the majority of committee members.

3. A168 (n) Standard: Medical Records Committee

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PROVIDER REPRESENTATIVE'S SIGNATURE | DATE (X5)

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. The asterisk means that the surveying State Agency has recommended that the deficiency be waived for this reason. If the State Agency recommendation has been accepted, this will be noted in the right hand column opposite the deficiency statement.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved.
OMB No. 72-R0731

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 2/10 - 3/18/77

NAME OF FACILITY AND PROVIDER NUMBER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manhattan Psychiatric Center	Dunlap Building - Wards Island, New York

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
The committee has not functioned in six months.	
4. <u>A274 VII. Medical Records Department - 405.1026</u>	
(c) Standard: Personnel	
5. A281 The facility does not employ a full-time registered records administrator nor a qualified ART. The consultant from central office is not visiting frequently enough to organize the department, train personnel, and evaluate the records and the operation of the department.	
6. A305 All definitive final diagnoses are not being recorded in terminology of a recognized system of disease nomenclature.	
7. A314 (j) Standard: Promptness of Record Completion	
8. A317 Records of discharged patients are not completed within 15 days following discharge. On last day of survey (3/18/77), there were 73 delinquent records.	

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FORM SSA-2567A (6-73)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 2/10 - 3/18/77

NAME OF FACILITY AND PROVIDER NUMBER: Manhattan Psychiatric Center

STREET ADDRESS, CITY, STATE, ZIP CODE: Dunlap Building - Wards Island, New York

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
9. A192 V. Nursing Department (405.1024) Not met	
10. A194 (a) Standard: Organization Not met	
There is no administrative delineation of authority. The director of Nursing Services functions in a staff position with no control over staffing.	
11. A195 (b) Standard: Licensed Registered Professional Nurse Not met	
Registered professional nurses are not available on a 24-hour basis for all patients. Time sheets show uneven destribution and deployment of personnel in nursing.	
12. A209 (a) Statutory Requirement Not met	
There are periods without an RN or LPN on duty in various units.	
13. A210 Staffing patterns show uneven destribution of personnel with many days of inadequate coverage.	
14. A212 The ratio of registered professional nurses to patients indicates lack of supervision as evidenced by day rooms left without staff supervision.	
15. A213 Care is assigned by the unit chief or deputy unit chief. Assignments are made unevenly with varying numbers of personnel available from day to day.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 2/10 - 3/18/77

...ME OF FACILITY AND PROVIDER NUMBER: ...nhattan Psychiatric Center

STREET ADDRESS, CITY, STATE, ZIP CODE: Dunlap Building - Wards Island, New York

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
16. A214 (d) Standard: Other nursing personnel - Not ...t	

Nursing personnel daily assignment varies from 4 R.N.'s ...d 34 aides for the entire facility (2/6/77) to 14 R.N.'s ...d 79 therapy aides (2/10/77). This deployment leaves ...ny wards uncovered.

17. A218 (f) Standard: Qualifications Not Met

18. A219 Promotions are determined through personnel ... the recommendation of the unit chief. The Director of ...rsing service has no authority to evaluate personnel or ...commend promotion.

19. A221 Functions of nursing personnel are not ...early defined and differ from unit to unit.

20. A224 RN's are oriented only if time is made avail...le by the unit chief.

(g) Standard: Working Relationships

21. A227 Interdepartmental policies affecting nursing ...e not made jointly with the director of nursing service. ...ere is no committee structure to provide formal nursing ...put. The DNS can only recommend and suggest.

22. A229 (h) Standard: Evaluation and Review of ...rsing Care Not Met

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Continuation Sheet

DATE SURVEY COMPLETED: 2/10 - 3/18/77

NAME OF FACILITY AND PROVIDER NUMBER: Manhattan Psychiatric Center

STREET ADDRESS, CITY, STATE, ZIP CODE: Dunlap Building - Wards Island, New York

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
23. A230 Nursing policies and procedures are written, however, they are only recommendations. Unit chiefs enforce their own policies. 24. A231 Nursing care is not planned or supervised by RN's in many instances. 25. A232 Nursing care plans lack sufficient professional nursing input. 26. A233 Nursing notes are primarily written by mental health therapy aides and do not reflect significant observations.	

Form SSA-2567A (4-73) 1. DO

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SOCIAL SECURITY ADMINISTRATION

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OMB No. 72-R09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 2/10 - 3/18/77

NAME OF FACILITY AND PROVIDER NUMBER: Manhattan Psychiatric Center

STREET ADDRESS, CITY, STATE, ZIP CODE: Dunlap Building - Wards Island, New York

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
III. Physical Environment (405.1022) (a) Standard: Buildings 27. A70 Housekeeping throughout the building is poor. Floors are not swept prior to mopping, resulting in dirt being mopped back and forth, leaving streaks. Mops are left in buckets of dirty water. Floors under beds and recessed radiators have heavy accumulations of dust. Many window screens are dusty or missing; many light covers are missing, many window curtains are torn, dirty or missing entirely. Bathroom sinks, stalls, cubicle curtains and toilet bowls are dirty and in many instances a curtain or stall door is completely missing or does not latch properly. Many stalls are missing toilet tissue. Wet linen was observed on the floors of several shower rooms, due to shortage of towels. Fans and exhaust vents throughout are dusty. Treatment rooms and utility rooms are dusty. Several seclusion rooms have foam mattresses without covers and are stained and odorous. Several co-ed wards do not have adequate signs differentiating male and female bathrooms. There is a total compliment of 43 security officers plus 3 vacant positions. This includes 5 supervisory personnel, 3 officers on children's hospital payroll and 4 stationed in the outpatient clinics, with the balance of 31 officers covering the entire hospital complex. There is no control as to who may enter the grounds. The security booth at the main entrance is unmanned. Although	

955

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 2/10 - 3/18/77

NAME OF FACILITY AND PROVIDER NUMBER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manhattan Psychiatric Center	Dunlap Building - Wards Island, New York

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
wards are locked and require a pass key, anyone may enter the buildings and walk around unescorted, posing a hazard to the safety and well-being of all persons at the facility.	
28. A73 Adequate floor space per bed is not provided. Based on the engineer's floor plans, dorms provide from 48 to 119 square feet per bed; small side rooms approximately 72 sq. ft./bed.	
29. A74 The emergency generator covers only half of each building plus elevators. There is no emergency lighting in stairwells that are in the half of each building not serviced by the generator.	
30. A79 Although needles and syringes are clipped and returned to Central Supply, they are disposed of along with other garbage. All infectious wastes must be incinerated.	
31. A82 Responsibility for supervision and training of housekeeping personnel has not been designated to one person. Ward aides are responsible for cleaning on their own wards and are under that ward's unit chief's direction, resulting in inadequate supervision and training.	
(c) Standard: Sanitary Environment	
32. A93 The infection control committee does not review such procedures as food handling, laundry practices, disposal of environmental and patient wastes, routine culturing of autoclaves and sterilizers, etc. No minutes	

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SOCIAL SECURITY ADMINISTRATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED
2/10 - 3/18/77

NAME OF FACILITY AND PROVIDER NUMBER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manhattan Psychiatric Center	Dunlap Building - Wards Island, New York

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE

for meetings are available. The "Infection Control and Prevention Manual" has not been reviewed since 12/75 and contains many non-applicable and out-dated procedures. (e.g. it includes areas no longer in existence)

33. A94 Although ~~[illegible]~~ STERILE supplies are supposedly reprocessed at the end of each month, there is no such written policy.

34. A97 The continuing education program is very fragmented. Although recently centralized, in-service education is still performed (though not consistently documented) by unit chiefs, by department heads and by the Central Education Training Department. As a result, ward housekeeping personnel are inadequately trained, as evidenced by poor cleaning techniques and poor conditions on many wards.

More control and interdepartmental planning and coordination is necessary to ensure adequate and appropriate training, and the continuing education of all personnel, but particularly of housekeeping.

35. A98 As far as can be determined by the surveyor, the only hospital employees monitored for infections are the dietary personnel. There does not appear to be any such process for those employees in contact with patients or their laundry.

FORM SSA-2567A (8-73)

1. DO

957

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SOCIAL SECURITY ADMINISTRATION

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OMB No. 72-R0931

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER NUMBER (X1) 33-4037

FACILITY: Manhattan Psychiatric Center - Kirby Bldg.

DATE SURVEY COMPLETED (X2) 3/18/77

STREET ADDRESS, CITY, STATE, ZIP CODE: Wards Island, New York 10035

NOTE: This document contains a listing of the deficiencies cited by the surveying State Agency as requiring correction. This Summary Statement of Deficiencies is based on the surveyor's professional knowledge and interpretation of Medicare and/or Medicaid requirements. In the column Provider's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time for correction. Copies of this form will be kept on file at local Social Security and Public Assistance Offices, to be made available to the public, upon request.

(X3) SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	(X4) PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
II. Governing Body 405.1021 A42 (g) Standards: Administrator Duties. Due to the number and nature of the deficiencies found on this survey, the means of accountability established by the Administrator on the part of his subordinates are either ineffective or non-existant.	
IV. Medical Staff- 405.1023 A105(a) Standard: Responsibilities toward Policies A106- Medical staff by-laws are not being adhered to as designated committees are not functioning or functioning without required medical and/or other professional staff representation. Some committee records do not verify that committee meetings are attended by the majority of committee members.	RECEIVED APR 19 1977 MEDICARE PROGRAM COORDINATION
A274- VII- Medical Records Department 405.1026 A280 (c) Standard: Personnel The facility does not employ a full-time qualified medical records administrator or qualified technician. The consultant's time is inadequate. A290- A314 Medical records are not being completed within 15 days of discharge.	PROVIDER REPRESENTATIVE'S SIGNATURE — DATE (X5)

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. The asterisk means that the surveying State Agency has recommended that the deficiency be waived for this reason. If the State Agency recommendation has been accepted, this will be noted in the right hand column opposite the deficiency statement.

FORM SSA-2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Continuation Sheet

DATE SURVEY COMPLETED: 3/18/77

NAME OF FACILITY AND PROVIDER NUMBER: Manhattan Psychiatric Center- Kirby Bldg.

STREET ADDRESS, CITY, STATE, ZIP CODE: Wards Island, New York 10035

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
A295- All final diagnoses are not being indexed according A305- to a recognized nomenclature.	
A192- V. Nursing Department (405.1024) Condition not met.	
A194- Standard Organization- Not Met. There is no administrative delineation of authority. The Director of Nursing Service (acting) functions in a staff position with no control over staffing.	
A195- Standard Licensed Registered Professional Nurse- Not met. Registered professional nurses are not available on a 24-hour basis for all patients. Time sheets show uneven distribution and deployment of personnel in nursing. Staff on day shift varies from 4 RN's- 52 aides on 2/6 to 16 RN's- 113 aides on 2/10.	RECEIVED APR 19 1977 MEDICARE PROGRAM COORDINATION
A209- Statutory requirement not met. There are periods without an RN or LPN on duty in various units.	
A210- Staffing patterns show uneven distribution of personnel with many days of inadequate coverage.	
A212- The ratio of RN's to patients indicates lack of supervision as evidenced by day rooms left unattended.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Continuation Sheet

DATE SURVEY COMPLETED: 3/18/77

NAME OF FACILITY AND PROVIDER NUMBER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manhattan Psychiatric Center- Kirby Bldg.	Wards Island, New York 10035

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
A213- Care is assigned by the unit chief or deputy unit chief. Assignments are made unevenly with varying numbers of personnel available from day to day.	
A214- Standard: Other nursing personnel not met. Personnel assignments do not provide even coverage and supervision.	
A218- Standard: Qualifications- Not met.	
A219- The director of nursing has no authority to evaluate personnel or recommend promotion.	
A220- The acting director of nursing does not have an advanced degree.	
A221- Functions of nursing personnel are not clearly defined and differ from unit to unit.	
A222- The procedure for following current licensure is not adhered to. Several are not up to date. One folder has an expired permit.	
A224- RN's are oriented only if time is made available by the unit chief.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
Continuation Sheet

DATE SURVEY COMPLETED: 3/18/77

NAME OF FACILITY AND PROVIDER NUMBER: Manhattan Psychiatric Center- Kirby Bldg.

STREET ADDRESS, CITY, STATE, ZIP CODE: Wards Island, New York 10035

SUMMARY STATEMENT OF DEFICIENCIES NOTED BY SURVEYING STATE AGENCY WITH REFERENCE CITATION	PROVIDER'S PLAN OF CORRECTION WITH TIME TABLE
Standard: Working Relationships. A227- Interdepartmental policies affecting nursing care are not made jointly with the Director of Nursing Service. There is no committee structure to provide formal nursing input. A229- Standard: Evaluation and Review of Nursing Care- Not Met. A230- Nursing policies and procedures are written, however, they are only recommendations. A231- Unit chiefs enforce their own policies. Nursing care is not planned or supervised by RN's in many instances. A232- Nursing care plans lack sufficient professional input. A233- Nursing notes are written primarily by MHTA's and do not reflect significant observations.	RECEIVED APR 19 1977 MEDICARE PROGRAM COORDINATION

FORM SSA-2567A (8-73)

[APPENDIX 7]

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., November 8, 1976.

Dr. LAWRENCE KOLB,
Commissioner, Department of Mental Hygiene, Albany, N.Y.

DEAR DR. KOLB: On November 4, I paid an unannounced visit to Manhattan State Hospital. I found the visit to be very interesting and highly informative. In order for me to better understand the situation at the hospital, I would appreciate your providing me with responses to the following questions and observations.

I. PATIENT POPULATION COSTS

1. What is the daily cost per patient at Manhattan State, and the daily cost per patient at comparable state facilities?
2. In what proportion is the funding of Manhattan State by Federal sources? State sources?
3. What was the patient population of Manhattan State in each of the following: January 1–March 31, April 1–June 30, and July 1–September 30 of this year?
4. What was the total number of patients enrolled in the calandar year 1975? the number to date in 1976?
5. What is the maximum capacity of the institution?
6. What percentage of patients are voluntarily admitted, and what percentage are involuntarily admitted?
7. Of those patients involuntarily admitted, what percentage are admitted by a certificate signed by two physicians (2PC), and what percentage are admitted as a result of a court order?
8. Since January 1 of 1975, what would you estimate to be the percentage of patients admitted who have a history of having committed some acts of violence, either to themselves or to others?
9. Are patients with such a "violent" history separated from those without one?
10. If not, why not?
11. And if so, at what point in the admission procedure are they separated?
12. And if so, how many wards, and how many bed sare allocated to "violent" patients, and how many wards, and how many beds are allocated to "non-violent" patients?
13. Of those allocated to each category, how many wards and how many beds are actually being utilized by each, at this time?

I was surprised to learn that for the most part, patients, whether they are deemed violent or non-violent, and whether they are voluntarily, or involuntarily admitted, are permitted to leave and return to the institution at will.

II. PROCEDURES REGARDING PATIENTS' RIGHTS TO COME AND GO FROM THE INSTITUTION

1. What is the general policy for patients leaving the institution, for short periods of time?
2. Within this policy, are distinctions drawn between those voluntarily admitted and those involuntarily admitted? between those with "violent" histories and those without?
3. And if these distinctions exist, what are they?
4. And if these distinctions do not exist, why not?
5. What policy is practiced at the proprietory and voluntary institutions in permitting patients to leave and return under the above circumstances?
6. With respect to the voluntarily admitted patients at Manhattan State, how many, in the calendar years 1975, and 1976 to date, left the institution without prior institution consent?
7. Of these voluntary patients, how many did not return?
8. With respect to involuntarily admitted patients at Manhattan State, how many, in the calendar years 1975, and 1976 to date, left the institution without prior institution consent?
9. Of these involuntary patients, how many did not return?

10. What is the general procedure for locating these patients who do not return so as to bring them back to the institution?
11. Within this procedure, are distinctions drawn between those voluntarily admitted, and those involuntarily admitted?
12. And if these distinctions exist, what are they?
13. Are the police authorities notified of these patients' disappearance?
14. Of those on leave without consent (LWOC) in 1975, and in 1976 to date, how many were never located?
15. Is it a fact that a voluntarily admitted patient absent without consent is deemed as discharged after three days and no longer carried on the absent without leave rolls?
16. Is it a fact that an involuntarily admitted patient absent without consent is deemed as discharged after 45 days and no longer carried on the absent without leave rolls?
17. Of the patients who left without consent since January 1, 1975, how many committed crimes while away from the institution? and what was the nature of these crimes?

I was informed during my visit that the hospital staff are not permitted to search patients for contraband (drugs, alcohol, weapons, etc.), even those who return to the institution after having left the premises.

III. POLICIES REGARDING THE SEARCHING OF PATIENTS FOR CONTRABAND

1. Is it indeed a fact that patients are not permitted to be searched by staff for contraband?
2. And if so, what is the regulation or statute that prohibits the searching of patients?
3. Under what conditions, if any, are patients searched?
4. Can you list the nature and quantity of all contraband found in the institution since January 1, 1975? Please be sure to include weapons, alcohol, and drugs.
5. Under what circumstances was the contraband found?

It is my understanding that Kirby Building of the Manhattan State Hospital, was subject to an inspection tour by Dr. Schaefer with the Board of Commissioners for the accreditation of psychiatric facilities. I was informed that prior to, and during the visit, the following occurred. I would appreciate having your comments on each allegation.

IV. PREPARATION OF THE HOSPITAL AND PATIENTS FOR INSPECTION TOURS

1. The patients were supplied with clean clothes, including shirts, jackets, ties, and socks, all of which were removed after the visit, not to be used by these particular patients again.
2. Patient records, not heretofore adequately maintained, were updated or created particularly for this inspection.

During my visit, after noticing the way the patients were dressed, I made an inspection of the clothing room. I was amazed at the condition of the clothing, which was old and ragged.

V. DRESS CODES AND PERSONAL HYGIENE

1. Is clothing supplied by the State?
2. Who checks for quality?
3. What was the amount of money budgeted for clothing in the current fiscal year? What does this amount to per person?
4. Is it a fact that patients are supplied with one pair of underwear each week, and not all supplied with socks?
5. Is it a fact that the patients who are incontinent are not supplied with a daily change in clothing?
6. Is it a fact that bathrooms are jointly used by both men and women simultaneously?
7. Is it a fact that patients are not all supplied with soap, towels, or bathrobes as needed?
8. Is it a fact that some water closet booths do not have doors, and the curtains supplied are often missing?

In the course of my visit, I was informed that during a recent review by the Quality Assurance Board in the Kirby Building, that Federal reimbursement for 38 patients was disallowed for an entire year, totaling approximately $330,000 because of a failure to provide required treatment.

VI. RESULTS OF THE QUALITY ASSURANCE BOARD REVIEW

1. If there was indeed such a disallowance of funds, what were the circumstances under which it occurred?

2. Is it also a fact that due to the disallowance of these federal funds, that the patients were denied their monthly personal expense allotment which I understand is approximately $25.00 a month?

3. What is the procedure for protecting each of the patients who do receive the Federal personal monthly allotment?

4. Are the patients given cash or are they permitted to charge their purchases against an account maintained in the patient's name.

5. If in fact the patients receive cash, how many reports of theft of cash have been reported since January 1, 1975?

6. Is it a fact that patients are charged for coffee? And if so, how much?

When I visited the day room, I found the patients sitting around, the most active of whom were watching TV. It appeared as though they had nothing to do, and certainly as though nothing was organized for them to do.

VII. THERAPEUTIC ACTIVITIES AND SURVEILLANCE OF THESE ACTIVITIES

1. What type of therapeutic activities are provided for the patients?

2. Is a patient treatment profile required for each patient?

3. What is the auditing procedure to ascertain whether (a) the records maintained are indeed accurate, and (b) the therapeutic treatment plans for each patient are indeed provided?

4. Is it a fact that while Kirby and Dunlop each has an active Visitor's Board, Meyer has none? And if so, why not?

5. What are the restrictions relating to allowing the patients to work, either for money, or as therapy? Are patients encouraged to work around the wards?

Finally, I was intrigued by the fact that there is open access to the hospital and its grounds, and that I could simply walk around without a security guard or hospital personnel ever questioning either my presence or that of the three members of my staff with me.

VIII. SECURITY PRECAUTIONS

1. In the last two years, how many reported assaults, rapes and other crimes were allegedly committed on the premises?

2. Of these crimes, how many were allegedly committed on patients?

3. Into which of the varying criminal categories did these alleged crimes fall?

4. In how many of these cases were the alleged assailants other patients? staff members? or intruders on the island?

5. In how many of these cases were the alleged assailants prosecuted?

6. I was more than intrigued by the existence of an unmanned guard house at the entrance of the institution, and wonder if it is ever manned?

7. And if it is not manned, why not?

8. What was the total cost of the guard house? and when was it built?

9. I was told that the fence at the island's perimeter was recently installed to prevent patients from throwing themselves into the East River. The fence from objective observations would not appear to be of sufficient height to deter such individuals. What was the cost of that fence and when was it built?

10. What are your comments on the usefulness of this particular fence?

I would appreciate your providing me with this information expeditiously. If the allegations made to me by others, and my own observations are not correct, I want to be made aware of that. On the other hand, if the allegations, and observations are substantially accurate, then much must be done, and expeditiously, to correct an overwhelmingly inhumane condition.

Sincerely,

EDWARD I. KOCH.

[APPENDIX 8]

STATE OF NEW YORK,
DEPARTMENT OF MENTAL HYGIENE,
New York, N.Y., November 23, 1976.

Congressman EDWARD I. KOCH,
New York, N.Y.

DEAR CONGRESSMAN KOCH: Commissioner Kolb has asked me to answer your letter of November 8 raising a number of questions about Manhattan Psychiatric Center.

I was glad to have the opportunity to meet with you last week and think that such meetings are particularly helpful when there are sensitive and complex issues.

As background to the accompanying response to your inquiries I would like to bring to your attention certain complicating factors which currently add to the difficulties of administering Manhattan Psychiatric Center.

The existing three separate hospitals on Ward's Island (Dunlap, Meyer, and Kirby) are in the beginning process of consolidation. It is anticipated that this will improve its administraton and save money. In addition, we have been looking for a new director for the past four months and hope one will be appointed by the end of 1976.

Attached is a list of documents that we are submitting.

I appreciate your interest and hope you will get in touch with me if you wish any further information.

Sincerely yours,

ALVIN M. MESNIKOFF, M.D.,
Regional Director.

INFORMATION ON MANHATTAN PSYCHIATRIC CENTER

I. PATIENT POPULATION AND COSTS

1. The average cost per inpatient day in the New York State facilities is $43.04.

Cost analysis has recently been computerized. We do not have the data for Manhattan Psychiatric Center where the estimate is complicated by the fact that the cost of certain services is shared with the Manhattan Children's hospital and the Keener Unit of Manhattan Developmental Center which are also located on Ward's Island.

The approximate costs for the other facilities within the New York City region are as follows:

Kingsboro	$59.85
Creedmoor	58.28
Bronx	89.02

It is anticipated that the Manhattan Psychiatric Center cost will be in the range of $58–$60 since the facility is similar to Creedmoor and Kinsboro Psychiatric Centers.

A copy of Manhattan Psychiatric Center's budget for 1976/77 is enclosed. (See Attachment A.)

2. 89 percent of the funding of Manhattan Psychiatric Center is from State sources. Of the remaining 11 percent, 6.9 percent comes from Medicaid and 4 percent from Medicare. This 11 percent goes to the General Fund of New York State and is then allocated to the hospital. There is no direct reimbursement to State facilities. Further budget details are enclosed.

3. Average population rolls:

Inpatient:	
January 1 to March 31, 1976	1,278
April 1 to June 30, 1976	1,350
July 1 to September 30, 1976	1,451
Outpatient	4,573

4. Number of Admissions:

1975	3,132
1976 (to date)	3,372

There has been an increase of 7 percent in admissions to date in 1967 over 1975.

Average Daily Population (census as of Nov. 14, 1976):

1975	1,450
1976	1,495

5. The maximum capacity of the institution is 1667 (as of Sept. 30, 1976).

6. 48 percent of the patients are voluntarily admitted. 47 percent are involuntary admissions.

7. Of those patients involuntarily admitted, 9.3 percent are admitted as a result of a court order.

8. It is estimated that the percentage of patients admitted since Jan. 1, 1975 who have history of significant acts of violence is below 10 percent.

9. No.

10. Violence as a factor determining a patient's admission is usually directed at a specific person. When the patient is removed from the situation which provokes this behavior the violence usually subsides.

11. After being admitted to the Admission Unit where the patient is evaluated and examined, he is transferred to his appropriate geographic unit. If the geographic unit finds that the patient is not manageable then the patient is transferred to the Special Treatment Unit.

12 and 13. Each geographic unit has quiet rooms or seclusion rooms. These rooms are used for the patient's protection when an individual is exhibiting violent or self-destructive behavior which is temporary in nature. They are used as needed.

Special Treatment Unit.—15 beds (plus 1 for emergency). Current census 15. The criteria for admission to this unit include the following: Homicidal patients; Suicidal patients; Self-destructive patients; Self-mutilating patients; Arsonists; Rapists; and Chronic elopers.

The patient returns to his geographic unit at the discretion of the clinical team on the Special Treatment Unit. The average length of stay is six weeks.

Forensic Unit.—This unit has beds available as required. The current census is 8. The criteria for admission to this unit is:

Commitment under 330.20 of the Criminal Procedure Law or Commitment under 730 of the Criminal Procedure Law with the exception of a Final Order of Observation.

II. PROCEDURES REGARDING PATIENTS RIGHTS TO COME AND GO FROM THE INSTITUTION

1. The policy of the New York State Department of Mental Hygiene is to encourage the practice of allowing appropriate patients to visit relatives or friends away from the institution. (see attachment B)

2 to 4. Whether a patient should be allowed out of the hospital on a pass is a decision which arises out of conference in which the patient and the clinical team members most knowledgeable about him participate. The decision depends on the current clinical status of the patient and not on whether the patient was an involuntary or voluntary admission. Any violent tendencies on the part of the patient are considered as factors in the clinical picture.

5. In voluntary and proprietory hospitals permission for leave is similarly a matter for clinical judgment.

6. The number of voluntary patients on LWOC 1975, 878; the number of voluntary patients on LWOC 1976, 702.

7. The number of above who did not return (in 1975), 318 (estimate); the number of above who did not return (in 1976), 258 (estimate).

8. The number of involuntary patients on LWOC 1975, 714; the number of involuntary patients on LWOC 1976, 532.

9. The number of above who did not return (in 1975), 369 (estimate; the number of above who did not return (in 1976), 279 (estimate).

The number of voluntary and involuntary patients who return from LWOC are not kept separately. Hence the figures on these returns are appropriate.

10 to 13. Families of those patients who elope from the institution are informed by telephone or telegram. Attempts to follow-up are made by the social worker if there is an address at which the patient can be located. Interviews with family members are arranged where appropriate.

The follow-up procedures do not vary according to the voluntary or involuntary status of the patient. However, the police are notified immediately if the patient's history indicates dangerous tendencies toward himself or others or if the patient is being held for examination under a criminal order.

14. An informed guess on LWOC patients in 1975 and 1976 who were never located would be close to 50%. (There are no separate figures for those patients on LWOC who are located but do not wish to return and those who are unlocated.)

15. Yes, Dept. Policy Manual Section 2001.

16. A patient admited involuntarily and on LWOC must be discharged at the expiration of the Two Physicians Certificate. Since a Two Physicians Certificate is issued for a 60 day period, the date of the patient's discharge will depend on the date on which he went LWOC. Dept. Policy Manual Section 2001.

17. We do not have information on how many patients who left LWOC committed crimes while away from the institution.

III. POLICIES REGARDING THE SEARCHING OF PATIENTS FOR CONTRABAND

1 and 2. A patient, like any other citizen is, in general, not subject to "search and seizure". This view is supported by the Mental Health Information Service whose role is to protect the rights of the patients. On admission, patient check in their property as part of the normal procedure. Any "weapons" are turned over to Security and any alcohol or medications are kept in the property office and surrendered to patients on their discharge.

Searching of patients returning from leave may be done at the Unit Chief's discretion and with the patient's consent. If the patient objects, and the hospital suspects that the patient has some illegal item, the police may be called.

3. If a paient is considered to be a danger to himself or others and is thought to have something harmful on his person then the clinician in charge has a therapeutic responsibility to see that the item is removed from the patient's possession.

4. The following contraband was found in the Institution since Jan. 1, 1975.

Item	Number
Weapons:	
Knife	45
Can opener	2
Bullet	2
Pipe	4
Gun	4
Molotov cocktail	1
Sharp instrument	1
Chuka stick	1
Ice pick	1
Iron bar	2
Scissors	2
File	1
Stick	1
Alcohol:	
Incidents	9
Bottles	12
Drugs:[1]	
Reefers	4
Marijuana (ounces)	2
Other:	
Hospital keys	5

[1] About 30 bottles of medication taken from patients on admission. These are legal medications.

A small quantity of contraband is found amongst the patients' belongings on admission. Most is found when security responds to a call from staff because of a fight between patients or employees and the contraband comes to light in the course of dealing with the upset.

IV. PREPARATION OF THE HOSPITAL AND PATIENTS FOR INSPECTION TOURS

1. This allegation is not true.

2. This statement is partially correct. Records are maintained on all patients. However, preparatory to an inspection an extra effort is made to inspect the records and to supply any data that may be missing.

V. DRESS CODES AND PERSONAL HYGIENE

1. Some patients supply their own clothing and this is encouraged. A clothing allowance is provided by the State but this is not adequate. Manhattan Psycriatric Center has a particular problem because such a large proportion of the patient population is on Welfare or SSI. It is not unusual for patients to go out on pass and give the clothes they are wearing to their families or sell them and then return to the hospital in rags.

2. The Office of General Services contracts with manufacturers after putting the items out for bid. If the institution objects to the quality of the clothing, it has to be proved to the Office of General Services before permission is granted the institution to buy elsewhere. Some clothing is made by the New York State Department of Corrections.

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3. $70 per capita is the clothing allowance for patients. This $70 is based on a 1500 resident population. The number of patients actually admitted during the year is over 3,000. This means that the real clothing allowance per capita is close to $30.

1976 to 1977:

Allocated	$105,595
Expended	101,800
Balance	3,795

4. Patients are supplied with the clothing we have available. There are washing machines and dryers on each floor.

5. Patients who are incontinent are provided with clothing as needed and are given priority in receiving clothes that are available.

6. Most bathrooms are located in either a male or female ward and available to the one sex. In the few coed wards, bathrooms are shared by men and women.

7. Soaps and towels should always be available. Bathrobes are not always available and are part of the general clothing problem.

8. This is true. A capital project to renovate all bathrooms to meet the Joint Commission on Accreditation standards has been approved by the Regional Office and is currently awaiting Central Office approval.

VI. RESULTS OF THE QUALITY ASSURANCE BOARD REVIEW

This review is a review by an internal committee of Manhattan Psychiatric Center.

1 and 3. The details of the process by which Federal Funds were disallowed are attached. (see Attachment D).

4. All monies received on behalf of patients are credited to individual accounts. The money is disbursed to patients in allowances from $1 to $10 weekly depending on the patient's capability to spend. Requests for more than $10 are handled separately on an individual need basis. Disbursements of this nature are part of the therapeutic process and are released upon clinical request to do so.

5. There have been 7 reports of thefts of cash from patients this year.

6. Patients who wish to have coffee other than at mealtimes buy coffee at the Community Store which is open to patients, visitors, and staff. Coffee is 25 cents for a small cup and 30 cents for a large cup.

VII. THERAPEUTIC ACTIVITIES AND SURVEILLANCE OF THESE ACTIVITIES

1. Therapeutic activities are tailored to the individual patients needs and capacities within what is available to the Unit. Recreation, music, occupation and dance therapy is available to a limited degree. It is agreed that more activities are needed. However, the Rehabilitation Department provides a number of recreational activities in its new building. Movies, swimming, gymnastics, pool and similar leisure time activities are provided. Volunteers provide extra services. Many patients choose not to participate. Every effort is made to encourage them to join in but often withdrawal from social life is part of the problem for which they have been admitted.

2. A treatment plan is required for every patient admitted to the facility.

3. Team Supervisors and Unit Chiefs are responsible for the completeness and accuracy of the patient records on their unit. In addition, the Utilization Review Committee provides a further check.

4. Recommendations of names for a Board of Visitors to Meyer have been submitted to the Governor. A Board has not been appointed.

5. Patients may be employed in the institution at the minimum wage. Patients may also be employed in a sheltered workshop where special Department of Labor Permits allow lower rates of pay.

The Mental Hygiene Law (Section 15.09(b)) severely limits the amount of work a patient may perform on the ward.

For details of policy and regulations concerning patient employment see attachment C.

VIII. SECURITY PRECAUTIONS

Manhattan Psychiatric Center is an open hospital and suffers from the disadvantages and advantages of such a system. There are 40 security officers items of which 35 are filled, to man the grounds and buildings round the clock. This spreads the security force very thin.

Entrance to the wards is a different matter and any stranger wishing to enter should be challenged. I can only assume that as you were accompanied by a known member of the Manhattan Psychiatric Center staff that the ward employees accepted that you were there under his aegis.

1 to 4. The following crimes were reported since January 1, 1975:

Alleged crime	Number	Committed by patient	Committed by employee	Unknown
Assault	17	13	1	3
Rape	15	7		8
Sodomy	2	1		1
Attempted rape	5	2		3
Sexual abuse	3	2	1	3

In addition 91 crimes were committed covering burglarly, robbery, arson, vandalism and criminal mischief.

5. Eight arrests were made.

6 and 7. The guardhouse will be manned when the ten staffing positions applied for have been approved.

8. The guard house cost $29,300. It was built in 1976 but still awaits a transformer to operate the automatic gate arm.

9. The installation of the fence was completed June 10, 1975 at a total cost of $37,695.80.

10. The fence seems to have achieved its purpose. Prior to its installation one patient drowned and four others were rescued from drowning. Since the installation there have been no such episodes.

[APPENDIX 9]

MANHATTAN STATE CITIZENS GROUP ANALYSIS OF DR. MESNIKOFF'S NOVEMBER 23, 1976 REPLY TO CONGRESSMAN KOCH'S LETTER TO COMMISSIONER KOLB

I. PATIENT POPULATION AND COSTS

1. We find it difficult to believe that Dr. Mesnikoff has the per patient costs for Kingsboro, Creedmore, and Bronx State but not for Manhattan State. On 12/2/1975, Dr. Anthony Aire, then Director of Meyer and Dunlop, indicated in writing:

Dunlop ($10,610,400):

Inpatients	390
Outpatients	1,000

Meyer ($9,723,000):

Inpatients	341
Outpatients	1,081

On December 9, 1975 Dr. Israel Kesselbrenner, then Director of Kirby, indicated in writing:

Kirby ($7,310,000):

Inpatients	494
Outpatients	1,506

The total was therefore:

(1975) MPC ($27,643,400):

Inpatients	1,225
Outpatients	3,587

(1976) MPC (?):

Inpatients	1,360
Outpatients	4,573

We cannot furnish the current figures because we have not been able to get them. We would very much like to see the '76/'77 and '77/'78 budgets. We do

know, however, that Manhattan State has, in anticipation, taken a larger budget cut (despite the increased patient load) than other State facilities—particularly N.Y.C. based state facilities. In addition a larger number of Manhattan State employees have been drained off to sister institutions (56 to N.Y. Psychiatric Institute alone) this year than last year. We are aghast at Dr. Mesnikoff's contention that Manhattan State is similar to Creedmore or Kingsboro—they have one administration while Manhattan State has the duplication of four administrations (Meyer, Dunlop, Kirby and Support Services/Rehabilitation) so that less of the available money goes directly to patient care than at the "similar" facilities. In addition Manhattan State is more remote than Creedmore and Kingsboro so our facility must subsidize employee bridge tolls—and this leaves even less of the money available for patient care.

2 to 8. No comment at this time.

9. Why are patients with a violent history not separated? It would seem such separation is clinically indicated for treatment and/or health safety and is, therefore, not illegal. Certainly the nonviolent patients deserve protection and the violent patients need specially trained staff if they are to get any benefit from any of the programs.

10. Why can't violent patients go directly to an Intensive Care, Forensic, or other special unit? The Mental Hygene Law may mandate geographic units but it does not, in any way, forbid "clinical" units where indicated.

11. See number ten.

12 and 13. As Dr. Mesnikoff should know, seclusion rooms can be *legally* used for only *very* limited durations and for very limited purposes. Such limitations may suffice for violent episodes in "average patients" but would hardly suffice for the "violent" type of patient that you were asking about in your letter. Incidentally, isolation should never be given P.R.N.—a common practice at Manhattan State.

A detailed investigation, by your office, of fires and rapes on the Greenwich Village Unit (alone) would show that the Special Treatment Unit is not being effectively used as described by Dr. Mesnikoff, if the Forensic Unit is only for "criminal" court referrals then it is obvious that there is no sufficient provision for violent patients as things stand at present.

[NOTE: The S.T.U. was closed on 12/10/76 in obvious answer to our group's mailgram to the Governor over the latest incidents to occur there; yet, up until now, the administration has shrugged off charges made against the mal-administration of this unit.]

II. PROCEDURE REGARDING PATIENTS RIGHTS TO COME AND GO FROM THE INSTITUTE

1 to 4. No comment at this time.

5. Surey Dr. Mesnikoff knows that voluntary, proprietary (and frequently the municipal) hospitals in N.Y.C. do not treat violent patients—they dump them on the state facilities.

6 to 9. I have not seen escape figures like these since they built the Berlin Wall:

1975:	
Population	1,450
Escapes	1,592
1976:	
Population	1,495
Escapes	1,234

I don't know what reason the department gives for such figures, but go to Project Release they will tell you that even the so-called "insane" have determined "that Manhattan State may be dangerous to (their) healths." I must also question the alleged drop in escapes for the higher population—have the figures been manipulated by a change in the reporting system or has the facility taken new steps to reduce the possibility of escape? What might these new steps be and how legal are they?

10 to 13. It is our experience that families of the patients are hardly ever informed of the elopement and/or the disappearances until after the family discovers the patient missing. It is also our experience that the facility seldom conducts a decent search, even of the grounds, for missing patients.

Furthermore, it is our experience that the police are not always notified—example: ask Mr. Burke (of the Governor's office) regarding the case of Mrs.

William Moilan, who disappeared, was not searched for, was not reported missing, and who was found to have died (under still unexplained circumstances) in the Island's inlet, hours after the search should have found her. Her death is still a mystery and no action has been taken against anyone for malfeasance. In fact Mr. Moilan had to go to the Governor's office to get the faculty to answer some very basic questions regarding the circumstances of his wife's death.

In addition, we strongly resent Dr. Mesnikoff's choice of wording that infers all LWOC patients are elopements" and voluntary. Our parents, as visitors to the hospital have reported many disturbing incidents—example: a young, attractive girl sitting on a bench between the rehabilitation building and Kirby building is suddenly surrounded by six or seven men; the observing parent goes to look for a security guard and, finding none, returns to find the guys moving off in a "huddle" with the girl inside the circle. Example: the hospital's van stops on the bridge between Ward's Island and Randall's Island and a female patient is transferred from the van to a private automobile. Are these LWOCs or abductions? The department lists them as LWOC's.

14 to 16. No comment at this time.

17. This is a tough question; perhaps some fairly recent cases would give you an idea of the possibilities:

(a) [N.Y. Post 9/23/76] Hector Melendez *an employee of the Manhattan State Hospital* was indicted for killing the daughter of a cantor as she walked her dog in Central Park.

(b) [N.Y. News 10/29/76] Carmen Torres bumped into Leroy Thomas in a corridor at Manhattan State Hospital. Thomas had slain her husband in Claremount Park three months earlier; he was described as a *former hospital patient.*

(c) [N.Y. News 10/23/74] Judith Becker was murdered by Ricardo Caputo who walked out of Manhattan State Hospital the previous Friday—he had been sent there for the slaying of his girl friend in 1971. Dr. Starace, deputy director clinical, said he was a model patient and he had not left the institution from the time he was transferred to Manhattan State in 1973 until that Friday. [N.Y. News 10/24/74] Residents of Miss Becker's apartment house told police that Caputo had visited the girl in Westchester frequently during the last year; another girl positively identified his picture as the man who had been at the house a month before [N.Y. Post 4/3/75] Caputo had been missing from Kirby Hospital for three days when Miss Becker's battered nude body was found.

III. POLICIES REGARDING THE SEARCHING OF PATIENTS FOR CONTRABAND

1 and 2. "My" patient was searched upon admission even though she was transferred fom Mt. Sinai to Kirby by ambulance in the company of a registered nurse. MHIS did not get around to seeing her until some time after the search.

3. No comment at this time.

4 and 5. We feel that these figures are too low. Example: you can find more than 12 empty bottles on the grounds on any given day. See how many you can count at the base of the tree North of the loading dock of the Manhattan State Children's Psychiatric Center on any Saturday morning.

IV. PREPARATION OF HOSPITAL AND PATIENTS FOR INSPECTION TEAMS

1 and 2. This allegation is true and you have testimony from hospital employees to that effect. Additionally, I can testify to the following:

a. When I arrived to testify before the J.C.A.H., at the Dunlop hearing in January 1975, the "wet paint" sign was still standing in front of the Basement elevator doors and pictures had sprouted, overnight, on the corridor walls—the pictures were gone two weeks later when the J.C.A.H. left.

b. When I arrived to testify before the J.C.A.H., at the Meyer hearing in January 1975, the black boards in the conference rooms used for the hearing still had chalked instructions for setting up (not filling out) patient records.

c. We have received reports that the institution has just received new drapes but that they will not be issued and/or installed until the next J.C.A.H. inspection which is due in January 1977.

d. If you examine the hospital records you will find a sudden (and gigantic) surge in overtime immediately preceding the J.C.A.H. survey dates in January of 1976.

e. I have been "unofficially" advised that the J.C.A.H. survey will *not* take place in January 1977, as required, because the J.C.A.H. is too busy—real reason as leaked out to me on the q.t.: the institution will stall and cause the delay by not paying the J.C.A.H. fee on time; this is a tactic they used before. Ask to see the dates of their 1972 and 1974 accreditation and the dates on their checks for the 1974 and 1976 accreditations.

V. DRESS CODES AND PERSONAL HYGIENE

1. Dr. Mesnikoff's reply to question 2, part I was that only 11% of the funding of Manhattan State comes from Medicare or Medicaid; here he says that a large portion of the patient population is on Welfare or SSI—isn't this contradictory? Dr. Mesnikoff also ignores the vast quantities of clothes furnished by the Manhattan State Citizens Group and by the employees of stores like Bergdorf Goodman and hospitals like MEETH. He ignores the fact that chronic patients who never go home, also "lose" any good clothing given to them. He also ignores the fact that good clothing disappears the first time the patient is showered (which is generally before the first time they go home).

2. Under this system the N.Y. State Department of Correction supplies most of the clothing that is purchased and (while this may take a law to change) the institution does not maintain adequate seamstress or tailoring services to repair linen and clothing, much less alter them, to fit the patients and be less dehumanizing. The accreditation manual of the J.C.A.H. (pg. 69) says "If clothing is provided by this facility, it *shall be* appropriate and *shall not be* dehumanizing."

3. Did the institution and/or the regional director request a clothing allowance for the 1500 resident or for the 4500 that went through the revolving door this year? How about the clothing they are *supposed* to furnish discharges? We believe that maladministration is rampant in this area but we are unable to get copies of the detailed budgets despite state "sunshine" laws.

4. Dr. Mesnikoff has side-stepped your question nicely. Let me try to answer by discussing the situation on two wards:

(*a*) On 11/19/76 we were advised that the patients on Dunlap Ward 3A had no bed clothes. I called the duty doctor (Dr. Gunderia) who investigated and confirmed (to me) the fact that the patients were asleep, not in night clothes, and that there were no night clothes in the storeroom. He admitted that the patients were sleeping in their street clothes and, although he said the clothes had "seemed" clean to him, he had been told the patients were wearing those street clothes for a week.

(*b*) After repeated reports of the lack of clothing (particularly woman's undergarments) on the Greenwich Village Unit, a team composed of the President of the Board of Visitors, the Executive Director of the Federation of Parents Organizations, the President of our group, and the facility chief of the MHIS paid an unannounced visit on 6/18/75. They confirmed the reports. I have on my desk, at this moment, a memo from the Greenwich Village Unit Manager to the Deputy Director, Administration, dated 7/2/76, stating "As you know there has been an extreme shortage of clothing, especially underwear for the patients." That shortage continues (I got another report this very week) but nobody cares enough to do anything about it.

If you will check you will see that most of Dr. Mesnikoff's washing machines and dryers are not operational—if they were, what would patients wear while the dirty clothes were being cleaned.

5. Does Dr. Mesnikoff mean to say (here) that incontinent patients are supplied with the clothing that they have available, and that clothing is inadequate? Your own records of the Imergna case, the boy you helped transer from Kirby to Bird S. Coler, show how incontinent patients are left half-naked and/or on wet sheets to shiver and stink.

6. No code, regulation, or any other criteria in the U.S. allows joint use of a public toilet room by more than one sex; in fact most codes prohibit such use. The parent/relative group has been for correction of this situation for over two years—especially since most of the toilet rooms so used have curtains instead of doors for the cubicles and/or broken doors. Why hasn't Dr. Mesnikoff told you of this? We feel this is a good example of both dehumanization and maladministration because:

(*a*) The department could and should, have waited for proper renovations to be made before turning the awards into co-ed wards.

(*b*) They still have not taken concrete steps to alleviate the deficiency of shared toilet facilities.

7. Dr. Mesnikoff says that soaps and towels "should" always be available—so "should" toilet paper. My three years exposure to Manhattan State indicates they seldom are—ask Mr. Lewis of WABC–TV who found that deficiency during his 10/18/76 visit to the S.T.U. ward. Not only the patients, but also the state, suffer from this deficiency—sheets are frequently used as substitutes for missing towels, and this increases laundry and linen cost. What specifically is the Regional Director doing to solve this problem?

8. When was the capital project requested? I voiced this complaint with the administration over two years ago. When will the work be done? Must it be done under a costly capital project; can't it be done (at least in part) by maintenance staff—quicker and cheaper?

VI. RESULTS OF THE QUALITY ASSURANCE BOARD REVIEW

1 to 3. This is the first *we* have heard of the disallowment; we would be interested in obtaining a copy of Attachment O. Did Dr. Mesnikoff answer questions 2 and 3; what were his answers?

4. How does $25 per month become $10 per week? Did Dr. Mesnikoff tell you about the draft copy of the last State Auditor's report which indicated that the patients *and staff* were being overcharged at the "company store"?

5. The Meyer administration, on 23 March 1976, admited that, *in the Meyer Building alone*, between 2/20/75 and 3/4/76 there were 141 assaults, 8 rapes, and 4 sudden deaths. The Kirby Administration, on 9 December 1975 admitted that, in the Kirby Building alone, between 1/1/75 and 11/5/75 there were 7 robberies. Can you, in light of this data, really believe there were only 7 thefts of cash for all 3 facilities from 1/1/76 through 11/23/76? I would seriously investigate both the reporting system and Dr. Mesnikoff's numbers—there is 18 minutes missing out of this tape!

6. If my memory serves me correctly there is a provision in the state budgeting for mental hospitals to provide at least one "snack" per day—why do the patients get coffee only at mealtimes? Do bureaucratic administrative staff draw coffee for the coffee urns and coffee breaks from patient supplies? How do patients who are not allowed off the ward (for whatever reason) get their coffee? How do patients too poor to pay 25¢ a cup get their coffee?

Patients between 16 (?) and 65 do not get S.S.I. when in State Hospitals.

Why does Dr. Mesnikoff not mention the "concessions" that operate on most wards? According to the State Auditors this money is not being properly accounted for by the operators?

Who runs the clothing and gift boutiques—where does that money go? Who gets the profits from dispensing machines on the State Hospital grounds? Is all the money verified and accounted for? Do any of the States' employees get any "consulting fees" or other compensation from these "concessions", "boutiques", or vending machine "owners".

VII. THERAPEUTIC ACTIVITIES AND SURVEILLANCE OF THESE ACTIVITIES

1. Privately held discussions with head therapists and rehabilitation personnel will tell you that these activities are grossly underutilized because;

(*a*) ward teams do not encourage elements to leave the ward go to the site of the activity.

(*b*) there are not too many volunteers because ward bureaucrats do not want them "nosing" around.

(*c*) the therapy and rehabilitation staffs are under-manned with regard to the number of patients needing their services.

(*d*) many therapists and volunteer coordinators are working "our of line" in public relations and administrative positions.

2 and 3. We all know a treatment plan is required and those of us at the hospital know treatment is virtually non-existant. If team supervisors, unit chiefs, and utilization review committees are not conventing the plans into treatment (which is obviously the case) what are higher level administration people doing to correct the deficiency?

4. This comment of Dr. Mesnikoff's is as interested for what it does not say as for what it says:

(*a*) Boards of Visitors are required by the Mental Hygiene Law but none of the last 3 Governors (Rockefeller thru Carey) appointed a Board for Meyer despite director entreaties from the ACLU and parent/relatives groups.

(*b*) Three parents are required as a minimum by the Mental Hygiene Law but only one "parent" sits on the Dunlap Board despite the fact that there is a vacancy.

(*c*) Seven members are required as a minimum by the Mental Hygiene Law but the Kirby board has had 3 or 4 vacancies for over a year.

(NOTE: Although I am past president of the Federation of Parents Organizations, Vice-President of the Manhattan State Group, set on the governing board of the N.Y.C./H.S.A., and was recommended by several sources two years ago I have been unable to get appointed to the Kirby Board).

I think that investigation will show that the DMH is advising the Governor not to make appointments (supposedly) because of the impending consolidation which would not effect the boards until written into law—a process not yet started) because it does not want to risk Manhattan State Group parent/relative "troublemakers" being appointed—one of the Board's primary duties is to investigate patient abuse and neglect.

Another problem with regard to Board of Visitors is the way the law is implemented. The second primary duty of the Board is to investigate the Director but, as presently practiced, the nominations to the board are made by the self-same Director, screened by the Regional office, and passed on to the Governor through the Commissioner of DMH. The Governor sometimes appoints someone different but, generally, he ends up appointing the Director's "safe" friends to oversee his work and institution. Shades of Watergate?

5. The problem here is again the problem of interpretation and human nature. In some wards we have found patients scrubbing public halls and toilets in exchange for a cigarete (which is blatantly illegal) but on other wards we can't get the staff to let patients serve themselves coffee (legally turning the coffee break into a humanizing social tea party). The department's policies and regulations need review but, more importantly, sensible (rather than bureaucratic) interpretation by administrators and supervisors.

VIII. SECURITY PRECAUTIONS

1–4. These figures are suspect! We know of one employee who was just allowed to resign after he faced (at a hearing) nine patients who he raped during the last year. We have complaints filed against two employees for striking patients during the last year and we are presently getting ready to file a complaint against a Doctor for two separate counts of assault on patients.

You have, from other sources, reports of more than three sexual abuse incidents or the S.T.U. alone! Let me give you 1975 figures given us (and we believe them to be "light") in the documents referred to in question 5 of item VI and question 1 of item I:

	1975 (11 mo.)
Fights:	
Kirby	
Meyer/Dunlop	103
Assaults:	
Kirby	200
Meyer/Dunlop	110
Rape:	
Kirby	2
Meyer/Dunlop	
Attempted rape:	
Kirby	[1]
Meyer/Dunlop	5

[1] Unknown.

According to letters from the Directors dated 8/24/76 there were eight reports of rape alleged and/or accused between 1/1/76 and 8/18/76 in the three buildings. Taking into account the rapes we know about, the percentages of incidents that the Directors have said are reported to them, and the percentages of rapes we know are never reported at all, we calculated between 75 and 125 rapes per year take place in these three hospitals—and that does *not* include employee seduction of patients, *and/or* mutually desired patient to patient sexual contacts.

Why such terrific discrepancies in figures—we don't know. We do, however, believe that figures don't lie but that liars do figure.

How extensive is the distribution of birth control pills on the wards at Manhattan State?

5. A private police force, these kinds and quantities of incidents, and only 8 arrests? Who is not doing their job? What are the bureaucrats responsible for administration doing to improve the situation?

6 and 7. According to the facility administration it take about five men to man one post, around the clock, seven days a week—why do we need 10 men to man one guardhouse? Why can't part of the staffing positions be used to man the security office in the lobby of Meyer in off hours and/or establish a security post in the lobby of Kirby to protect the other end of the complex?

Has Dr. Mesnikoff told you that the security force is also the fire brigade? Three posts (15 of the available 35 to 38 men) are assigned to fire house duty leaving 4 posts (20 to 23 men) to guard the 3–17 story buildings, the administration building, the rehabilitation building the service buildings, the children's center, the Keener unit, Odyssey House, Staff house Nurses Residence, several abandoned buildings, a foot bridge, the main bridge and acres of island. Why weren't more than 10 guards requested—even if it meant giving up some administrative "lines" to reduce the financial impact?

Has Dr. Mesnikoff told you that there are less guards now than there was 18 months ago—why was that allowed to happen?

What is the possibility of having the DMH security force organized and supervised by NY State Police?

Why weren't the ten staffing positions requested far enough in advance to be assigned simultaneously with the finishing of the guardhouse—is this another . . . example of mal-administration that the tax-payer will pay for when the unmanned new guardhouse is vandalized like the two old guard houses are?

8. and 9. How do buses and visitors get through the "automatic" gate arm if the transformer comes but the guardhouse isn't manned?

Did Dr. Mesnikoff indicate that they had estimated the gate and fence at $60,000 instead of the $70,000 they cost? Did he mention that they are planning to spend additional thousands on electronic locks for the building doors? We need "people solutions" not more "bricks and mortar"!

Isn't it time the parents/relatives recommendation to provide Watchmen's boxes throughout the long, drab, lonely corridors of the buildings and throughout the grounds was given consideration? With this system the Security force would have to make rounds to punch the clocks instead of cooping out somewhere—an inexpensive, more secure system.

10. A more decorative, less institutional fence would have accomplished the same goal and provided a therapeutic setting. We were told the fence was erected to keep predatators out; you were told different. We strongly suspect (though we may be accused of paranoia) that the fence/gate system was provided to furnish an "Early Warning System" to protect the faculty from unannounced Congressional, Media and parent/relative inspection tours.

X. SOME OTHER QUESTIONS THAT NEED TO BE ASKED

1. What are the details of the "Manhattan Plan" and why were key components such as St. Vincents' Director of Psychiatry, and the Parents/relatives group never allowed to see the details?

2. Why haven't the parents/relatives group been allowed to establish a grievance procedure (Parents Assistance Teams) after 28 months of negotiating when other State facilities, such as Kingsboro and Creedmore, have them?

3. Why isn't control over the Washington Heights unit (housed at the N. Y. Physchiatric Institute) put back under the Director of the Manhattan State Hospital who is supposed to be responsible for all mental health services in Manhattan? Why is staffing at the N.Y.P.I. unit so superior to its counterpart on the Wards Island unit? Why is the N.Y.P.I. Washington Heights units now establishing an outpatient service when the MPC Washington Heights unit already has such a service only a few blocks away?

4. How many of the patients transferred from Pilgrim State to MPC are really N.Y.C. residents? Were an equal number of staff "transferred" with them to maintain the one to one ratio used as a guideline by the J.C.A.H? Will the "transferred" staff be available as long as the patients are?

5. What, specifically, is being done to meet deficiencies picked up by the J.C.A.H. in January 1976 and why weren't they corrected sooner?

6. What, specifically, has been done to meet the deficiencies recognized at the Regional Directors "Crisis Meeting" of July 8, 1976?

7. Why has consumer (partent/relative) participation in the Consolidation issue (granted by the previous Regional Director) been terminated by the (present) Regional Director?
8. Why haven't the "Guidelines for Citizen Participation" (written last year) ever been promulgated?
9. Why has the department suddenly cancelled parent/relative mailing privileges, so vital to their continuation, when it doesn't cost the department less than $200 per year in a $27,000,000 budget?
10. Why wasn't the N. Y. C. Regional Director selected by means of a search committee when the Search Committee technique is being used for the Long Island and Westchester Regional Directors?
11. Why did the Hyne's Commission on Nursing Homes' investigators find it necessary to upbraid two members of the DMH's N.Y.C. Regional Office (one of them a special assistant to the regional Director) for their attempts to interfere in the Commissions' investigation?
12. Why hasn't the DMH done anything to reflect the state legislature's (and consumer advocates) stated desire to redeploy resources from institutionalization to begin to create community alternatives?
13. Why doesn't the DMH sell off excess real estate to raise money to create community alternatives? Why don't they charge Directors (who earn over $43,000 per year) a fair market value rental for their on facility housing? Better yet, why don't they make Directors live in the community and use the on-site Director's housing accommodations for transitional service type facilities?
14. The J.C.A.H. requires that all services be designed to meet the patients needs. Why isn't a level and distribution of staffing maintained that will allow full psychiatric, activity program, and rehabilitation efforts on weekends? The patients don't cease being patients or needing the services at 5 PM every Friday—but Ward's Island is like an abandoned city on Saturday and Sunday.
15. What kind of investigation is being made of the co-relation between Bert Yulke's (the patient you recently helped transfer from Metropolitan Hospital to Bird S. Coler instead of back to Manhattan State) smashing some employees' car windows and his subsquent near murder and crippling by medication poisoning? Is there a possibility that there is a co-relation between his beatings and his extracted teeth and the fact that he was the son of the parents/relatives group President? Shouldn't these possibilities be investigated—if only to keep the department's name clean?
16. Why doesn't the Governor appoint a blue ribbon, Moreland Commission type, panel (selected and operating completely independent of the state department of mental hygiene) to investigate the horrendous failure of the Department at the Manhattan Psychiatric (enter the Manhattan Children's Psychiatric, enter the Bronx State Hospital, Willowbrook, etc. ?

[APPENDIX 10]

DECEMBER 30, 1976.

JAMES D. ISBISTER,
Administrator, Mental Health Administration Department of Health Education and Welfare, Rockville, Md.

DEAR MR. ISBISTER: Conditions at the Manhattan State Psychiatric Center rival those that existed at Willowbrook. You'll be interested in the enclosed correspondence initiated as a result of my recent visit to the facility to see for myself what was occurring. Patients are not receiving adequate treatment and the physical facilities—the bathrooms in particular serve to dehumanize those using them. The failure to meet federal standards for the maintenance of patient records and the lack of proper treatment has resulted in the facility losing federal Medicaid contributions. Furthermore, monies are paid to state employees for transportation, this year exceeding $200,000 that should not be paid unless every state employee is deemed entitled to transportation expenses which surely is not warranted.

I urge that you designate a member of your staff, and I would be pleased to designate a member of my staff to pay an unannounced visit to the facility to see firsthand what is actually happening.

If you have any questions please do not hesitate to contact me.

All the best.

Sincerely,

EDWARD I. KOCH.

[APPENDIX 11]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Rockville, Md., February 4, 1977.

Hon. EDWARD I. KOCH,
House of Representatives,
Washington, D.C.

DEAR MR. KOCH: Thank you for your letter of December 30 in which you expressed great concern about conditions at the Manhattan Psychiatric Center and requested assistance in reviewing these conditions during an unannounced visit. Your effort indeed indicates a deep interest in improving the care and treatment of mentally ill patients. The National Institute of Mental Health has similar concerns and interests.

The Bureau of Health Insurance is responsible for the quality of care for patients under the Medicare program. Your letter was discussed with Mr. Stanley Rosenfeld, Chief of Hospital Section in the Bureau of Health Insurance, Social Security Administration. As a result of this discussion, Mr. Rosenfeld telephoned Ms. Jean Ashkenazi, of your office, and tentatively arranged for a member of his staff from the New York Bureau of Health Insurance Regional Office to accompany a member of your staff on a visit to the Center.

The National Institute of Mental Health works closely with the Bureau of Health Insurance on surveying of psychiatric hospitals for two special conditions of participation: medical records and staffing. Under Medicare regulations, inpatients must receive active treatment in order for the facility to qualify for certification and to be reimbursed with Federal funds. To make sure that persons receive active treatment, the Medicare regulations impose two special requirements for staffing and medical records. The medical records must document active treatment. The staff must be adequate in number and qualifications to carry out an intensive and comprehensive treatment program, including professional psychiatric, nursing, social work, psychological and therapy activities.

I have asked Dr. Bertram Brown, Director, National Institute of Mental Health, to assign Dr. Alvira Brands to accompany your staff member and the Bureau of Health Insurance staff members on the visit to Manhattan Psychiatric Center.

We appreciate your interest in improving the care of the mentally ill. If I may be of further assistance, please let me know.

Sincerely yours,

FRANCIS N. WALDROP, M.D.,
Deputy Administrator.

[APPENDIX 12]

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE,
New York, N.Y., February 3, 1977.

Re Manhattan Psychiatric Center, Kirby, Dunlop, and Meyer Divisions.

Hon. EDWARD I. KOCH,
Member U.S. House of Representatives,
New York, N.Y.

DEAR CONGRESSMAN KOCH: We have reviewed your statement regarding the health facility named above and appreciate the interest that you have shown in bringing this situation to our attention.

This hospital, like many of the hospitals in the United States, is accredited by the Psychiatric Hospitals Division of Joint Commission on Accreditation of Hospitals. an instrumentality of the American College of Surgeons, the American College of Physicians, the American Hospital Association, and the American Medical Association. Section 1865 of Title XVIII of the Social Security Act provides that a hospital accredited by the Joint Commission will be presumed to meet all Medicare health and safety requirements with the exception of those relating to utilization review, institutional planning, and special psychiatric records and staffing, where applicable. Section 1864 of the above Act as amended by Public Law 92-603 (the Social Security Amendments of 1972) further provides that the Secretary of Health, Education, and Welfare may authorize a survey of a JCAH accredited hospital participating in Medicare if he determines that there is a substantial allegation of the exisence of a significant deficiency

or deficiencies which would, if found to be present, adversely affect the health and safety of patients.

If following a substantial allegation survey, a hospital is found to have significant Medicare health and safety deficiencies, the New York State Department of Health, which acts as a survey agent for the Medicare program, will assume responsibility for assessing the facility's efforts in correcting such deficiencies and will offer consultative assistance accordingly. Continued failure to sufficiently correct such deficiencies and/or present definitive plans to do so may result in a finding under Medicare regulation 405.1905 that a hospital is no longer eligible to participate in the Medicare program.

Accordingly, your information is being referred on this date for an unannounced investigation by the Department of Health. A copy of the investigation findings will be made publicly disclosable in the appropriate social security district office and public assistance office within 90 days of the completion of the investigation, unless the Department of Health possesses information in its files demonstrating that the conditions you describe no longer exist.

In addition to any other action being taken by ourselves or by New York State authorities, a copy of your statement has been forwarded to the JCAH for their information and any action they may deem necessary. The Division of Direct Reimbursement, Social Security Administration, which acts as the facility's intermediary, has also been advised of the portions of your statement dealing with fiscal matters.

Please note that Section 1801 of the Social Security Act, which forbids any federal agency or representative from interfering with the practice of medicine, obviates us from investigating or requesting an investigation of any specific case histories you may have mentioned in your statement.

Sincerely yours,

MILTON WEBBER,
Program Officer, Bureau of Health Insurance.

[APPENDIX 13]

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., June 16, 1977.

Mr. DREW S. DAYS III,
Assistant Attorney General, Washington, D.C.

DEAR MR. DAYS: My concern with three New York City mental hospitals has prompted me to write you concerning the violation of the constitutional rights of patients confined in these institutions. Particularly, I have found these hospitals to be grossly inadequate in providing sufficient protection from physical harm as well as inadequate in providing patients with meaningful treatment.

The Mental Hospital I am most familiar with is the Manhattan State Psychiatric Center. On November 8, 1976 my staff and I paid an unannounced visit in response to the requests of some of the patients families. The conditions I found there were deplorable! The sleeping rooms were filthy and the clothing ragged. There was no privacy for the individual patients, and security provisions were practically non-existent, as evidenced by a New York Post report of May 17 which cites hospital records which show 3 rapes, 38 assaults, 42 patient fights, 24 injuries, and 93 patient escapes in the month of April 1977 alone.

In response to this, I wrote to Dr. Lawrence Kolb, Commissioner of the Department of Mental Hygiene for the State of New York who is responsible for overseeing the facility. I subsequently made his response available to the Manhattan State Citizens Group which had originally approached me. Dr. Kolb's response, as well as the critical reply to his response by the Citizens Group is enclosed. Because I was so concerned with the situation, I then wrote to the Mental Health Administration within the Federal Department of Health, Education, and Welfare and requested that they undertake an investigation of the facility. Briefly, H.E.W.'s investigation confirmed my own findings of uncleanliness and improper supervision.

However, these investigations have not improved the conditions. It is clear to me that the State of New York and the hospital itself are not responsive to the legitimate problems at the Manhattan State Psychiatric Center. A more detailed

report of this situation is enclosed in the form of a testimony I gave before the House Judiciary Subcommittee on Courts, Civil Liberties, and the Administration of Justice, chaired by Congressman Robert Kastenmeier.

The second facility I wish to report on is the Bronx Psychiatric Center. On June 9, 1977 a New York State Commission of Investigation completed a thorough inquiry into the deaths of six patients and the beating of another. After reading their report, (of which I enclose a copy) I am sure you will agree that this type of situation is absolutely intolerable.

Let me cite some examples from the Commission report: One female patient had been taken to a different part of the hospital and forcibly beaten, resulting in four fractures of her right arm, the fracture or dislocation of from six to eight ribs, as well as extensive lung and internal damage. Another patient, critically injured when a man with a history of violent behavior struck him on the head with a broom handle, was forced to wait, after the ambulance had arrived, a full fifteen minutes while paperwork for his transfer was being filled out. Doctors report his life may have been saved had he received prompter treatment.

The report goes on to outline case after case of patient abuse and neglect. One woman's record was examined which gave no evidence that she had ever received any type of treatment prior to her reported suicide. Autopsy reports showed that one young man's death was caused by the administration of powerful biomedical drugs which had never been prescribed for him.

The Investigative Commission summarized: "In each of the cases scrutinized, the Commission found that little had been done to prevent the incident and that after the incident, BPC (Bronx Psychiatric Center) failed to respond adequately and to take essential corrective measures . . ."

The third institution I wish to bring to your attention, the Creedmoore State Hospital, is currently under investigation by the Queens County District Attorney, once again because of allegations of patient abuse.

It is discouraging and frustrating to all those involved that even when these facts are made known to hospital administrators and State officials, that there is little effective action being taken. The situations described remain basically unchanged. Furthermore, I believe that the abuses I have outlined may indicate a pattern of patient abuse and lack of treatment in other New York City institutions run by the State of New York.

I therefore urge you to undertake a thorough investigation of these three institutions so that we may find a way to protect confined persons and insure that they are guaranteed those basic rights to which all citizens are entitled by the Constitution of the United States.

All the best.

Sincerely,
EDWARD I. KOCH.

[APPENDIX 14]

PREPARED STATEMENT OF STANLEY C. VAN NESS, PUBLIC ADVOCATE-PUBLIC DEFENDER, STATE OF NEW JERSEY BEFORE THE COMMITTEE ON THE JUDICIARY, HOUSE OF REPRESENTATIVES IN SUPPORT OF H.R. 2439 AND H.R. 5791, MAY 23, 1977

MR. CHAIRMAN: Thank you for giving me the opportunity to testify in support of H.R. 2439. This legislation would authorize the Attorney General to intervene in or institute civil actions when the federal constitutional and statutory rights of individuals, incarcerated or institutionalized in state facilities, are violated. I understand that this Subcommittee is also considering H.R. 5791, which is identical to H.R. 2439, except that it is limited in application only to the involuntary confined and that it attaches an exhaustion of State remedies requirement to 42 U.S.C. 1983. Because H.R. 2439 appears to provide the potential of relief for a greater number of individuals who would otherwise have no means of reparation, I prefer it to H.R. 5791.

The role of the Attorney General envisioned in H.R. 2439 is similar to that of several divisions of the Department of the Public Advocate in New Jersey. Our Division of Mental Health Advocacy, Division of Public Interest Advocacy, Office of Inmate Advocacy, Developmental Disabilities Program and Child Advocacy Program each handles cases analogous to those which would confront the Attorney General should H.R. 2439 become law. Based upon our experience, I believe

that this piece of legislation is necessary to redress the fundamental grievances of those confined persons least able to represent themselves; the mentally ill, the developmentally disabled, the young, the aged and the imprisoned.

In 1974, New Jersey became the first State in the Nation—and, to date, the only State—to create a cabinet-level agency for the purpose of providing representation for citizens in a wide range of public interest matters. The enabling legislation that created the Department of the Public Advocate; N.J.S.A. 52: 17E–1, directly authorized two divisions to represent the institutionalized and the incarcerated.

The Division of Mental Health Advocacy provides legal representation for any indigent mental hospital admittee in any proceeding concerning the admittee's admission to, retention in, or release from confinement. A new Developmental Disabilities Program provides legal complaint services and community programs for the developmentally disabled and victims of mental retardation, cerebral palsy, epilepsy, autism and dyslexia. A class action office within the Division of Mental Health Advocacy represents the interests of indigent mental hospital admittees in such disputes and litigation as will best advance the interests of mental hospital admittees as a class on issues of general application to them.

The Division of Mental Health Advocacy has uncovered numerous cases of neglect or mistreatment of the mentally ill in our state institutions. At some institutions these instances are not isolated. Rather they are indicative of a pattern and practice of physical assaults and mental abuse of patients, and of unhealthy, unsanitary and anti-therapeutic living conditions.

As a result, the class action office within the Division of Mental Health Advocacy has brought suits against some state hospitals. The basis of these actions has been federal constitutional law. In recent years, the United States Supreme Court has recognized and affirmed the obligation of the courts to protect the rights of the mentally impaired who are involuntarily confined, noting specifically that the rights of the involuntarily committed had escaped meaningful scrutiny in the past. In *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972), a unanimous Court stated that:

"At the least, due process requires that the nature and duration of the commitment bear some reasonable relation to the purpose for which the individual is committed."

In *Jackson*, the Court found that incarceration without meaningful treatment bore no reasonable relation to the purpose of confinement; i.e., restoration to mental competency. Thus, in New Jersey, we have argued that the anti-therapeutic conditions that exist at some state hospitals, including the complete lack of meaningful, adequate and individualized treatment programs, render patients' confinements violative of due process, in direct contravention of the Fourteenth Amendment to the United States Constitution.

We have also alleged that the living conditions at certain state institutions constitute cruel and unusual punishment in violation of the Eighth Amendment. These conditions include lack of basic sanitation, lack of physical exercise, lack of privacy, inadequate diet, assaults on patients by attendants and other patients, lack of adequate medical care and psychiatric care and the indiscriminate use of seclusion and restraints.

In short, relying on such cases as *Wyatt* v. *Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), aff'd *sub nom*, *Wyatt* v. *Aderholt*, 503 F. 2d 1305 (5th Cir. 1974), we have claimed that patients at State mental hospitals are guaranteed a constitutional right to treatment including (1) a humane psychological and physical environment; (2) qualified staff personnel in sufficient numbers; and (3) individualized treatment plans.

Other alleged violations of federal law have not escaped our scrutiny. The Division successfully argued that persons could not be barred from registering to vote merely because of residence at a state school for the retarded. The court's decision on this issue in *Carroll* v. *Cobb*, 139 N.J. Super. 439 (App. Div. 1976), was the first of its kind nation-wide.

The second agency within the Department of the Public Advocate directly involved in cases of the kind that H.R. 2439 would give the Attorney General the authority to litigate is the Office of Inmate Advocacy. In its first two years of operation, the Office dealt principally with the conditions of State institutions—as opposed to those run by counties or municipalities. In a major class action filed in federal district court, the Office provided representation for inmates housed at

the Readjustment Unit at Trenton State Hospital, who had made the following allegations: that they were confined up to 24 hours a day in small cells, each of which contained an open toilet; that the cells were pervaded with the smell of urine and excrement and received virtually no natural light, that the inmates were denied healthful exercise, receiving one hour of "yard privilege" every ten to twenty days; that they were denied access to representatives of various religions and to a law library; that they were provided with no education or rehabilitative programs; and that they were systematically beaten by prison officials. After many months of negotiations, a stipulation of settlement providing for numerous reforms was entered into between plaintiffs and the State.

In 1976, the State legislature refused to appropriate monies for Inmate Advocacy. We then petitioned the Law Enforcement Administration Agency for funds and received a grant that allowed us to investigate the condtions of county and municipal jails. After having visited every county penal facility in the State, we have found that no more than four out of thirty are operated in conformity with constitutional requirements or with standards as developed by such organizations as the American Correctional Association, the National Advisory Commission on Criminal Standards and Goals and the National Sheriffs's Association. There are jails in operation in New Jersey that were built before 1900; only four major institutions are less than ten years old. In a majority of the jails, residdents never receive outdoor exercise, and most of those lack indoor gymnasiums. Often, a person will not leave the tier to which he is assigned except to go to court. Some literally never see the light of day, even through a window, for weeks or months. Confined persons are barred from having newspapers, magazines and books to read. Discipline is conducted in an informal and often arbitrary manner. Telephone contacts with attorneys and families are limited or nonexistent. Physical abuse at the hands of officers and other inmates is a frequent occurrence, most often inflicted upon those who are young, weak and mentally deficient.

I must emphasize that the facilities which I am describing are pre-trial detention facilities. In general, State prisons, which hold persons convicted of the most serious offenses are relatively more desirable places to be than local jails which hold only detainees, who are presumed to be innocent, and minor

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offenders sentenced to short terms.

The activities of two other agencies within the Department of the Public Advocate, the Child Advocacy Program and the Division of Public Interest Advocacy, have uncovered similar illegal conditions at juvenile detention facilities and nursing homes respectively. The allegations of beatings, chainings and other instances of physical abuse of juveniles housed in facilities that offer little or no education or recreation programs are particularly alarming.

It might be argued that my recitation of the Public Advocate's activities may have proved too much—that these are State problems that can and should be handled by State agencies. However, it should be emphasized that New Jersey is the only one of fifty States that provides such comprehensive representation for the incarcerated and the institutionalized. Even in New Jersey, the necessity for intervention by the Attorney General may arise. While our activities in the mental health field would more than likely obviate the need for the Attorney General to involve himself in that area in New Jersey, federal intervention may be essential in other areas. One example is the New Jersey State Prisons system, which is presently operating at greater than 150% of capacity. The effects of this overcrowding on the inmates may have risen to the level of cruel and unusual punishment. As I stated earlier, the State legislature has refused to continue funding for the advocacy of prisoners' rights.

Even were every State to adopt legislation creating agencies similar to the Public Advocate, the federal government's interest in the passage of a bill such as H.R. 2439 would remain intact. If the federal law is violated anywhere in this country, whether it be by an income tax evader or by the warden of a state prison, the federal government has the power and, indeed, the duty, to uphold the legitimacy of its laws. No strawman argument of "federalism" can vitiate the Supremacy Clause of the federal Constitution. As the Supreme Court stated in *Cunningham* v. *Neagle*, 135 U.S. 64, 10 S. Ct. 658 (1890):

"This power to enforce its laws and to execute its functions in all places does not derogate from the power of the state to execute its laws at the same time and in the same places. The one does not exclude the other, except where both

cannot be executed at the same time. In that case, the words of the constitution show which is to yield. 'This constitution, and all laws which shall be made in pursuance thereof . . . shall be the supreme law of the land . . .' Without the concurrent sovereignty referred to, the national government would be nothing but an advisory government . . . It must execute its powers, or it is no government."

The constitutional mandate for this legislation is buttressed by its practical and moral necessity. While 42 *U.S.C.A.* § 1983 provides possible remedies for individuals whose civil rights are abridged by state government officials, many prisoners and the mentally handicapped cannot utilize that avenue of redress. Pretrial detainees are often afraid to voice their opposition to jail staff and jail policies because they are afraid that their actions will affect the outcome of pending criminal prosecutions. In addition, they are a transient population and may not be in jail when an action is ready to be filed. While classaction certifications alleviate some of these problems, the remedy supplied by H.R. 2439 appears more practicable. Furthermore, institutionalized persons, such as the mentally disabled, often may not have full cognizance of their rights or may themselves acquiesce in an illegal practice such as racial segregation. Indeed, the vast majority of those involuntarily confined in state institutions are those without sufficient funds to represent themselves. Class representation by the Attorney General may be the only means by which their grievances will be redressed.

It is unlikely that the Attorney General, in exercising his mandate under H.R. 2439 would be resented for "outside interference" any more than is the Public Advocate. It should be noted that the state agencies against which we have brought civil actions are represented by the State Attorney General. As advocate for those who run the State institutions, the State Attorney General has at times assumed a position distinctly adversarial to that of those institutionalized or incarcerated.

Moreover, the relationship between federal authorities exercising their discretion under H.R. 2439 and the state institutions need not necessarily result in the lessening of confidence between the state and federal governments feared by the National Association of Attorney Generals. The experience of Inmate Advocacy in the county jails program is important on this point. In that program, we are a State agency investigating conditions of county institutions. We visit each institution, prepare detailed reports and distribute the reports to all relevant county officials. Following distribution of the reports, meetings are held with those concerned county officials. Some issues have been resolved at these meetings; others are resolved via formal written response. Compliance has ranged from almost total in one county to partial elsewhere. We make every effort to settle the grievances administratively. This negotiation process, which has also been successfully utilized in the mental health field, often does away with the need to resort to litigation. Section 4 of H.R. 2439 appears to envision a similar process as it requires the Attorney General to certify that he has notified officials of the problems and has given them time to correct them. Through this process of what Assistant Attorney General Drew Days termed "realistic pre-suit negotiations," the Attorney General is likely to discover, as we have, that many of the State officials are sincerely interested in running their facilities in accordance with the law. Lack of awareness of the problems, lack of knowledge of how to correct certain conditions or lack of wherewithal may have frustrated good faith attempts at amelioration.

In order to effectively fulfill the purpose of this bill, we do recommend the following amendments and clarifications:

Section 1, paragraph 2 should be amended to read as follows:

> "Any facility, including shelter or detention, in which juveniles are held awaiting trial *or hearing*, or to which juveniles are committed for purposes of *receiving rehabilitative care or treatment including residential, special education, psychiatric and medical facilities;*"

This amendment is necessary so as to include facilities that, in New Jersey and other states, house juveniles who have not been adjudicated delinquent but merely in need of supervision. For instance, juveniles in New Jersey are not "committed" to residential facilities but are "referred" to the Division of Youth and Family Services for placement in such facilities. While it can be argued that residential placement does fall within the intent of H.R. 2439, the bill should be amended to make it clear that the legislation is intended to include *all* facilities to which juveniles are held or sent.

Section 1, paragraphs 3, 4, 5 and 6 should be consolidated to include facilities which provide treatment or training for or care of any mentally handicapped, developmentally disabled, aged, chronically ill or other substantially handicapped person.

The bill, as presently drafted, overlooks boarding homes, group homes and foster care facilities which are either state supported or supervised. Consequently, we suggest that Section 1, paragraph 6 be amended to read:

> *"Any nursing home, group home, boarding home, foster home or similar establishment;"*

Such an amendment would cure the disparate treatment given the mentally ill and mentally retarded in the legislation. Mentally ill persons appear to be protected by H.R. 2439 only when residing in a "mental hospital," Section 1, paragraph 3, or a "nursing home," Section 1, paragraph 6. However, the trend is to move such persons into group homes, boarding homes and the like. Section 1, paragraph 4 extends coverage by the legislation to "any institution or treatment facility for mentally retarded persons." While many of these persons have physical infirmities, mental retardation is not an illness and does not require treatment. Rather, mentally retarded persons require care, maintenance and training—if they require anything at all. This distinction was recognized by the New Jersey Legislature more than a decade ago when the state colonies for the mentally retarded were renamed training schools. See *N.J.S.A.* 30:1–7.

The aged do not appear to be covered by the bill unless they are "chronically physically ill," Section 1, paragraph 5, or reside in a "nursing home," Section 1, paragraph 6. Again, the extension of the bill to boarding homes and group homes would serve to protect senior citizens.

Finally, I might briefly touch upon the issue of administrative burden and costs that would ensue from implementation of this legislation. The deprivation by a state of fundamental constitutional rights can never be justified by a claim of inadequate fiscal resources. A state legislature is not free, for budgetary or any other reasons, to provide a social service in a manner which results in the denial of individual constitutional rights.[1] The choice between administrative convenience and economy on the one hand and federal privilege and immunities on the other hand has already been made by those who drafted our federal constitution and the several states that agreed to abide by its dictates.

The spirit of a nation, it has been said, can be judged by the condition of its prisons. I might add that other factors equally important in a judgment of this sort are how the nation treats its mentally handicapped and developmentally disabled, the justice it shows its very young and the basic decency it demonstrates to its aged who are forced to live in nursing homes. Are we to be judged on the basis of state officials who condone physical abuse of the incarcerated and unsanitary environments for the mentally ill? Or are we to be judged on the basis of a federal government authorized to prod state governments into compliance with federal laws which insure that human beings are treated humanely? The fate of H.R. 2439 may be dispositive of these questions.

[APPENDIX 15]

OFFICE OF THE ATTORNEY GENERAL,
San Francisco, Calif., June 27, 1977.

Re S. 1393

Hon. BIRCH BAYH,
Chairperson, Subcommittee on the Constitution,
U.S. Senate, Washington, D.C.

DEAR SENATOR BAYH: The purpose of this letter is to express to the subcommittee my opposition to S. 1393. While I believe that certain provisions of S. 1393, such as its absolute preemption of all state remedies, are particularly unnecessary, I further believe that there are inherent defects in the presumed theoretical and factual basis for S. 1393 which warrant rejection of S. 1393. Accordingly, I will limit my comment to what I believe are inherent flaws in the legislative approach reflected in S. 1393.

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[1] See *Inmates of Suffolk County Jail v. Eisenstadt*, 360 F. Supp. 676, 687 (D. Mass. 1973); *Wyatt v. Aderholt*, 503 F. 2d 1305 (5th Cir. 1974).

It is evident that S. 1393 vests in the Attorney General and the district courts virtually unlimited discretion in assuming responsibility for all state and local institutions, and arguably for all private institutions which are subject to state or local licensing and regulatory provisions. The scope of the authority granted presupposes a finding of a nationwide pattern and practice of subjecting institutionalized persons to conditions which deprive them of their basic constitutional rights. As is demonstrated below, such a finding would be unwarranted. Nevertheless, assuming arguendo that it was shown that there was a widespread pattern and practice of deprivation of basic constitutional rights, experience has shown that such generalized grants of authority to the Attorney General and the district courts are ill suited to achieving redress for persons who are in fact aggrieved.

The similarities between S. 1393 and 42 U.S.C. § 1971 (voting rights) are readily apparent. The major differences are primarily a reflection of successive amendments which were intended to render litigation by the Attorney General under § 1971 efficacious. (74 Stat. 86, Civil Rights Act of 1960; 78 Stat. 241, Title 1, Civil Rights Act of 1964; *see South Carolina* v. *Katzenbach*, 383 U.S. 301, 314 (1966)). Despite these amendments, Congress was forced to conclude that 42 U.S.C. § 1971 was ineffective; and, this was largely due to defects which are inherent in the process of litigation. *See South Carolina* v. *Katzenbach, supra,* 383 U.S. at 308, 314–315 (1966).

Similar and additional deficiencies are likely to render litigation under S. 1393 an ineffective means of protecting the rights of institutionalized persons if there do in fact exist situations wherein there is a widespread pattern or practice of resistance to the full enjoyment of federal rights. Any federal court action is a time consuming process. Trial preparation problems can be anticipated simply because of the fact that the aggrieved person is institutionalized, and further problems may arise if the person is subject to some particular disability. While the discovery procedures afforded by the Federal Rules of Civil Procedures are intended to expedite trial, their effect is often to embroil the parties in protracted pretrial proceedings. Pursuing appellate remedies to their conclusion may delay the final judgement for several years or more. Whatever relief is afforded will be circumscribed by the issues and parties before the court. Implementation of a specific decree may do little to effect the overall quality of life in an institution and the effect of the decree might be diluted by subsequent administrative decisions respecting the institution.

Given the history of litigation under 42 U.S.C. § 1971, it must be concluded that if there are in fact widespread patterns and practices of abuse, a generalized grant of authority to the Attorney General and to the district courts is an inherently deficient means for securing redress. Such legislative abdication to the executive and to the judiciary offers a false hope to any persons who may in fact be aggrieved and presents a vehicle whereby any officials who are in fact evading their responsibility may continue to do so.

Moreover, not only is S. 1393 ill suited to redressing pervasive problems should any in fact exist, but also it will serve to impede progress which is in fact being made in insuring institutionalized persons a quality of life which exceeds minimal constitutional requirements.

First, legislation such as S. 1393 may serve to short circuit the implementation of recent federal legislation which reflects the assumption that the needs of institutionalized persons can be more fully satisfied by comprehensive and cooperative national and state legislative programs. The implementation of such programs is a more promising avenue for improving the quality of life of all institutionalized persons as such programs are not imbued with the deficiencies inherent in litigation. Such programs provide for federal supervision through administrative regulations and procedures and thus obviate the need for granting the Attorney General a specific authorization to initiate civil actions. Moreover, as is reflected in the actions of the California Legislature, states recognize the desireability of more fully responding to the very complex needs of institutionalized persons and are receptive to constructive congressional leadership.

One example of such legislation is Public Law 94–103, codified as 42 U.S.C. § 6001–6081, the Developmentally Disabled Assistance and Bill of Rights Act. California has responded with extensive legislation (Calif. Stats. 1976, Ch. 1364 through 1373; California Health and Safety Code, sections 38000 through 38500) recognizing the State's affirmative obligation to move forward in a coordinated effort to achieve measurable desirable results in this area. This legislation

established the California Developmental Disability State Plan (Health and Safety Code sections 38100-38107), an independent State Council on Developmental Disabilities (Health and Safety Code sections 38050 through 38062), and Area Boards which are required to protect and advocate the rights of all persons with developmental disabilities (Health and Safety Code sections 38150-38188). AB 1111, introduced in the California Assembly on March 24, 1977 would create in the office of the State Public Defender the Mental Health Advocacy Service with broad powers to represent mentally handicapped persons, including the power to initiate litigation in "any appropriate court or administrative hearing tribunal, against any person, agency or corporation, public or private, or any officer or employee thereof." Under the bill the Public Defender's decisions cannot be subject to approval or review by any other state agency.

This response by California underlines in various respects the inappropriateness of legislation such as S. 1393. It obviously refutes any assumption that the State has adopted a posture of benign neglect toward the needs of institutionalized persons or that the State is simply adverse to any federal involvement. More significantly, it points out the potentially negative impact which S. 1393 may have upon the further implementation of legislation similar to the Developmentally Disabled Assistance and Bill of Rights Act.

For example, it is provided in 42 U.S.C. § 6012 that the State must establish an independent authority for the advocacy of the rights of persons with developmental disabilities, with independent authority to pursue legal, administrative and other appropriate remedies to protect the rights of persons receiving treatment, services, for rehabilitation within the State. By contrast, S. 1393 tells the State that compliance with this requirement is immaterial. In light of such contradictory congressional directives, it is certainly not inconceivable that other states might be dissuaded from pursuing legislation such as California Assembly Bill 1111.

Secondly, S. 1393 affords no recognition to states which continue to move forward in dealing with these complex problems, but rather transfers responsibility to the federal executive and judiciary. As is reflected in California's extensive legislative and administrative provisions regarding institutions and the concomitant enforcement remedies, the State has not abdicated its responsibilities. Clearly all states should be encouraged in continuing such efforts, and none should be induced by measures such as S. 1393 to leaving such matters to the federal executive as judiciary.

In California, the rights of institutionalized persons are not limited to those guaranteed by the Constitution, but are further expanded and guaranteed by state law. For example, California Welfare and Institutions Code section 5235 guarantees to persons who are voluntarily or involuntarily admitted to facilities for psychiatric treatment and evaluation and to each mentally retarded person committed to a state hospital the rights delineated therein, as well as any other rights delineated by regulation. Similarly, California Penal Code section 2601 delineates a number of rights which are guaranteed to persons sentenced to state prison.

In California, all facilities not actually maintained and operated by the State, are subject to licensing provisions and all institutions are subject to inspection by various authorities or agencies. For example, facilities for the custody of treatment of juveniles come under the provisions of California Welfare and Institutions Code sections 200 et seq. Facilities where juveniles are detained for 24 hours or more are subjetc to inspection, and must be inspected at least annually, by juvenile judges, the Youth Authority, Juvenile Justice Commissions, and probation officers (Cal. W & I Code, sections 209, 229, 282). Facilities which are unsuitable cannot be used for the detention or custody of juveniles (Cal. W & I Code section 209). Also, the Youth Authority is required to adopt minimum standards relating to the construction, operation, programs, training, and population of juvenile facilities and those which do not meet the standards are unsuitable and unusuable (Cal. W & I Code section 210, 885, 1857).

California Penal Code section 6030 requires the Board of Corrections to establish minimum standards for local detention facilities, and requires the board to review the standards biannually and to make appropriate revisions. The standards promulgated by the Board of Corrections must include health and sanitary conditions, safety conditions, security conditions, rehabilitation, recreation, and treatment of persons confined, as well as the training of personnel. California Penal Code section 6031 required the Board of Corrections to

inspect local detention facilities at least biannually, and section 6031.1 requires the Board to report the results of their inspection to the person in charge of the facility, to the local governing body, to the grand jury, and to the presiding judge of the superior court. The report must indicate where the facility complies and where it does not comply with minimum standards established by the board. The minimum standards promulgated by the board are published in the California Administration Code, Title 15, Division One, Chapter One, Subchapter 4.

California Penal Code section 4300 requires counties to establish advisory committees on adult detention, and these committees must annually inspect adult detention facilities for conditions of inmate employment, detention, care custody, training and treatemnt in accordance with, but not limited to, the minimum standards established by the Board of Corrections (Cal. Penal Code section 4305). The advisory committee must report its inspection to the Board of Supervisors, the presiding judge of the Superior Court, the sheriff, the Board of Corrections, and the California Attorney General. Also, grand juries are required to inquire into the conditions and management of public prisons within their county (Cal. Penal Code section 919(b)).

California Health and Safety Code sections 1417 et seq. provide for the regulation and inspection of long term health care facilities in the state, and also provide for enforcement of the regulations through injunction and civil penalties. California health facilities generally come under the provisions of California Health and Safety Code sections 1250 et seq., which provide for the Department of Health to promulgate regulations governing the standards of adequacy, safety, and sanitation of the physical plant, governing the staffing of facilities with duly licensed personnel, and governing the adequacy of services to fit the needs of persons served (California Health and Safety Code sections 1275, 1276). Willful or repeated violation of regulations may be penalized as a misdemeanor (California Health and Safety Code section 1290, and failure to follow regulations may be grounds for suspending or revoking a license (California Health and Safety Code section 1296) or an injunction (California Health and Safety Code section 1291). Regulations governing the licensing and certification of health care facilities and referral agencies are extensive and are set forth in the California Administrative Code, Title 22, Div. 5, secs. 70001 through 73727. These regulations govern general acute care hospitals, acute psychiatric hospitals, skilled nursing homes, intermediate care facilities, and community care facilities.

Neither time nor space permit an exhaustive and detailed listing of all the provisions under California law, including adminstrative regulations, which afford avenues of review or redress of the alleged deprivation of rights of institutionalized persons. The possibilities include criminal actons against persons or institutions; civil actions for redress under theories of tort law; civil actions for redress by way of mandamus or injunction; civil actions for business fraud or consumer fraud involving fines, penalties, or injunction—these actions may be instituted by the Attorney General or by district attorneys; state habeas corpus actions; state civil rights actions on an exercise of concurrent jurisdiction under 42 U.S.C. section 1983; license revocation actions; and innumerable supervisory and administrative actions short of litigation in the courts of California.

Other examples include the power of the Department of Health to investigate and to grant appropriate relief whenever any person in custody as mentally retarded, mentally disordered, or incompetent is wrongfully deprived of his liberty, is cruelly or negligently treated, or is not adequately provided skillful medical care, proper supervision, and safekeeping (California Welfare and Institutions Code section 4021). The department is also authorized to investigate any complaints against any institution for the mentally disordered, mentally retarded, or other incompetents regarding the management of any person detained in the institution or held in custody by it (California Welfare and Institutions Code section 4022).

The above is only a somewhat sketchy sampling of the many statutes and regulations in California which bear on the institutions within the purview of S. 1393. Quite clearly the area of concern of S. 1393 has not been ignored in California. Many legislators, courts, officials in the executive departments of state and local government, as well as numerous professionals in the area, private advocates, and concerned citizens groups are all actively grappling with the very complex problems in this area.

Given the active and sustained role which has been taken by California in fulfilling its responsibility of insuring that the rights and needs of institutionalized persons are recognized and vindicated, I believe that it is singularly inappropriate for Congress to grant to the Attorney General and the district courts authority which in effect vests them with the responsibility heretofor met by the State.

Furthermore, even if it were demonstrated in Congressional hearings that there are localities wherein officials are indifferent to the rights of institutionalized persons, S. 1393 is not necessary to effectuate federal intervention. Federal courts are readily available for actions for redress under 28 U.S.C. sections 2254 and 2241 (habeas corpus); under 42 U.S.C. section 1983 (civil rights actions), and under 28 U.S.C. section 1331(a) (federal question jurisdiction).

Though habeas corpus is most familiar to persons seeking postconviction release, it also appears available for pre-conviction relief, *Moore* v. *DeYoung*, 515 F.2d 437, 441–442 (3rd Cir. 1975), and to commitment under civil process, *see Wales* v. *Whitney*, 114 U.S. 64, 571 (1885), including use by mental patients under involuntary civil commitments, *Kendall* v. *True*, 391 F.Supp. 413 (420 W.D. Ky. 1975) (three-judge district court); *Souter* v. *McGuire*, 516 F.2d 820, 823 (3rd Cir. 1975). Habeas corpus may be used to litigate the fact or duration of confinement, conditions of confinement, and procedures employed in making decisions affecting confined persons.

Under section 1131(a), suit may be brought against a unit of government. *Clark* v. *State of Illn.*, 415 F.Supp. 149 (N.D. Illn. 1976).

Even without the provisions of S. 1393, federal judges have assumed supervisory responsibility for institutions of state and local government in proceedings brought under 42 U.S.C. § 1983. Once a federal judge determines a federal right exists and has been violated, he may fashion "appropriate relief" the detailed provisions of which are original to the order. *E.g.*, *Morals* v. *Turman*, 383 F. Supp. 53 (E. D. Tex. 1974), reversed 535 F.2d 864 (5th Cir. 1976), reversed — U.S. —, 45 U.S.L.W. 3631 (No. 76–5881–March 21, 1977 (court ordered comprehensive statewide system for youth corrections); *Holt* v. *Sarver*, 309 F. Supp. 362 (E. D. Ark. 1970), affirmed, 442 F.2d 304 (8th Cir. 1971) (court ordered revision of state prison system); *Wyatt* v. *Stickney*, 325 F. Supp. 381 (M. D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala 1972) (court ordered revision of state mental institutions); *Rhem* v. *Malcolm*, 371 F. Supp. 594 (S.D.N.Y. 1974), affirmed 507 F.2d 33 (2nd Cir. 1974), on remand 389 F. Supp. 964 (S.D.N.Y. 1975), affirmed 527 F.2d 1041 (2nd Cir. 1975); *Miller* v. *Carson*, 401 F. Supp. 835 (D. Fla. 1975); *Jones* v. *Wittenberg*, 330 F. Supp. 707 (N.D. Ohio 1971), affirmed *sub nom Jones* v. *Metzger*, 456 F.2d 854 (6th Cir. 1972) (pre-trial detention facilities, county jail facilities).

In *Morales*, *supra*, two Texas juvenile facilities were required to be closed altogether, and the facilities remaining open were subject to detailed federal court control. In *Miller* v. *Carson*, *supra*, a federal ombudsman was appointed by the court to supervise implementation of court orders and to report to the court. In *Wyatt* v. *Stickney*, *supra*, the federal court threatened (a) to appoint a panel of masters to run the state mental hospitals; (b) injunctions against nonessential expenditure of state funds by the state treasurer and the comptroller (to free existing funds on a priority basis for use at mental institutions in accordance with the court order); (c) directives to the state Mental Health Board to sell or encumber its land holdings to raise funds to implement the court order [344 F. Supp. at 376–377].

Even without the provisions of S. 1393, the United States Department of Justice has been involved in such actions. The Department of Justice appeared as *amicus curiae* in *Morales* v. *Turman*, *supra*. In *Wyatt* v. *Stickney*, *supra*, it was invited by the court to join as *amicus curiae* (325 F. Supp. at p. 786), and subsequently did appear (334 F. Supp. 1341; 344 F. Supp. 373; 344 F. Supp. 387).

As is demonstrated above, California is not opposed to securing the Constitutional rights of institutionalized persons. On the contrary, California has consistently moved forward in adopting innovative and progressive measures which recognize the State's responsibility of affording institutionalized persons a quality of life which surpasses minimum constitutional requirements. As is likewise demonstrated above, California is not opposed to constructive federal programs which serve to expand the resources available to the State in further fulfilling its responsibility. On the contrary, the California legislature has demonstrated its willingness to participate in such promising programs.

Accordingly, from my perspective I can see no basis for Congress subsuming to the federal executive and judiciary a responsibility which properly should be met by the State and which is in fact being met by the State. Furthermore, improving the quality of life for institutionalized persons is a complex task which requires the cooperative effort of many persons. Experience has demonstrated that a generalized grant of authority to the Attorney General to initiate litigation in the district courts is not an effective means for securing redress should there in fact exist widespread patterns and practices of abuse.

In any area of legislative concern, an appropriate and effective legislative response requires first, a delineation of the problem which is to be met, and, secondly, the construction of legislation specifically designed to resolve the problem. Legislation such as S. 1393 which presupposes that all states have failed to meet their responsibilities and that the only solution is to transfer responsibility to the federal executive and judiciary meets neither requirement.

For all of the reasons set forth above, I respectfully urge that the Subcommittee not support passage of S. 1393.

Sincerely yours,

EVELLE J. YOUNGER,
Attorney General.

[APPENDIX 16]

NATIONAL JUVENILE LAW CENTER,
St. Louis, Mo., July 25, 1977

Re Senate Bill 1393.

Hon. BIRCH BAYH,
Chairperson, Judiciary Subcommittee on the Constitution,
Washington, D.C.

DEAR SENATOR BAYH: As I indicated in my mailgram of June 29, 1977, the National Juvenile Law Center is currently involved in federal litigation in Utah in the Case of *Manning* v. *Mitchell*, No. NC–75–34 (D. Utah), which dramatically demonstrates the need for Senate Bill 1393. Before I get into the specifics of the Utah situation, I would like to make a few general comments regarding the national situation.

The National Juvenile Law Center has been involved in institutional litigation on behalf of juveniles for many years. We currently list eight cases on our docket which involve institutional law suits. These suits include actions against juvenile detention centers, jails and state training schools. These cases, however, represent only the tip of an enormous iceberg. Hardly a day goes by at the National Juvenile Law Center that does not include a request from a Legal Services attorney, public defender or other interested person seeking assistance for institutionalized juveniles. It is impossible to take on all these cases, particularly broad-based cases which attack a state-wide system. The financial cost and human resource demands of such cases are quite substantial. Every institutional case which we have entered has always involved the expenditure of thousands of dollars and hundreds of hours of legal time. It has been our experience that the local offices within legal aid and the public defender system have very little if any resources to prosecute these actions. We, therefore, must proceed with caution before we can lend our assistance to such cases and if the bonus of the U.S. Justice Department is available, it makes possible what otherwise might be impossible. In any event, it enhances the possibility of bringing the action and prosecuting it to its fullest, if the Justice Department resources can be brought into play. The Center has had experience with the Justice Department in this respect in current litigation in Puerto Rico, and the impact of the department's involvement has been substantial. In summary, it is our collective experience that this bill is absolutely necessary to ensure that law suits challenging the conditions and practices in juvenile institutions be brought.

Concerning the state industrial school in Utah, I have enclosed copies of the original complaint, the supplemental complaint, copy of preliminary injunction and permanent injunction order, dated June 30, 1975, copy of the pertinent portions of the John Howard Association report on the Utah State Industrial School, court appointed special master's reports on conditions at the institution and recommendations for change and a copy of the Utah State Department of Social Services analysis of the manpower utilization and organization of the Utah State Industrial School.

I would like to call particular attention to the John Howard Association report which found an average daily population of 176 students in 1974/75 consisting of a broad range of temporary detainees to long-term court commitments (John Howard report, page 94, 98). Among the longer termers were federal contract commitments from the Bureau of Indian Affairs and Federal Bureau of Prisons. Although the school served these different populations groups, the report notes that all students were basically treated and programmed the same despite the difference in the groupings. The report found the staffing to be forty positions short of the general recommended overall one-to-one staff/child ratio (John Howard Association report, page 95). It found the average length of stay at the school to be 10.12 months for boys and 11.67 for girls (John Howard Association report, page 95). It found the average length of stay at the school to be 10.12 months for boys and 11.67 for girls (John Howard Association report, page 95). The existence of four spearate groups of children in a facility designed for one purpose was found by the Association to be a major problem that had to be solved if other problems were to be solved or reduced appreciably (John Howard Association report, page 98). The school's treatment focus, called "social learning" and consisting of a form of behavior modification applied to all the students' activities during his or her stay at the school was to be, in reality a "punitive, repressive and inappropriately applied and misunderstood" program by the John Howard Association consultants (John Howard Association report, page 102). The report found the program to rely heavily on the youth's institutional adjustment rather than on factors that brought him to the institution and to be overly mechanical in its use of a point system. As other deficiencies, the report found that the behavior modification program was not understood or properly applied by the staff, that it pitted staff against students with the granting or removal of poins on a continual basis and that it expected youth to fit into one program (John Howard Association report, page 102). Fifty percent of the staff stated that youth released from the institution were no better off than when they were first admitted. In general, the single-minded program was based too heavily on one program assumption without providing alternative methods for youth for whom the social learning approach was not effective (John Howard Association report, page 103). Distressingly, the Association found that staff resorted to corporal punishment in disciplining youth and, more prevalently, violence between the youth themselves was found to exist (John Howard Association report, page 103). The employee attitude survey conducted by the Association revealed that 56 percent of the staff noted they knew of incidents of youth being slapped, kicked, punched or having their hair pulled by other staff; 84 percent of the respondents thought that such behavior on the part of the staff existed; 95 percent of the staff indicated they knew of incidents of youth slapping, hitting, punching and abusing other youth (John Howard Association report, page 104). One cottage was designated as the "victim's cottage" where younger, smaller, and more immature children were confined indicating to the Association "serious program deficiencies at the institution" (John Howard Association report, page 104). Another related condition which suggests insufficient constructive programming at the institution was the incidence of runaways. In 1974 there were 129 runaways and in 1975, 156, or roughly one half of the total number of commitments. The John Howard Association report found that a consistant high runaway rate over a long period is indicative of basic program weakness (John Howard Association report, page 105). Also it found an enormous number of "special incident" or behavior reports (8,579 alcohol or drugs; the Association found it "hard to reconcile this level of incident in two years), 40 percent of which were of a serious nature including such things as assault, destruction of property, running away, assault with a weapon, use of reports of behavior with good programming" (John Howard Association, page 105). Although finding that the educational program was the best developed program at the school, the report also concludes that vocational education is limited. The report also found a series of administrative and general management deficiencies at the school, and concluded with a series of recommendations for change.

The court appointed special masters report, echoing many of the John Howard Association findings, is also significant in its finding that the defendants had violated the preliminary injunction regarding physical conditions in and procedures relative to isolation, as well as violating the permanent injunction against opening of student mail. This report was dated nine months after the court had entered the preliminary and permanent injunctions. The report suggests the ap-

pointment of a monitor to review the school's progress in compliance with the court orders. These recommendations are found at the end of the document marked "Recommendations for Change at the Utah State Industrial School", dated March 26, 1976.

The enclosed reports and pleadings in the case should speak for themselves concerning the diligence and interest of the Attorney General of Utah in safeguarding the rights of institutionalized juveniles in that state.

I would, in addition, like to add a few comments regarding the testimony of Attorney General John Ashcroft from Missouri before the subcommittee. First, unlike adults, juveniles do not seek out judicial redress except upon rare occasions. Through lack of sophistication, fear and other reasons, the grievances of institutionalized children are rarely brought to the attention of the Judicial System. Usually some extraordinary event, e.g. a death, or exceptionally long solitary confinement brings a case to the attention of attorneys or organizations such as ours. This was the case in *Harris* v. *Bell*, 402 Fed. Supp. 469 (D.C. Mo. 1975), wherein the Center sued the Missouri Division of Youth Services regarding confinement at Boonville, Missouri, the maximum security institution for boys in the state. A quick reading of the facts recounted in this opinion highlights the necessity for legal action due to the failure of legislative and executive reform. Reform may follow such litigation, but instances of executive and legislative reform in this country on behalf of institutionalized persons prior to suit is indeed rare.

I would be happy to provide the subcommittee with any further information which it would desire. I appreciate this opportunity to provide the subcommittee with the above remarks.

Very truly yours,

HARRY F. SWANGER,
Deputy Director.

Training School Litigation: Manning v. Mitchell, No. NC–75–34 (D. Utah 1975), *Sub nom.* Manning v. Rose and Reed v. Rose, Clearinghouse No. 15,726; Santana v. Rios, No. 75–1187. (D.P.R. 1975), Clearinghouse No. 18,757, Butler v. Henderson, No. C–76–91 (W.D. Tenn. 1976), Clearinghouse No. 19,918, Hilliard v. Morris, No. 807314, (Super. Ct., King County, Wash. 1976). Clearinghouse No. 17,783; Doe v. Holladan, No. CV–77–74 BLG (D. Mont. 1977).

Jail and Detention Center Litigation: Ahrens v. Thomas, No. 74CU34–SJ. (W.D. Mo. 1975), Clearinghouse No. 16,298; Missouri ex rel. Farmer v. Dent County, No. C–30–76 (Cir. Ct. Dent County, Mo. 1976), Clearinghouse No. 18,358, Roe v. Commonwealth of Pa., No. 74–519, (W.D. Pa. 1974), Clearinghouse No. 12,931, and Tommy P. v. Bd. of County Commissioners, No. 224974, (Super. Ct. Spokane Wash. 1975), Clearinghouse No. 16,941; Thomas v. Mackey, No. LR–73–C–26 (E.D. Ark. 1973), *Sub nom.* Thomas v. Frank, Clearinghouse No. 10,057.

PART 2—NEWSPAPER ARTICLES AND REPORTS

[APPENDIX 17]

[From the New York Times, Dec. 3, 1976]

ALBANY INVESTIGATES VIOLENT DEATHS AT PSYCHIATRIC CENTER IN THE BRONX

S.C.I. SUBPOENAS HOSPITAL RECORDS OF 6 INMATES AFTER WATCHDOG GROUP REPORTS ASSAULTS

(By Nathaniel Sheppard Jr.)

At the request of a citizen's watchdog group, the State Commission of Investigation has subpœnæd the hospital records of six patients from the Bronx State Psychiatric Center who committed suicide, were victims of assaults or who died under unclear circumstances.

The group said the cases were part of an "intolerable pattern of patient suicides, sexual abuse and assaults," at the psychiatric hospital during the last 17 months.

A spokesman for the seven-member group—the center's Board of Visitors, which was appointed by the Governor—said it received about 100 "unsual-incident" reports a month from the 780-patient, maximum-security hospital, giving skimpy details of patient injuries, assaults and unexplained deaths.

Six of the more-recent hospital-reported cases that have been scrutinized by the group have been turned over to the commission, according to the board's president, Blanche Sanchez.

SIX CASES CITED

These are the cases:

Luis Echevarria, a 16-year-old patient who committed suicide under unexplained circumstances at the hospital last summer after being shuttled back and forth between state institutions for several months. Before his death he acknowledged that he had engaged in sexual relations with a male employee at the hospital. The employee, who has since been dismissed, had been reprimanded in the past for showing up for work dressed in women's clothes, hospital officials said.

Ester Rodriquez, who died allegedly as the result of an assault at the hospital.

Angelina Cruz, a young mother who was found hanged at the hospital. When her body was found the face was battered as if from a beating, according to the Board of Visitors.

William Morales, found hanged in a bathroom at the hospital.

Frank Cursio, who was found by his mother during a visit undergoing a seizure in an unattended, locked room. He died as a result of the seizure.

Olga Vasquez, a patient who was found in the lobby of the hospital at about 6 A.M. one morning unconscious and severely beaten. She had three fractured ribs, a punctured spleen and lung and a fractured dislocated arm. She also was said to have been sexually violated.

A spokesman for the State Commission of Investigation acknowledged that the hospital records of the six patients had ben subpœnæd, but he declined to disclose the status of the investigation.

Dr. Hugh F. Butts, who has been director of the center for the last three years and is black, said he felt the allegations against his facility were unfounded and racially motivated.

"The incidence of assaults and deaths here is not worse than that of any other psychiatric facility in the state yet we are repeatedly subjected to investigations and exposes which I believe to be the result of blatant racism," he said.

"I believe it is a case of nobody wanting a black director of a major psychiatric facility," he said.

Numerous other instances of alleged patient abuse at the controversial facility at 1500 Waters Place in the North Bronx have been detailed during the last two weeks by medical and psychiatric personnel and some formerly associated with the hospital as well as by parents of patients.

The incidents included two cases in which women patients were said to have been required to have sexual relations with an employee in exchange for such privileges as using the telephone and receiving furlough passes.

One of the women was released from the hospital but was returned a short time later after she attempted suicide, believing that she had become pregnant as a result of one of the sexual encounters she had had with the employee. The employee was recently dismissed.

According to officials at the hospital, the most recent of 19 reports of alleged sexual abuse of patients between April 1975 and March, 1976 took place about seven months ago.

In that incident a male aide is said to have taken a female patient off the hospital grounds and to have raped her.

CASE GOES TO ARBITRATION

The officials said that they had sought to dismiss the employee, but that they had been prohibited from doing so during an arbitration hearing in which that hearing officer instead recommended that the aide be assigned to an area where he would have limited contact with female patients.

Most of the charges of patient abuse focused on assault, often involving one patient attacking another, and an alleged lack of other than minimal medical care.

In one case, a mother complained that her young daughter, who is mentally retarded, was badly beaten four times during the last year, twice by the same patient.

The mother, who asked that she and her daughter not be identified because her other children might be ridiculed by their friends, said that in yet another incident, for which she has received no explanation, her daughter was found early one morning with a broken arm.

"My daughter would complain that the cast hurt her arm and I kept asking the hospital to check it," she said. "When they finally did they said it had been improperly set by the public hospital to which she was sent but that hospital insisted that it had been set properly," she said.

"Now the cast is off and she has no use of the arm and I am told she needs an operation to correct the problem," the mother said. "The hospital that initially set the cast refuses to do the operation," she said.

The mother said she had sought to have another psychiatric center to accept her daughter after the second beating, but that all had turned her down because her daughter was retarded.

The huge complex, which covers nearly 114 acres, and is near the Jacobi Hospital cluster, has been the focus of criticism for much of its 13-year existence.

During a seven-hour interview at the facility on Wednesday, Dr. Butts said he felt much of the current criticism was displaced hostility at the previous administration.

And he said that while no patient abuse or suicides were "acceptable," he felt his hospital's record was no worse than any other psychiatric institution in the state.

"When I came here the place was a filthy pigsty and there was virtually no meaningful patient care or staff accountability," he said.

"Since 1973 there has been a 10 million percent improvement in these and most other areas and I have had to accomplish this during a time of shrinking budgets and staff and rising patient admissions."

[APPENDIX 18]

[From the New York Post, May 16, 1977]

TERROR BARED AT MENTAL HOSPITAL

(By Michael Rosenbaum)

The 1500 mental patients at Manhattan State Hospital live under constant threat of murder, rape, assault and theft because of inadequate security, a Post investigation has found.

The lack of protection affects not only patients, but also visitors to the Wards Island facility, located under the Triborough Bridge.

The assailants include violent patients as well as muggers and rapists who can reach the huge hospital complex by bus or car or simply by walking across a footbridge from East 103d Street.

The investigation by The Post discovered:

Only nine security guards are on duty at any given time to monitor the 122-acre, 18-building complex, plus its four community clinics in Manhattan.

In April alone, according to hospital records, there were three rapes, 38 assaults, 42 patient fights, 24 injuries and 93 patient escapes.

In the past month two patients died under mysterious circumstances.

Drugs and liquor are regulary smuggled in to patients, according to the hospital staff.

Violent patients, who should be isolated, are housed among the non-violent.

$30,000 GUARDHOUSE

A symbol of Manhattan State's vulnerability to crime is a $30,000 guardhouse which was built last year at the hospital entrance but which never has been manned by security guards.

A city park occupies half the island. A wire fence between the park and the hospital was built last year for $40,000—but it is constantly being cut.

Access to all hospital facilities—except for wards, which are locked—is practically uncontrolled. A reporter recently passed unchallenged onto the grounds and then into several hospital buildings. Only one guard was seen in five hours.

"Patients and visitors are constantly under assault by outsiders," said Dr. Gabriel Koz, the hospital's new director. "And theft is massive—a lot worse than any other state hospital."

Security, he said, "is absolutely ridiculous," because the hospital is "too easily accessible."

While it's too easy for criminals to get into the hospital, it also is too easy for patients to get out.

Patients at the facility are generally chronic or acutely psychotic adults, according to Koz.

About half the inmates are committed involuntarily by doctors or courts—some in criminal cases. While 200 to 400 are long-term patients, the remainder are supposed to be there for two weeks to a year, he said.

Improper supervision of patients' movements apparently played a significant role in the recent deaths of two patients.

The body of Petra Oueas, an inmate in her late 20s, was found April 20 in an abandoned building on the hospital grounds. She had been dead about 10 days.

The hospital staff last saw her on March 25 when she went for treatment to the Rehabilitation Building.

According to Donald D'Avanzo, of the Manhattan State Citizens Group, several patients saw her being taken from the hospital grounds by two men.

D'Avanzo, whose group represents relatives of Manhattan State patients, said another patient saw her April 1 in Times Square.

"I'm convinced she was abducted, and either escaped or was returned by her abductors to the hospital," D'Avanzo said. "I'm sure she was murdered."

The medical examiner has not yet determined the cause of death.

The body of a second patient, a male whose name was not released, was found floating in the East River May 5. Koz confirmed that the man had been seen on the 103rd Street footbridge earlier that day, but said the cause of death—suicide, accident or murder—has not yet been determined.

Easy access causes other problems...

Al Sunmark, a therapist at the hospital who is active in the staff's union, describes a "large liquor and drug traffic" that flourishes in the absence of security.

"Drugs are available in the wards," according to D'Avanzo. He said the most common drug is marijuana, which is sold for $1 per joint. A large tree near one of the main building, he said, is always littered with empty liquor bottles.

VIOLENT PATIENTS

Patients obtain the contraband, he said, either on unauthorized trips to the city or from what he termed "regular sellers" who come from Manhattan through the park.

But not all crime results from contact wtih the outside, the wards and in the hallways and elevators of the huge complex makes it difficult to protect non-violent patients from violent ones.

Two special units for violent patients were disbanded last year, largely due to staff shortages. The patients were redistributed among the hosiptal's general population which included many elderly people.

[APPENDIX 19]

[From the New York Post, May 17, 1977]

MORE HORROR UNCOVERED AT HOSPITAL

(By Michael Rosenbaum)

The wards are overcrowded at terror-ridden Manhattan State Hospital and a lack of staff has sharply curtailed treatment of mental patients there, a Post investigation shows.

The Post reported yesterday that crime was rampant at the hospital because of lack of security guards.

Wards designed to house 30 patients instead hold 35–54, The Post found. Shortages of nurses, therapy aides and maintenance personnel impair both medical care and rehabilitation for patients at the hospital, located on Wards Island under the Triborough Bridge, according to sources.

The hospital's new director, Dr. Gabriel Koz, has made significant improvements in sanitary and living conditions since February. But he said further staff and budget cuts loom. Among conditions found by The Post are:

Closing of 20 of the hospital's 82 wards and transfers of 200 patients from Pilgrim State Hospital have resulted in severe overcrowding.

Shortages of maintenance workers mean that therapy aides have to do cleaning work instead of treating patients.

Personnel has been cut by 20 per cent since 1973. An unpublished federal study, obtained by The Post, found that many wards do not have nurses on duty around the clock.

The same federal study found insufficient personnel to keep adequate medical records.

The hospital lost $220,000 in federal aid last year because of inadequate treatment of patients.

Between 35 and 50 patients escape from Manhattan State each month because there is insufficient personnel to supervise their activities.

The impact of short-staffing is readily apparent. One ward visited by a reporter house 54 patients from the Washington Heights-Inwood section of Manhattan. Since the ward had only 43 beds, some patients were shipped out every night to other wards, and returned the next morning.

The ward was neat and well-maintained, but a housekeeping aide said she could get only 20 towels for all patients in the ward.

Another ward, housing about 35 female patients from Greenwich Village, also had shortages of towels and clothing, staff said .

One cleaner was responsible for three wards housing more than 100 patients, and on nights and weekends therapy staff had to spend their time cleaning wards instead of treating patients.

An audit of the hospital, conducted by the U.S. Dept. of Health, Education, and Welfare at the request of Rep. Edward Koch (D-Man.), found overcrowding throughout the hospital, especially in sleeping areas.

The audit also found many wards without nurses on duty 24 hours a day, "many days of inadequate coverage" and day rooms "without staff supervision."

Al Sunmark, a therapist at Manhattan State and leader of the Civil Service Employes Assn. chapter there, charged that lack of staff "means there is no treatment [for patients] of a systematic or meaningful nature, only thorazine three times a day." Thorazine is a powerful anti-depressant.

He said one employe broke his finger while on duty at night, but had to remain at his station because "there was no one who could relieve him."

His remarks were echoed by Donald D'Avanzo, of the Manhattan State Citizen's Group, which represent patients' relatives.

"Aside from medication," he said, "there is little treatment there." He cited lack of rehabilitation activities "that teach people how to live in society. With only one employe on a ward, you can't be a jailer, let alone rehabilitate people," he said.

[Appendix 20]

[From the New York Post, May 17, 1977]

Beatings and Suicides at Bronx State Center

(By Michael Rosenbaum)

The State Investigation Commission today charged that "indifference and ineptitude" at Bronx State Psychiatric Center led to the deaths of six patients and the serious injury of a seventh.

The deaths included suicides and beatings.

In one of the incidents, the commission said, the hospital was directly responsible for the death last year of a male patient, 25, who had a history of seizures.

He died last June 24 after being injected with Haloperidol, a drug that should never be given to patients with such a condition, the report says.

INADEQUATE CARE

Commission Chairman David W. Brown said information on the death would be turned over to the Bronx District Attorney's office for possible prosecution.

The deaths occurred, the report charges, because of "inadequate" and "superficial" supervision of patients and a "careless and indifferent" administration at the hospital.

It charges the hospital failed to implement "policies intended to insure adequate patient care and protection."

The SIC report quotes Dr. Hugh F. Butts, the hospital's director, as admitting, "The majority of patients are not receiving what I would regard as appropriate psychiatric treatment."

Dr. Alvin Mesnikoff, regional director of the state Mental Hygiene Department, which operates the hospital, said today he was "aware of the deficiencies and shortcomings" cited in the report.

His staff, he said, conducted its own study of the problems last winter and has "taken steps to correct" them.

CHARGE COVERUP

The SIC's 8-month investigation of the hospital, at 1500 Waters Place in the north Bronx, also found that the hospital administration:

Took no steps to change its procedures after each incident in order to prevent further deaths.

Was "often able to obscure improprieties" from scrutiny by those outside the hospital.

The report, entitled "Life and Death at Bronx Psychiatric Center," was compiled at the request of a citizens' watchdog group which charged last fall that the other deaths were a part of an "intolerable pattern" of inadequate care of the 700-bed facility.

Some patients at the hospitals are admitted voluntarily or through civil court action, others are sent there after criminal convictions for violent crimes.

not report the names of patients, but describes the following incidents:

The hospital was directly responsible for the June 24, 1976, death of a 25-year-old male patient, who had been institutionalized most of his life and had a history of seizures. The hospital, the SIC found, "took little notice of his death."

But the medical examiner's office reported 8 months later that he died from "acute poisoning" from an injection of Haloperidol, a drug doctors warn should never be given to patients prone to seizures.

The panel was not able to determine who injected the drug, but uncovered substantial inaccurate and contradictory information on the incident in the hospital's files.

On July 14, 1975, a female patient was beaten severely at the hospital, and was treated for multiple fractures, bruises and dislocations at Jacobi Hospital. The SIC found Bronx State never determined who beat the patient, or how she walked unnoticed through several halls and down a flight of stairs before being discovered.

A male, 31, died September 26, 1975 in Jacobi Hospital after being beaten with a broom handle by another patient at Bronx State. Both patients had violent histories.

The SIC found that the patient could have been saved had there not been a 15-minute delay in getting him to an ambulance. The hospital did little, or nothing, to determine how the situation could have been avoided.

A male patient hanged himself in a bathroom on October 13, 1975 at noon, despite a warning from doctors that he was suicidal. The hospital failed to investigate the death seriously or take steps to prevent similar deaths.

The SIC found the circumstances surrounding the October 25, 1975 suicide of a female patient suspicious. Although the death was deemed a suicide by hanging, the report notes that the symptoms indicated strangulation by another person.

A male, 16, hanged himself in a room that was supposed to be locked on July 14, 1976. The hospital's response to his death, the report said, "was as superficial as the care and treatment accorded to him during his hospitalization."

The final death occurred March 24, when a 57-year-old male wandered away while he was not being supervised. He was found dead of exposure the next morning on the hospital's 114-acre grounds.

While the report deals mainly with the seven incidents and goes into little detail on the hospital's shortcomings, describes overall care as "inadequate" and says the hospital has been "unresponsive to the needs of its patients."

Robert K. Ruskin, one of the SIC's three members, said, "This is not a simple problem of seven patients alone."

Warning that "conditions seem mostly unchanged" at Bronx State, the SIC made three recommendations: creation of an outside body to probe patient abuse, "immediate and complete review" of the hospital's operations and stronger control by the regional director's office.

[Appendix 21]

[Editorial from the New York Post, May 17, 1977]

Hospital Under Siege

A new survey of wretched security situation at the Manhattan Psychiatric Center on Wards Island indicates that little has changed—except possibly for the worse. The condition is apparently as chronic as the official practice of promising various mental health care reforms.

"Community based" mental hygiene services offer many attractions to both patients and professionals. But the Carey administration's emphasis on that approach seemingly provides the state-operated MPC facility with no visible security benefit.

On the contrary, there have been regular accounts in recent years of dangerous security deficiencies. Figures reported by The Post yesterday, on the alarming incidence of rapes, assaults and escapes, conform to a long-standing pattern of neglect.

Recurrent appeals from administrators, staff and outside investigators for strengthened security measures—the complex has a current maximum guard force of nine—have evidently been unanswered. The chief administrator says the security situation is "absolutely ridiculous." That is an understatement.

[APPENDIX 22]

[From the New York Daily News, June 10, 1977]

BLAME HOSPITALS IN DEATHS, BEATINGS

(By Marcia Kramer)

Six patients died and a seventh was seriously injured because of the "ineptitude" and "indifference" of the staff at Bronx Psychiatric Center, state investigators said yesterday. The report gave a gruesome account of drug poisonings, beatings and suicides.

The probers' study, which included an admission from the center's administrator that most patients are "overmedicated or undermedicated," called for the creation of a committee to investigate abuses of patients at all state hospitals.

Reporting on its 8-month investigation, the State Investigation Commission said the hospital was directly responsible for the death last June 24 of a 25-year-old male with a history of seizures. The SIC said he was given an unauthorized and lethal dose of the drug haloperiod, which brings on seizures and increases their severity. The report said the patient never should have been given the drug and added that the center records show the man died of natural causes.

BRONX DA GETS CASE

Commission Chairman David Brown refused to call the case a "coverup," but said the center's inadequate reporting "would amount to that." He said the case has been turned over to the Bronx district attorney's office.

In each case it investigated, the SIC found what it termed "a consistent pattern of institutional indifference and ineptitude" that resulted in sloppy, sporadic supervision of patients. All of the incidents could have been prevented by a proper degree of supervision and staff training, the commission said.

BEATING DEATH ALLEGED

It cited the death of a 31-year-old man who allegedly was beaten over the head with a broom handle by another patient.

The SIC said the man lay unconscious in an ambulance for 15 minutes with no attempt being made to resuscitate him while staff members filled out papers to transfer him to Jacobi Hospital for medical attention where, the report said, doctors insisted that the man could have been saved if he had received attention more promptly.

The SIC also released its interview with Dr. Hugh F. Butts, the center's administrator, in which he admitted that many patients are improperly diagnosed and are either "overmedicated or undermedicated."

"The majority of patients are not receiving what I would regard as appropriate psychiatric treatment," Butts said.

Brown said that the administration as a whole at the 700-patient center in the North Bronx was guilty of failure to take corrective steps to prevent future deaths.

INACCURATE REPORTS CHARGED

He also charged administrators with filing inaccurate reports to prevent authorities from discovering "the incompetence and failures of employees," and with failure to recover $600,000 in 1976 because of faulty billing practices.

The report, entitled "Life and Death at Bronx Psychiatric Center" also recounts the following incidents:

On July 14, 1975, a female patient was beaten at the hospital. Her arm was fractured in four places and six to eight ribs were fractured or dislocated. The report found that hospital staff never determined who beat the patient.

On October 13, 1975, while a doctor only 5 months out of medical school was in charge of the entire hospital, a male patient hanged himself in a bathroom. The SIC said no suicide precautions had been taken despite warnings that the man was suicidal.

The SIC found suspicious circumstances surrounding the death of a female patient on October 5, 1975. Although staff said that death was a suicide by hanging, the medical examiner found signs of manual strangulation.

A 16-year-old boy hanged himself in a room that was supposed to be locked, on July 14, 1976.

Last March 24, a 57-year-old man with chronic organic brain syndrome wandered away from two staff members and was found dead of exposure the next morning on the hospital grounds.

[APPENDIX 23]

[Editorial from the New York Times, June 16, 1977]

LIFE AND DEATH AT BRONX PSYCHIATRIC

Stories of the mistreatment of inmates of mental institutions have become so familiar that the recent report of the New York State Commission of Investigation—"Life and Death at the Bronx Psychiatric Center"—may not shock many readers.

The investigators looked into five deaths and a severe beating that occurred at Bronx Psychiatric between July 1975 and July 1976 and found a pattern of "institutional indifference and ineptitude." One death, officially attributed to "natural causes," actually had been caused by a lethal dose of an unauthorized drug. One patient beat another to death with a stick from a broom closet that should have been locked. The "suicide" by hanging of a woman who had never shown suicidal tendencies was found to be "suspicious."

Dr. Hugh Butts, director of the center, who has made a good reputation in a difficult job, denies the charge of a "bureaucratic cover-up" leveled by the commission chairman, David Brown, but concedes that "institutional deficiencies" might have contributed to one or two deaths.

The inmates of institutions like Bronx Psychiatric are among the most helpless wards of the state. Dr. Butts acknowledges that most of them do not receive appropriate psychiatric treatment; he simply lacks the staff or facilities available to private institutions serving the more affluent. Misdiagnosis is common, and medication is typically used to maintain patients in a relatively subdued condition. But even if they cannot get first-class treatment, these people must, at the least, be safe-guarded from injury. The report is most disquieting on that score.

The commission urges the creation of a new "oversight body," independent of the State Department of Mental Hygiene. This State Commission on Quality of Care for the Mentally Disabled, as it is called in pending legislation, would have the power to initiate investigations of patient mistreatment or abuse. The argument for such an addition to the Albany bureaucracy is not persuasive. Every state hospital and school already has a "board of visitors" with the power to "investigate all cases of alleged patient abuse or mistreatment." In recent years, moreover, state hospitals have become more tolerable places—less crowded, cleaner, better regulated. Surely there is enough professionalism and compassion among state officials and hospital administrators to continue improving conditions and to root out "institutional indifference and ineptitude." We prefer to believe that the guardians of our mentally ill do not need to be heavily policed to fulfill their most basic responsibility to protect their charges from harm.

[APPENDIX 24]

[From "Wards of the State," a report on the causes, nature, and extent of patient abuse in State mental health facilities. Prepared at the request of the New York State assembly standing committee on mental health as outlined in its resolution adopted Nov. 9, 1976.]

INTRODUCTION

Myths and abuses surrounidng the so-called mentally ill have existed for as long as the warehouses euphemistically referred to as mental hospitals that housed them have existed, and the institutions themselves are a visual sign of society's attitudes toward those persons placed within them. Typically, the buildings have been vast and dreary, and it has been a practice to locate these human storehouses far from population centers. Local communities were detached from any type of responsibility for the inhabitants of institutions. The isolation of these facilities was no less great than that imposed upon and felt by the persons

forced to remain in them. Based on fear and ignorance, "treatment" was typically brutal and violent. At best, minimal custodial care was rendered to persons locked within institutions. Because they were viewed as less than human, no thought was given to the quality of the lives of the patients or to the possible improvement thereof.

Financial priorities in institutional maintenance have been paramount consistently throughout the last century. There was a move as far back as the 1880s that reflected the fiscal priorities of the policy-makers. Centralized control of mental institutions for children and adults was implemented with the rationale that it would be economical, less costly than the previous approach to operating them, and thus the New York Care Act was passed in 1890. Upon passage of the Act, the state assumed full responsibility for the care and treatment of psychiatric patients. Still, by definition and practice, care and treatment were synonymous with institutional maintenance. Abuses and neglect were still a part of the daily lives of the patients.

Things had not significantly improved from the conditions described by Dorethea Dix when, in 1843, she presented her "Memorial to the Legislature of Massachusetts." In that statement she cited many examples of children being caged, bound, beaten, starved, neglected and abused in even more abhorrent ways. More than one hundred years after Dorethea Dix gave her presentation, there was much evidence that the situation in psychiatric hospitals was very much as she had described the almshouses of her own time.

Blatt and Kaplan, in 1966, visited a number of facilities in the United States and wrote:

"We know personally of few institutions for the mentally retarded in the United States that are completely free of dirt and filth, odors, naked patients grovelling in their own feces, children in locked cells, horribly crowded dormitories, and understaffed and wrongly staffed facilities."

Testimony presented to the Subcommittee on Patient Abuse of the New York State Assembly Standing Committee on Mental Health repeatedly confirmed the fact that abuse and neglect have been, and continue to be, part of the daily routine, particularly in State Childrens' Psychiatric Centers and Developmental Centers. On December 15, 1976, Jack E. Herman, President of the Society for Good Will to Retarded Children (serving Suffolk Developmental Center) stated the following in his testimony:

"The practice of physical and mental abuse of residents of Suffolk Developmental Center is frighteningly widespread. There is much abuse which results in bodily injury, pain, disfigurement and death. There is abuse which destroys the spirit. This is caused by lack of programs, a herding atmosphere of behavior and dehumanizing procedures. There is much abuse which results from neglect and insensitivity to the needs of the residents. There is abuse which results from the deprivation of basic human rights."

The Willobrook Consent Decree of 1974 was enacted in response to greater public concern about abusive conditions within that facility and within other childrens' centers throughout the state. The decree mandated that facilities must provide more than custodial care to their patients. It also stipulated that Willowbrook and other overcrowded institutions must reduce their in-patient populations. It was assumed that smaller facilities could, in part through a smaller client-staff ratio, prevent abuses from occurring and could provide more services and programs for the patients. Apparently, conditions have improved at Willowbrook since the decree was presented. A majority of residents have been relocated into the community or into other childrens' centers. However, according to Dr. Alvin Mesnikoff, New York City Regional Director of the State Department of Mental Hygiene, conditions within Willowbrook and the other facilities within his jurisdiction (including five childrens' developmental centers and three childrens' psychiatric centers) have not significantly improved since 1974. In testimony presented by Dr. Mesnikoff on December 16, 1976, he stated that there are numerous cases of abuse reported daily. "No incident is minor and the people in our care who are the most vulnerable are entitled to the best care available in a safe and protected environment. Unfortunately, we are not consistently able to provide these conditions." Dr. Mesnikoff further stated that the system must be totally reformed to change the situation that presently exists within the facilities.

Blanche Sanchez, President of the Board of Visitors of the Bronx Psychiatric Center, also presented testimony at the December 16 patient abuse hearing. She stated that there is a universal lack of supervision, lack of treatment, lack of

94-420—77——64

amenities for patients, and widespread abuse and neglect within the state hospital system. She further defined abuse in relation to programs and stated that neither facilities nor programs are geared toward patient care, and there are no active rehabilitation programs. In summation, Mrs. Sanchez stated, "The patients have nothing to do."

On November 1, 1975, the legal procedure for reporting incidents of alleged abuse was changed from Article 75 to the new Article 33. The latter change was prepared by the state and the CSEA, the union which represents state hospital employees. The intent of the new procedure was to encourage reporting of abuses and to offer an arbitration mechanism through which the psychiatric centers and the alleged abusers could optionally meet with an arbitrator to determine disposition of cases. When presented, Article 33 was hailed as a desirable reform that would potentially make it easier to ascertain accurate reports of abuse incidents and to take the appropriate action on these cases. Article 33, however, has exemplified how "progressive" reforms may in practice be regressive, control-oriented, and unresponsive to the needs of service recipients. There is a surveillance quality to the reporting procedure, whereby staff members have been encouraged to report against their co-workers. This has been particularly true with the psychiatric therapy aides who have the most direct contact with the patients and, thus, would most frequently be the accused. This component of the procedure has borne much conflict and tension among staff members. Many staff aides testified in a series of closed patient abuse hearings in December of 1976 that they have consciously chosen to reduce their interactions with the children who are patients at state psychiatric centers, for fear that their contacts would be misconstrued and that they might become the subject of an incident report alleging an abuse.

More importantly, these staff members stated that they have received repeated threats from administrative staff that actions would be taken against them if they filed reports that would present the facility in a bad light. Examples of this relate to misuse or overdosing with psychotropic pharmaceuticals, inappropriate utilization of restraints, and maltreatment or non-treatment that would be deemed neglect on the part of an institution or its adminisrative staff. The fears of the employees were borne out by the fact that they wished to give testimony to the Subcommittee on Patient Abuse but would only do so if they were subpoenaed. These employes gave testimony in closed hearings so that their jobs would not be jeopardized. It says something about the mental health of our state's mental hygiene facilities.

Another component of reporting of abuse and Article 33 relates to the rights of patients. Patients are neither present, nor do they have the automatic right to have legal representation on their behalf when they have been abused. A bill presented in the last 1976 New York State Legislative Session would have mandated legal representation for patients. This bill which became Chapter 334 of the state mental hygiene laws and stated that the Mental Health Information Service provide legal counsel to patients in matters "relating to patient abuse or mistreatment." Through much pressure from the CSEA, after the bill was passed by the legislature it was amended at the Governor's request. The result is that patients still do not have the right to automatic legal representation.

During the public hearings on patient abuse, many persons who testified, including hospital staff, administration and patients' advocates, expressed dissatisfaction with the present procedures and their apparent ineffectiveness. As one person who testified expressed it, "the State Department of Mental Hygiene shouldn't be the only agency investigating its own dirty laundry," and the rights of patients must not "continue to be ignored in processes relating to abuse incidents."

It is important to note that abuse and neglect are not easily defined terms. The New York State Legislature has not in fact defined these terms; perhaps they cannot be defined specifically to cover all possibilities. That has continued to compound the issue in that, lacking definitions, much has necessarily been left to the interpretation of individuals or of individual centers. It has been clear, however, that no matter how one chooses to define abuse and neglect, they have been altogether too common within childrens' facilities, and they appear to be inherent within the massive institutions as they have historically been structured and as many of them still exist today.

A memorandum (number 75-32) issued on September 29, 1975, from the New York State Department of Mental Hygiene, Division of Mental Retardation and

Children's Services to Regional Directors and Directors of developmental and children's pychiatric centers presented definitions and policy statements relating to abuse of patients. Abuse was defined as follows:

"Abuse of residents is defined as inflicting, allowing to be inflicted, causing to be inflicted, or inducing a resident to inflict upon self or other residents any pain or discomfort. This includes teasing, slaps, blows, arm twisting or any similar action. In addition to physical abuse, abuse may be psychological or verbal if it willfully subjects a resident to shame or dehumanization . . . Abuse, mistreatment, or neglect is not permitted under any circumstances. Neglect is defined as a condition or deprivation in which residents receive insufficient, inconsistent or inappropriate services, treatment or care to meet their fundamental and ongoing needs."

In regard to policy, the memorandum states that "An employee who observes resident abuse has an obligation to intervene and attempt to terminate or limit the abuse." Relating to reporting procedures, employees are instructed to report any incidents to their immediate supervisors.

This memorandum is quite specific about utilization of restraints, medication and use of seclusion. Restraints, according to the memorandum, may not be used as punishment and may only be used with the authorization of a facility director or specifically designated "professional" staff. They are described as something to use as a last resort, and not to be used for extended periods of time. In addition, prior to using restraints, parents of the child for whom they are deemed appropriate must be notified in writing of their use. Straitjackets and seclusion are never permitted, according to the memorandum.

Medication, it states, "shall not be used excessively, as punishment, for the convenience of staff, for control of behavior, as a substitute for program, or in quantities that interfere with a resident's rehabilitation program."

According to much testimony presented in both the private and public patient abuse hearings, the practices are highly inconsistent with the stated policies of the New York State Department of Mental Hygiene. The purpose of this report is to reveal the extent, nature and causes of these inconsistencies as they are manifested in the physical, sexual and emotional abuse and neglect of clients in our state hospitals.

I. EXTENT OF PATIENT ABUSE

Determining the extent of patient abuse is extremely difficult due to the inadequacies of the present reporting procedures and the absence of a clear, legal definition accepted by all parties. Several Department of Mental Hygiene employees reported to the Mental Hygiene Information Service that it is not unusual for patients' complaints of abuse to go unreported by staff members. Even when an incident report is made in the proper form, problems arise. At the present time the regulations of the Department of Mental Hygiene (14 NYCRR Section 24) require only that reports of "alleged or apparent abuse or mistreatment be served upon the Mental Health Information Service." The meaning of the term "abuse or mistreatment," however, is not self-evident.

Although one might think that a report about a patient who was slapped by an attendant clearly alleged "patient abuse or mistreatment," in one instance the person who filled out the report form categorized such a complaint as an "assault" rather than as "patient abuse." Because the regulation only requires that reports of "patient abuse or mistreatment' be served upon the MHIS, this report might not have been served. As it happens, this particular institution's Director had ordered reports of all incidents.[1] In order for the MHIS to properly perform its functions, reports of all incidents involving patients ought to be submitted to MHIS within 48 hours after they occur.

The absence of DMH personnel trained to investigate charges of patient abuse results in problems in adequately determining, investigating and disposing of such cases. Recommendations surrounding all areas of inadequacy within the present reporting system have been made by the MHIS.

Peter Strand, in his task force report to the subcommittee indicated that after dealing with over 10,000 children and hundreds of abuse allegations, there were few situations where one could categorically say this is always abuse, no matter

[1] Report of the Mental Health Information Service on the Adequacy of the Current Grievance and Disciplinary Procedures.

what the patient's history. He further states that patient abuse must be understood as a complex interaction between two or more people occurring in a highly specific context.

Russell Barton, M.D., Director of Rochester Psychiatric Center, stated in his report to the subcommittee on Feb. 4, 1977 that "the extent of patient abuse cannot be known, due to the provisions of the Department of Civil Service combined with the exploitation of race discrimination regulations, making it impossible to build up and maintain adequate staff in DMH facilities." Dr. Barton expressed the view that incident reports are often filed by "unreliables and malcontents," who side with other employees to give false testimony or to intimidate other witnesses. This makes honest, reliable reporting practically impossible.

In a Report to the Commissioner for Client Abuse and Disciplinary Grievance Procedure, the Department of Mental Hygiene last year concluded from its data that "over a 2½ year period, *one* out of every 100 clients is likely to be the victim of abuse that will result in initiating disciplinary action against an employee." The report also showed that such incidents occur four times as often in developmental centers as in psychiatric centers, and eight times as often in children's psychiatric centers as in other psychiatric centers. Four percent of the employees in a children's psychiatric center are charged with client abuse over a 2½ year period. Two percent of employees in developmental centers are charged with client abuse in the same period, and only 1 percent of employees in psychiatric centers are so charged in the same period. Male employees were involved in abuse cases six times as often as female employees, according to the report.

Physical abuse cases occurred mostly in psychiatric centers, with "lesser but still significant numbers of physical abuse charges initiated in developmental centers and children's psychiatric centers." Reports of neglect of clients, on the other hand, occurred most frequently in developmental centers and consisted of sleeping on the job, failure to provide adequate supervision, or abandonment of work station. Finally, the report concludes, "The proportionally high rate of sexual abuse of patients in children's psychiatric hospitals appears worthy of note." While the figures on sexual abuse show only 3–4 percent in psychiatric and developmental centers, they reveal an astonishing *17 percent* in children's psychiatric centers. (See Appendix B.)

This April 1976 DMH Report was prepared as part of an examination of client abuse cases reported during the Department's 2½ years of experience with a disciplinary procedure "designed to encourage use and eliminate practically all of the formality and ritual traditionally associated with discipline in the public sector." Since much abuse emanates from fellow patients and usually involves no disciplining of an employee, the DMH Report's limitations as a measure of the extent of patient abuse needs to be noted.

It is important also to note that several DMH employees reported both to MHIS and to this subcommittee that it is not unusual for patients' complaints of abuse to go unreported by staff. Beyond that, it is logical to assume that some incidents of abuse by fellow patients upon victims like the autistic or otherwise uncommunicative patient probably also go unreported by the victim himself/herself. This would be particularly likely in children's psychiatric centers and heightens significance of the 17 percent figure cited above as to *reported* cases of sexual abuse charges in children's centers. The very case which brought about the creation of this subcommittee involved physical abuse of a four-year-old autistic patient. The abuse had gone unreported and uninvestigated until parents visited the child, discovered the bruises, and "blew the whistle." We are left to wonder how many others, whose parents were not so alert, were abused without report or official action.

To be fair to the employees, we must note that they are dealing with a client population with a great variety of mental and emotional disabilities. Some patients are affected with paranoid disorders, hypochondria or sado-masochistic tendencies. All of these can play a role in abuse cases. Often there are only unproved allegations by a disturbed patient. It is quite possible that some of the complaints about abuse by staff or fellow patients are purely the product of an overactive imagination associated with particular disorders, or with medication which induces hallucinatory experiences. On the other hand, even such reports as these must be filed and investigated, if the Department's responsibility for protecting patients is to be fulfilled. Absence of evidence to substantiate imagined allegations of abuse will serve to dismiss such cases, but failure to seek evidence would be a dereliction of duty to the disabled and possibly abused client.

The findings of the subcommittee are that, while reported incidents of abuse by employees in which disciplinary procedures are involved has been slight, except in the case of reported sexual abuse of children, there are too many limitations on the scope, depth and accuracy of such a report to make valid conclusions from it about the actual extent of patient abuse. All we can say is that this report shows us the *minimum* extent, and that this could be only the top of a much larger iceberg. In any event, even if there were no more to the iceberg, the Department and the Legislature have a responsibility to take immediate corrective action toward reducing the extent of abuse of those who are incapable of protecting themselves and are "wards of the state." We must as Dr. Michael Kalogerakis, Associate Commissioner of the DMH Office of Children and Youth states, "pursue reform as vigorously as possible to root out abuse wherever it appears."

II. FINDINGS ON THE NATURE OF PATIENT ABUSE

II. A.—Definition of abuse

Testimony and research by subcommittee staff revealed that, while there is a definition of abuse (*Social Service Law*, Section 371–4b) covering abuse of children less than 16 years of age, there is no legal definition of abuse of individuals 16 years and older. Under Title XX of the Federal Social Security Act as implemented by the Comprehensive Annual Social Services Program Plan for New York State, protective services for adults 18 years of age or older are provided in *some* social service districts in *some* situations that are "abuse" related. However, there is no legal definition for abuse of the mentally disabled in either the *Mental Hygiene Law* or the *Social Service Law*. Individuals aged 16 to 17 are not covered under either the child or adult definitions. This situation infuses reporting, investigatory, and adjudication proceedings with ambiguity and uncertainty and does not fully protect patients.

Testimony has reflected a contrast between a narrow legal definition, namely the willful physical or verbal mistreatment of a patient by an individual or individuals responsible for the patient's care, and the wider definition, namely the overt act, or lack of action, that results in physical, mental, or emotional injury to the patient and which could have been prevented through awareness, understanding, or positive action. The subcommittee finds the latter definition too vague and the former too narrow. Neither definition in the context of its current usage fully protects the patient.

We recommend consideration of the definition provided in DMH Memorandum No. 75–32, issued September 29, 1975, and provided on page 7 of the introduction to this paper. We also concur in the MHIS recommendation that the Department "clearly communicate to all personnel its concern for the humane treatment of its clients and its procedures for reporting incidents of patient abuse and mistreatment."[2]

II. B.—Sources of abuse

1. Official abuse derives from many sources, including the Legislature itself and the Budget Division of the Executive Chamber. When budget cuts are made, when hiring freezes and wage freezes are established, patients are bound to suffer from the resulting frustrations. A budget director who impounds funds that are urgently needed for care and treatment of retarded children sees statistics instead of people as the end of his efforts. Playing games with numbers is a habit of the Budget Division to which several prominent mental health professionals addressed themselves.

Beyond that, however, there is the unintentional official abuse that derives from:

a. lack of coordination among public, voluntary and private groups active in mental health and having a common goal of providing alternative institutional and community care for the mentally disabled,

b. lack of understanding of the significance of terminology used in the field of mental health, as when inadequate diagnosis tragically and premanently "labels" a patient. In a system that conditions acceptance of one's disability and promotes the dependency syndrome that further erodes the ego, such insensitivity constitutes one of the grossest forms of abuse of the mentally disabled.

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[2] Report of the Mental Health Information Service on the Adequacy of the Current Grievance and Disciplinary Procedures, p. 7.

c. lack of clarity as to goals and measures to provide the optimal care possible for the mentally disabled, to help prevent intensified mental illness, to educate the community regarding mental health, to assist families of the afflicted, to promote training and effectively utilize the skills of clinical staff and therapy aides.

While it is essential that the state move as rapidly as possible to eradicate remaining inhumanities in DMH facilities, it is equally imperative that facts, honesty and perspective by the guidelines for proposed programs.

Testimony from many direct care workers gave insight as to the frustrations felt by workers when there were no clearly defined expectations for care and treatment of the patients assigned to them. In redesigning the mental health system to remove abusive conditions, positive consideration must be given to the training and education of *all staff* to specific limitations and valid expectations of care. The care of the mentally ill is a pressure-type work situation even under the best of circumstances. These pressures are accelerated by unrealistic expectations and limited training.

Tolerance and empathy are very difficult characteristics to maintain across the board. When unclear or unrealistic expectations induce frustration, even the most competent direct care staff member, well meaning and anxious as he may be to do a decent job, can be driven to a destructive reaction. Guidelines should be developed to educate and train all staff to the special needs of specific types of patients.

2. *Patient to patient abuse.*—Patients are people with special problems. They are extracted from diverse community life styles and put into a uniform setting with other people who also have special problems, sometimes more intense than their own. Without proper education and training of staff, the hospital environment becomes a degrading and abusive one for many patients. Testimony indicated that a major source of patient abuse—physical, mental and sexual—derives from fellow patients. The nature of the illness, lack of competent supervision, and absence of programs interact to intensify hostilities and create an environment for abuse.

Patients known to be self-abusive are sometimes placed in restraints and left unsupervised. This allows for abusive situations to occur when patients with aggressive disorders prey upon restrained, unsupervised persons and are free to abuse them because of the placement mix and the absence of staff to prevent this.

Testimony indicated that too often adults admitted for observation as a result of criminal charges are housed with mentally disabled adolescents. In several cases this has led, according to allegations, to incidents of physical or sexual abuse which could have been avoided. In the final analysis, all patient to patient abuse is the product of faulty or negligent supervision, sometimes due to administrative error in placing patients, sometimes to workers without a commitment to protect their patients, and sometimes to budgetary constraints which leave a ward inadequately staffed.

3. *Worker to patient abuse.*—Testimony alleged that drinking is widespread among workers at certain institutions, leading to neglect and abuse of patients. It was also alleged that night staffing in particular is so minimal in some of the most violent wards that a lonely night staffer will lock herself into a safe room and leave patients to their own devices rather than risk his/her own life in an unmanageable situation. Such neglect situations set the stage for patient to patient abuse.

Working hours for professional staff seem to be designed at some facilities for the convenience of the professionals rather than for the needs of the patients. It is not unusual to find not a single doctor available during night hours at an entire facility, and untrained therapy aides left to their own devices to cope as best they can with difficult situations. Many witnesses testified that the hours after professionals leave the premises are the most difficult of all and are the hours when abuse most frequently occurs.

To a certain extent, this problem is directly related to the widespread practice among D.M.H. professionals to hold outside employment, a practice which the Governor recently sought to curtail, but not without the vehement opposition of those affected. In June of 1975 a survey was done by the Department to determine what percentage of those earning over $30,000 were holding outside employment. "Of almost 1300 positions in this category, 553 employees, about 45 percent, reported outside employment. This is a minimal figure, since information was not supplied by all facilities."[3]

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[3] Department of Mental Hygiene, Legislative Study, October 1, 1975. (See Appendix C).

The Department's Policy Manual states that "outside employment of staff should be controlled only to the extent that conflict of interest is avoided and that the outside employment does not adversely affect the accessibility of the employee in the full performance of duties to the Department of Mental Hygiene." No comment was made as to the hours of requisite accessibility for departmental duties, and the Department hastened to conclude that "these limits on employment are appropriate and should not be broadened." It further warns that "prohibition of outside employment would threaten good patient care, because many trained and experienced professionals would leave state service rather than give up outside employment. This is the expressed position of Department physicians and Facility Directors concur in their evaluations."

A most intolerable situation occurs when a worker accused of patient abuse is not removed from the ward where the alleged abuse occurred. Given the right of a worker to be assumed innocent until proved guilty, it is nevertheless unfair to subject a patient who may very well have been abused by a particular worker to the continued control of that same worker, whose wish to stifle the complaint could lead to even more serious abuse.

Workers who are on the firing line most are the psychiatric therapy aides. They serve patients most directly throughout the 24 hours of every single day. They are hired through a civil service system which includes no psychological screening, leaving a situation where the mentally disabled may be left under the control of persons who are themselves emotionally disturbed or mentally ill. They are too often untrained for their work, thrown into a ward with autistic children and permitted to administer medication without knowledge of the nature and treatment of autism or the possible side-effects of particular drugs. They are required to serve also as custodians, cleaning the floors and the toilets, making beds, and washing clothes at the same time as they are expected to be supervising patients. The hiring freeze affects some wards far more drastically than others, as a particular ward may have several elderly workers retire in a given year, leaving the remaining workers much overloaded. Too often, the attitude of supervisors and directors toward therapy aides leaves them no room for pride in their work, for they are regarded and treated as the "lower echelon" whose role is quite unimportant and whose input is neither asked nor wanted by the professionals who are "in charge."

II. C.—Use of restraints

Several witnesses testified that the policies and procedures regarding the use of restraints such as camisoles and bedsheets were implemented too often without respect for the patient's rights. Sometimes this resulted in substantial physical impairment or marked pain and discomfort. In some instances, restraints like a cumbersome "goalie mask," not specifically prohibited by law or regulation but clearly an extreme measure, were inhumanly administered and inadequately monitored. Administrative irresponsibility was often cited as the major reason for this all-too-frequent state of affairs. The frequent mixture of tranquilizing medication *and* physical restraints was frequently cited as a major source of incidents of "official" abuse of patients, because this combination left the patient completely helpless to resist sexual or physical attack by another patient.

On the other hand, the difficulty in handling the highly active and sometimes self-destructive patient was cited as a mitigating reality in many of these cases, but not so mitigating as to divert responsibility from front-line, supervisory, and administrative personnel to deal humanely with even these behaviors and to ensure that drugged, restrained patients be given needed extra protection against attack. Furthermore, many parents and relatives testified that, to their amazement and disbelief, they were not informed when restraints were to be used on their children or relatives.

Finally, members of the Boards of Visitors were too often unaware of the extent to which physical restraints were used in their respective facilities, or of the substantial risks inherent in the use of such restraints. In fact, in one instance it was alleged that an incident of patient abuse occurred as a direct result of an administrator overreacting to a complaint by a member of the Board of Visitors, whose child was allegedly hurt by a particular patient. The offending patient thereafter suffered extreme punitive restraints in order to assuage the influential member of the Board of Visitors.

II. D.—Absence of adequate medical care

It is cruelly ironic that patients who reside in a state *hospital* are so substantially lacking in adequate *medical* care. One witness alleged that an elderly woman was found dead in her bed, eyes open, body uncovered, with no attendants

nearby and no doctors in attendance. In the same ward it was alleged that a non-English speaking woman lay in bed, obviously in great pain and lacking medical attention.

Several witnesses alleged that two incidents involving the deaths of young children resulted from inadequate and incompetent medical care. An autistic child was identified as suffering from sickle cell anemia based upon the results of five blood tests taken over an extended period of time. The DMH doctor handling the case apparently did not believe, despite test results, that the girl had sickle cell anemia, or he did not realize the gravity of the situation. The child was taken eventually to a hospital by her parents, after her condition had greatly deteriorated. She died three days after leaving the state facility. It was later determined that the psychiatric center knew of the sickle cell anemia after running the series of blood tests, but took no action to ease the child's pain or treat the disorder, because of the doctor's continued doubts about the results of the blood tests. Workers allege that all medical records were immediately removed upon her death, and what was previously recorded in the medical journal was struck out and replaced by the word "ERROR." In this case, too little was done for the girl while she was alive, and when treatment finally was initiated, only because parents insisted, it was too late. The doctor who handled this case is now acting director of the center.

In another instance, it is alleged that a thirteen year old girl in the same autistic unit slipped while in the shower and injured her spine. For some time afterwards, she walked hunched over and in great pain. An incident report form was filed, and the attending therapy aide requested that x-rays be taken for the child's back. The medical staff ran tests but gave no follow-up care, according to ward attendants, and the child died three weeks after her fall. Altough the official cause of death was listed as "unknown," it would appear that there was a direct correlation between the child's accident and her death. Six months after her death, the medical staff received the laboratory reports regarding her x-rays and the tests taken after her fall. One of the team leaders at the autistic unit gave the following incredible explanation for lack of proper medical attention: "We don't expect these autistics to live beyond 15 anyway."

In another case, a young boy plagued with chronic nosebleeds at least four times a week for a period of over two years was finally sent to the infirmary for tests to determine the cause of the nosebleeds. At the hospital, it was determined that the boy suffered from hemophilia. No prior blood tests had been taken.

Perhaps most representative of the lack of proper medical care is the case in which medical staff was made aware of an instance of pinworm epidemic spreading through a ward. The staff did not inform therapy aides of the spread of the pinworms for fear they would overreact to the information and unfavorable newspaper publicity might result. It was only after one nurse refused to abide by the decision to keep quiet about the epidemic that the therapy aides learned of the widespread pinworm problem. Upon learning of the epidemic, the therapy aides demanded and finally received proper instruments for combatting the spread. The employee who informed the therapy aides of the epidemic was later reprimanded by her supervisor for releasing the information.

Patients frequently must seek medical care outside the institution despite the seriousness of their mental condition. On a personal basis one doctor testified to such abuse when a patient from a psychiatric center was discovered by his family to be on the floor for more than 24 hours as a result of a diabetic coma and was brought to Montefiore Hospital where he was treated. When the patient was stabilized, the institution refused to readmit him based on the fact that he had a "medical problem." The implications for those who remain in the psychiatric hospital are very serious and disturbing.

Another case in point involved Mrs. X at a State Psychiatric Center and was brought to the subcommittee's attention by a Mental Health Association representative. The family of this 63-year-old woman complained to the Mental Health Association that the physical and psychiatric condition of this patient had deteriorated badly. She was spending most of her time lying on the floor—either in her room or on cold bathroom tiles. She had lost 50 pounds, was not eating, and, when on a weekend visit home, had suffered from heavy vaginal bleeding. She was not responding to psychiatric medication, and according to a Center doctor, could not take ECT because of a possible spinal injury. When relatives, visited, they saw one attendant on the ward trying to care for 30 patients. The day before the family called the Mental Health Association, Mrs. X complained

that "her leg was made of wood," and was suffering from chills. The Association immediately directed a letter to the hospital director, indicating the need for an immediate and thorough medical and psychiatric evaluation of the patient. The next day Mrs. X was sent to a municipal hospital on an emergency basis and was suffering from an *undiagnosed heart attack and a gangrenous leg*. The leg was amputated on Friday, October 1.

The family has told the Mental Health Association that prior to her last psychiatric hospitalization on Ward's Island, Mrs. X had suffered from circulatory problems and had had treatment for varicose veins in the leg which was not amputated. This took place at Metropolitan Hospital in Manhattan. There also seems to be a strong possibility that the patient had diabetes, although this is now denied.

In former years, Bronx Psychiatric Center patients requiring more than superficial medical care were sent routinely to the nearest municipal hospital, where, reportedly, they and accompanying staff routinely were compelled to wait several hours before admission or treatment took place. Accordingly, the center last year worked out an agreement with a voluntary hospital to treat its patients. This arrangement failed, and the center—once again unable to get swift and good care for its patients—now is attempting to establish an agreement with another voluntary hospital. Meanwhile, seriously ill patients must again be sent to Bronx Municipal Hospital Center—where rejection, interminable waiting and otherwise unstatisfactory treatment has been routine.

These incidents are just a small representative portion of the many situations in which a lack of proper and adequate medical care led to serious and harmful consequences for residents of the state's psychiatric centers. At times, this ineptitude has led to unfortunate and unnecessary deaths. As residents of these centers, all patients are entitled to receive not only adequate attention for emotional ills, but proper medical care and attention.

Because of their extremely delicate emotional state, the patients at the state's psychiatric centers constitute a medically "high risk" population. They have special needs, needs which require very special medical attention. All too often, however, an air of apathy prevails. Not only are special medical needs not adequately fulfilled, but oftentimes even fundamental custodial care is not provided.

II. E.—Dispensing of medication

Medication now plays a far more important role in the rehabilitative process for the mentally disabled than ever before. The role of chemotherapy in reducing the scope and intensity of behavioral disorders is a phenomenal achievement of New York State's DMH research facilities. It is of the utmost importance, however, that proper care and extreme caution be exercised by employees to ensure that medication is properly administered and that patients are not suffering from adverse side effects.

Too often medication is dispensed by untrained and uncertified personnel who are not familiar with the prescribed medication nor with its possible side-effects. All too frequently, medication is dispensed in an unprofessional manner. Reports indicate that often the medication was not dispensed at the prescribed times or in the proper amounts, and that some physicians had signed blank prescriptions, leaving an unlicensed person to execute details.

In one instance, that of a twelve year old boy, doctors prescribed Haldol as part of the treatment for the boy's disorder. 200 mgs of the medication were to be given four (4) times daily, for a total of 800 mgs a day. An eye witness alleged that the youth's doctor thought it best to change the daily dosage amounts, but failed to notify the attending therapy aide who was to administer the medication. As a result, the boy had already received some 600 mgs of the drug prior to bedtime, when the night attendant was prepared to give him 800 mgs more of the drug. Prior to administering this additional amount of Haldol, another attendant realized that the boy had earlier been given a total of 600 mgs and fortunately stopped the near overdose. This situation typifies the extremely poor communication that exists too often between doctor and therapy aide in many state facilities. The child was fortunate in this instance, but care needs to be taken to ensure that the person administering the medication is aware of previously administered dosages of medication.

In another situation, attendants in a facility funded at a rate exceeding $25,000 per client were told to re-use paper medication cups because of a "shortage." What resulted was a widespread epidemic of strep throat among the children, at far greater cost to taxpayers than the few cents saved by the recycled paper cups, not to mention the cost to patients in unnecessary illness.

In yet another instance, a young girl received Haldol for a period of seven or eight months. After this extended use of the drug, several signs emerged of extensive deterioration of her central nervous system and of loss in motor control. It was learned later that Haldol is not recommended for children under fourteen years of age, because of its heavy side-effects. This realization occurred after eight months of extensive use of the drug. At that point, doctors discontinued its use by suddenly withdrawing the medication. No incident report form was ever filed as to the abuse of this patient, as far as we can tell.

During the hearings, several therapy aides expressed deep concern and extreme fear regarding the dispensing of medication of which they knew very little of and whose possible side-effects they were totally unaware. All too often, these medically uncertified and untrained personnel are not knowledgeable about the potency of the medication or about the color coding, side effects, name, or proper amounts of the drug to be dispensed. Frequently the only directions issued are "dispense as needed," without recognition that untrained attendants are not appropriate decision-makers for determining what a particular patient's needs are.

During the writing of this report, *Newsday* headlines indicated "Patient's Death is Tied to Drugs." A fifty year old woman, being transferred involuntarily from one psychiatric center to another became violent in resisting the undesired move. Placed in a locked, "secure" ward, she was found two days later with both eyes black and blue. She complained that ward staff had beaten her, according to a man and woman who told a reporter they were employees but refused to give their names. Later she was found dead. MHIS and the Homicide Squads investigated and were unable to confirm any assault. An autopsy report revealed "a touch of salicilates" (aspirin) and a "therapeutic dose" of Mellaril in her bloodstream. The County Medical Examiner attributed the patient's death to overmedication with powerful tranquilizers, agranulocytosis, which also explains the bruised eyes. Easy bruising is one of the early signs of agranulocytosis. The patient's medical record showed she had been receiving powerful transquilizers of the phenothiazine family since 1972. Literature accompanying the bottle states that these drugs can block or interfere with production of white blood cells in some patients. She also had been taking aspirin for a sore throat. Aspirin can also lower the white blood cell count. Had agranulocytosis been detected, the patient could have been treated with other drugs, such as phenobarbitol, to calm her, or a camisole could have helped to restrain her.

PART 3—COURT CASES

[APPENDIX 25]

Cite as 334 F. Supp. 1341 (M.D. Ala. 1971)

Ricky Wyatt, by and through his Aunt and legal guardian Mrs. W. C. Rawlins, Jr., et al., Plaintiffs,

v.

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, Civ. A. No. 3195-N.

United States District Court, M. D. Alabama, N. D.
Dec. 10, 1971.

Proceeding relating to conditions at public mental institutions of state. The District Court, Johnson, Chief Judge, held that where court, which decreed that patients involuntarily committed to public mental institution have constitutional right to receive such individual treatment as would give each of them a realistic opportunity to be cured or to improve, allowed defendants six months to set standards and implement fully a treatment program and defendants' reports and objections thereto showed that the treatment programs were still wholly inadequate, because of demonstrated good faith court would defer turning over operation of the institutions to a panel of masters but would set a further hearing to establish proper standards and in due course would order their implementation.

Ordered accordingly.

Mental Health ⚷51

Where court, which decreed that patients involuntarily committed to public mental institution have constitutional right to receive such individual treatment as would give each of them a realistic opportunity to be cured or to improve, allowed defendant six months to set standards and implement a treatment program and defendants' reports and objections thereto showed that the effective treatment programs were still wholly inadequate, because of demonstrated good faith court would defer turning over operation of the institutions to a panel of masters but would set a further hearing to establish proper standards and in due course would order their implementation.

George W. Dean, Jr., Destin, Fla., and Jack Drake, University, Ala., for the plaintiffs.

William J. Baxley, Atty. Gen., and Gordon Madison and J. Jerry Wood, Asst. Attys. Gen., State of Alabama, Montgomery, Ala., for the defendants.

David L. Norman, Asst. Atty. Gen., Civil Rights Div., Dept. of Justice, Washington, D.C., and Ira DeMent, U.S. Atty., Montgomery, Ala., for amicus curiae, The United States of America.

James F. Fitzpatrick, Jeffery D. Bauman and Stephen M. Sacks, of Arnold & Porter, Washington, D.C., Charles R. Halpern, Washington, D.C., and Bruce J. Ennis, New York City, for amici curiae the American Psychological Assn., American Orthopsychiatric Assn., and American Civil Liberties Union.

ORDER

JOHNSON, Chief Judge.

In this class action, originally filed in behalf of patients involuntarily confined for mental treatment purposes at Bryce Hospital, Tuscaloosa, Alabama,[1] this

[1] On August 22, 1971, this Court granted plaintiffs' proposed amendment to enlarge the class to include patients involuntarily confined for mental treatment purposes at Partlow State School and Hospital and Searcy Hospital at Mt. Vernon, Alabama. This did not necessitate additional defendants since by authority of Title 22, Section 318, Code of Alabama, the defendant board has control and jurisdiction of all the mental institutions herein involved.

Court on March 12, 1971, in a formal opinion and decree, 325 F.Supp. 781, among other things, held:

"The patients at Bryce Hospital, for the most part, were involuntarily committed through non-criminal procedures and without the constitutional protections that are afforded defendants in criminal proceedings. When patients are so committed for treatment purposes they 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. . . .

"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." Ragsdale v. Overholser, 108 U.S.App. D.C. 308 [315], 281 F.2d 943, 950 (1960). The 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. . . ."

At the request of defendants, the Court in the March 1971 order allowed defendants six months to set standards and implement fully a treatment program so as to give each treatable patient a realistic opportunity to be cured or to improve his or her mental condition. The case is again submitted upon defendants' reports and the several objections thereto.[2]

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

The psychological and physical environment problems are, in some instances, interrelated. For example, the dormitories are barn-like structures with no privacy for the patients. For most patients there is not even a space provided which he can think of as his own. The toilets in restrooms seldom have partitions between them. These are dehumanizing factors which degenerate the patients' self esteem. Also contributing to the poor psychological environment are the shoddy wearing apparel furnished the patients, the non-therapeutic work assigned to patients (mostly compulsory, uncompensated housekeeping chores), and the degrading and humiliating admissions procedure which creates in the patient an impression of the hospital as a prison or as a "crazy house". Other conditions which render the physical environment at Bryce critically substandard are extreme ventilation problems, fire and other emergency hazards, and overcrowding caused to some degree by poor utilization of space. In addition, the quality of the food served the patients is inferior. Only fifty cents per patient per day is spent for food, and sanitation procedures with regard to the preparation and service of food, commonly recognized as basic health practices and utilized at other such hospitals, are not followed at Bryce.

The second fundamental condition needed for effective treatment is a qualified and numerically sufficient staff. It is clear from the reports of Bryce's expert consultants that Bryce is wholly deficient in this area, both as regards its professional staff and its nonprofessional staff. More psychiatrists, Doctor of Philosophy level psychologists and qualified Medical Doctors are not only a medical but are also a constitutional necessity in this public institution. Special staff is needed to place the custodial patients still residing at Bryce. Although, as *Rouse* v. *Cameron*, 125 U.S.App.D.C. 366, 373 F.2d 451 (1966) points out, contact with the nonprofessional staff should be therapeutic, very little of this therapeutic value is realized at Bryce. The nonprofessional staff is poorly trained; nurses aides, for example, are required to have only a tenth grade education. Also there is no effective "in-service" training program for, or even any regular supervision over, the nonprofessional staff. The nonprofessionals are spread very thinly; thus,

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[2] As directed, the United States of America formally appeared as amicus curiae. By leave of the Court the American Psychological Association, the American Ortho-psychiatric Association, and the American Civil Liberties Union have also appeared as amicus curiae. The plaintiffs and all amici have filed objections to defendants' reports.

they are overworked, creating not only an inadequate situation for the patients but extreme stresses for individual aides. Both Bryce consultants agree with amici and plaintiffs that additional aides and activities therapists are a necessity.

The third necessary condition for an effective treatment program is individualized treatment plans. Bryce is also deficient in this area. Although every patient has been classified as to treatability, the records made on each patient are inadequate. Minimum medical standards require that periodic inquiries be made into the needs of the patients with a view toward providing suitable treatment for them. Yet, at Bryce the records evidence no notations of mental change. They consist generally only of notations of the times and amounts of drugs given and participation in the Patient Operated Program, the Token Economy Program or the Level Program. Bryce's own consultant advises that treatment is geared primarily to housekeeping functions. The three main programs which have been implemented motivate the patients to some activity and do effect some degree of socialization, but at a minimum level. What programs there are do not yet seem to be operating effectively, partly because of the untrained staff members supervising them.

All the objections raised by amici and by plaintiffs generally are supported by the reports of Bryce's consultants. There seems to be a consensus of opinion among the experts that the treatment program at Bryce Hospital continues to be wholly inadequate. There are strong indications from the evidence before the Court, sparse as it is, that the conditions at Partlow and Searcy are no better than those at Bryce.

The primary and fundamental question remaining in this case, therefore, is not whether the defendants have promulgated and implemented a program that meets minimum medical and constitutional standards, but what procedure this Court should now pursue to ensure that this be done.[3] Although the goals defendants have set are rather vague, the defendants Stickney and Folsom, who has since the earlier hearing in this cause been retained as Superintendent of Bryce Hospital, have to this point generally demonstrated good faith and a desire to attain minimum medical and constitutional standards in the three primary mental institutions now operated by the State of Alabama. Consequently this Court will again defer turning over the operation of these institutions to a panel of masters.

Nonetheless, minimum medical and constitutional standards for the operation of these institutions must be formulated. Defendants have been given an opportunity to perform this task and have failed. It must be kept in mind that plaintiffs' rights are present ones, and they must be not only declared but secured at the earliest practicable date. This Court has concluded that the most feasible procedure to be followed as to this phase of the litigation is for this matter to be set again for formal hearing, this time for the purpose of allowing the parties and amici the opportunity to present proposed standards that meet medical and constitutional requirements for the operation of the three mental institutions herein concerned and to present evidence by experts in support thereof. From this evidence this Court will establish standards and in due course order their implementation.

Accordingly, it is the order, judgment and decree of this Court that this cause be and the same is hereby set for hearing for the purposes hereinabove stated commencing at 10:00 a.m. on January 18, 1972.

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[3] As stated earlier, the treatment program now being implemented at Bryce is wholely inadequate. Likewise, the interim report filed by defendants on June 10, 1971, is inadequate. This report and the other matters presented to this Court upon this submission affirmatively reflect that defendants have formulated no standards for staffing, for improving the physical environment or for realistically improved treatment plans. While it may be that adequate financial means had not at the time of the filing of defendants' reports been made available by the Alabama Legislature to satisfy these medically and constitutionally mandated standards, the standrds should at least have been formulated.

[APPENDIX 26]

Cite as 503 F. 2d 1305 (5 Cir, 1974)

Ricky Wyatt, By and Through his aunt and legal guardian Mrs. W. C. Rawlins, Jr., et al., etc, Plaintiffs-Appellees,

v.

Charles Aderholt, as Commissioner of Mental Health, et al., Defendants,

The Alabama Mental Health Board, an Agency of the State of Alabama, and George C. Wallace, as Governor of Ala., Defendants-Appellants.

No. 72-2634.

United States Court of Appeals,
Fifth Circuit.
Nov. 8, 1974.

A class action was brought upon a complaint alleging that an Alabama state school designed to habilitate the mentally retarded was being operated in a constitutionally impermissible fashion. The United States District Court for the Middle District of Alabama, Northern Division, Frank M. Johnson, Jr., Chief Judge, 344 F. Supp. 373, and 344 F. Supp. 387, granted injunctive relief, and the defendants appealed. The Court of Appeals, Wisdom, Circuit Judge, held that the Constitution guarantees persons civilly committed to state mental institutions a right to treatment, that the suit was not barred by the Eleventh Amendment that the right to treatment could be implemented through judicially manageable standards, that the granting of relief did not invade a province of decision-making exclusively reserved for the state legislature and that adequate legal remedies were not available.

Affirmed in part; remanded in part and decision reserved in part.

1. Mental Health ⚷51

Civilly committed mental patients have constitutional rights to such individual treatment as will help each of them to be cured or to improve his or her mental condition. 28 U.S.C.A. § 1343(3).

2. Mental Health ⚷31

Alleged "need to care" for mentally ill and need to relieve their families, friends or guardians of burdens of doing so did not supply constitutional justification for civil commitment. U.S.C.A.Const. Amend. 14; 28 U.S.C.A. § 1343(3).

3. Courts ⚷303(2)

Suit for denial of federal constitutional rights of state hospital inmates to treatment was not barred by Eleventh Amendment. U.S.C.A.Const. Amends. 11, 14.

4. Mental Health ⚷51

Constitutional right of mental hospital inmates to treatment can be implemented through judicially manageable standards. 28 U.S.C.A. § 1343(3); U.S.C.A.Const. Amend. 14.

5. Constitutional Law ⚷70.1(7)
Mental Health ⚷51

State, which undertook to confine mentally ill persons to state hospitals, could not do so constitutionally without providing care and treatment, and federal court did not invade legislative province in requiring such care and treatment. 28 U.S.C.A. § 1343(3); U.S.C.A. Const. Amend. 14.

6. Courts ⚷262.4(4)

Legal remedies of habeas corpus, medical malpractice and ordinary tort actions were not adequate remedies for state hospital inmates seeking to require establishment of program, institution-wide in scope, for developing and formulating individual treatment plans. U.S.C.A. Const. Amend. 14.

7. Stipulations ⚷17(1)

State governor, as party to court stipulations, through counsel, was bound by agreement that specified standards of care and treatment in state hospitals were

minimally acceptable under Constitution, but legislature was not bound; it was accordingly governor's rôle to propose relief to legislature and, having stipulated as to standards, to use his best efforts to accomplish the relief. 28 U.S.C.A. § 1343(3); U.S.C.A.Const. Amend. 14.

8. Mental Health ⟹51

In action by state hospital inmates for denial of federal constitutional rights to care and treatment, any issue as to whether district court should appoint special master to sell or encumber state lands to finance stipulated standards or should enjoin certain state officials from authorizing expenditures for nonessential state functions and thereby alter state budget or by other means order a particular mode of financing the implementation or stipulated standards was premature. 28 U.S.C.A. § 2281.

9. Courts ⟹101.5(2)

Any federal injunctive decree which could be entered which involved state laws of statewide significance required convening of three-judge district court before it could be entered. 28 U.S.C.A. § 2281.

Charles M. Crook, Montgomery, Ala., for Gov. Wallace.

William Baxley, Atty. Gen., George Beck, Deputy Atty. Gen., Montgomery, Ala., for Ala. Mental Health Board.

George W. Dean, Jr., Destin, Fla., Shelly Mercer, Nat'l. Health & Environmental Program, School of Law, UCLA Los Angeles Cal. Jack Drake, Tuscaloosa, Ala., Morton Birnbaum, Brooklyn, N.Y., for plaintiffs-appellees.

Paul Friedman, Patricia M. Wald, Mental Health Law Project, Washington D.C., for Nat. Council on the Rights of the Mentally Impaired.

Bruce Ennis, New York City, for NCRMI & Am. Psy. Assoc., and others.

Stanley Herr, NLADA, Nat. Law Office, James F. Fitzpatrick, Jeffrey Bauman, Washington, D.C., Ira DeMent, U.S. Atty., Kenneth E. Vines, Asst. U.S. Atty., Montgomery, Ala., Edward Lynch, President's Committee on Mental Retardation, Washington, D.C., for United States.

Robert H. Johnson, Atty., Civil Rights Div., U.S. Dept. of Justice, Louis M. Thrasher, Associate Director, Washington, D.C., for United States, amicus curiae.

Charles R. Helpern, Center for Law & Social Policy, Washington, D.C., for Mental Health Law Project, amicus curiae.

Warren E. Magee, Washington, D.C., for Amer. Psychiatric Association, amicus curiae.

Sheridan Neimark, Washington, D.C., for NSAC, amicus curiae.

Before WISDOM, BELL and COLEMAN, Circuit Judges.

WISDOM, Circuit Judge:

In this case, we must decide whether federal district courts have the power to order state mental institutions to provide minimum levels of psychiatric care and treatment[1] to persons civilly committed to the institutions.

The guardians of patients civilly committed to three Alabama facilities for the mentally handicapped brought this class action on behalf of their wards and other civilly committed patients at those institutions. The Honorable Frank M. Johnson, trial judge, held that mentally ill patients "have a constitutional right to receive such individual treatment as will give each of them a reasonable opportunity to be cured or to improve his or her mental condition". Wyatt v. Stickney, M.D.Ala.1971, 325 F.Supp. 781, 784. In a later order, Judge Johnson held that the mentally retarded patients have a constitutional right to such individual habilitation as will give each of them a realistic opportunity to [illegible] a more useful and meaningful life and to return to society". Wyatt v. Stickney, M.D.Ala. 1972, 344 F.Supp. 387, 390. The district court found that conditions at the three facilities deprived the plaintiffs of these constitutional rights, and ordered the defendants-appellants, Alabama officials responsible for the administration of the

[1] "Treatment" means care provided by mental health professionals and others that is adequate and appropriate for the needs of the mentally impaired inmate. Treatment also encompasses a humane physical and psychological environment. The term "habilitation", used by the parties and amici in the district court and by the district court in its order of April 13, 1972 (Partlow State School and Hospital) is a term used to describe that treatment which is appropriate to the condition of the mental retardate For convenience, in this opinion we group "habilitation" and "treatment" under the single term "treatment", and to include those instances where rehabilitation is impossible in which event the requirement is minimally adequate habilitation and care, beyond the subsistence level custodial care that would be provided in a penitentiary. *Donaldson* v. *O'Connor*, 5 Cir., 1974, 493 F.2d 507, 522.

state's mental health programs, to implement a detailed set of standards designed to ensure the provision of minimally adequate treatment and habilitation at the institution. From this order, the Alabama Mental Health Board and Alabama's Governor George C. Wallace bring separate appeals.

Together, the Mental Health Board and the Governor advance six major contentions on appeal. They contend (1) that the district court erred in holding that civilly committed mental patients have a constitutional right to treatment; (2) that the court lacked jurisdiction because the suit was in effect a suit against the state proscribed by the eleventh amendment; (3) that the case involves rights and duties not susceptible to determination by judicially ascertainable and manageable standards, and therefore presents a non-justiciable controversy; (4) that the order of the district court invades a province of decision-making exclusively reserved to the state legislature; (5) that the plaintiffs were not entitled to equitable relief because they had adequate remedies at law to protect the rights they asserted; and (6) that the district court erred in awarding plaintiffs a reasonable attorneys' fee.

Neither in the district court nor on appeal to this Court have the defendants challenged the detailed set of standards articulated by the district court. They have conceded that if there is a constitutional right to treatment enforceable by a suit for injunctive relief in federal court, those standards accurately reflect what would be required to ensure the provision of adequate treatment.

I

A. The proceedings below

This case began innocuously enough, when a cut in the Alabama cigarette tax forced the state to fire 99 professional, subprofessional, and intern employees[2] at the Bryce Hospital, a state-run institution for the mentally ill at Tuscaloosa. The plaintiffs filed their complaint October 23, 1970. The complaint named two classes as plaintiffs. One, represented by Ricky Wyatt and two other named plaintiffs, appellees here, consisted of the patients at Bryce. The other, represented by five of the then recently terminated employees, consisted of the employees who had been dismissed for budgetary reasons. The defendants were Stonewall B. Stickney, the Executive Officer of the Alabama State Mental Health Board; Dr. John V. Hottel, his Chief Deputy; the members of the Board; then Governor Albert P. Brewer, both in his capacity as Governor and in his capacity as a member of the Board; and Judge Perry O. Hooper, Probate Judge of Montgomery County, both individually and as a representative of the class consisting of all probate judges in Alabama.

The complaint alleged that the defendants had effected the staff reductions purely for budgetary reasons; that the discharges of the 99 employees had been accomplished without notice and a hearing, and violated the employees' rights under the due process clause; and that as a result of the discharges the patients at Bryce would not receive adequate treatment. The complaint sought injunctive relief requiring the defendants to insure that treatment programs then being administered at Bryce would not be interrupted or altered, and requiring the defendants to rescind the terminations of the 99 employees.

The original complaint did not allege that treatment levels at Bryce had been inadequate before the terminations. For reasons not entirely clear from the record before us, however, the focus of the litigation soon shifted from the effects of the October 1970 terminations to questions of the overall adequacy of the treatment afforded at the Alabama state mental hospitals. On January 4, 1971, the plaintiffs amended the complaint to add prayers that the defendants be enjoined from operating Bryce "in a manner that does not conform to constitutional standards of delivering adequate mental treatment to its patients"; that the Court order defendants to prepare a "comprehensive constitutionally acceptable plan to provide adequate treatment in any state mental health facility"; and that the court declare that patients confined to a state mental health facility are entitled to "adequate, competent treatment".

On March 12, 1971, the district court ruled on the plaintiffs' motion for a preliminary injunction. 325 F.Supp. 781. The court's opinion reflected the shift in the focus of the case. In its opinion, the court declared that patients "involuntarily

[2] The 99 employees included 41 who were assigned duties such as food service, maintenance, typing and other mechanical duties not involving direct patient care; 26 persons involved in planning social and other recreational activities for the patients; nine persons from the department of psychology; eleven from the social service department; three registered nurses, two physicians, one dentist, and six dental aides.

committed through noncriminal procedures and without the constitutional protections that are afforded defendants in criminal proceedings" are "committed for treatment purposes" and so "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". 325 F.Supp. at 784. The court found that the treatment programs in effect before the institution of a staff reorganization then in progress were "scientifically and medically inadequate", failing to "conform to any known minimums established for providing treatment for the mentally ill". *Id.* The court stated that it was not at that time in a position to determine whether the treatment which would be provided after the reorganization was completed would be adequate. Accordingly, the court allowed the defendants ninety days to report progress made in the reorganization plan, and to file with the Court a "specific plan" for the provision of adequate treatment at Bryce. Also in the March 12 order, the court invited the United States, through the Department of Justice and Health, Education and Welfare, to appear as amicus.

On August 4, 1971, the plaintiffs amended their complaint to allege that the Searcy Hospital at Mount Vernon, Alabama, the one other state hospital for the mentally ill in Alabama, and the Partlow State School and Hospital, Alabama's state facility for the mentally retarded, were being operated in a constitutionally impermissible manner.

On September 13, 1971, six months after the March 12 order, the defendants filed their report on proposed standards of adequate treatment and their implementation. Objections to the report were later filed by the plaintiffs and by the United States, as well as by several interested private organizations which had been granted leave to appear as amici.[3]

The court announced its conclusions upon review of the report and the objections to it in an opinion issued December 10, 1971. 334 F.Supp. 1341. In this opinion, the district court held that there are three "fundamental conditions for adequate and effective treatment"; a "humane physical and psychological environment"; qualified staff "in numbers sufficient to administer adequate treatment"; and individualized treatment plans. The court held that the reports before it showed "rather conclusively" that the treatment programs at Bryce did not meet any of these conditions. It also noted that conditions at Searcy and Partlow seemed little better. It concluded that the defendants had failed to "formulate minimum medical and constitutional standards for the operation of these institutions". The court scheduled a formal hearing to take evidence necessary to establish standards, and said that after the hearing it, the court, would itself "establish standards and in due course order their implementations".

The court postponed the hearings to give the defendants another opportunity to formulate proposed minimum standards. On January 17, 1972, the parties and *amici* met in Atlanta, Georgia, where they undertook extensive discussions concerning the proper standards of treatment at the Alabama hospitals. Out of these discussions came two Memoranda of Agreement stipulating certain of the standards necessary to define what would constitute minimally adequate mental treatment at a state psychiatric institution. One of the Memoranda covered standards for treatment at the mental hospitals, Searcy and Bryce; the other covered standards to be imposed at the school for the mentally retarded, Partlow. These Memoranda were filed with the district court at the times for the hearings set for determining the proper standards. The hearing concerning Bryce and Searcy was held February 3 and 4, 1972; the hearing concerning Partlow was held February 28–March 2.[4]

[3] By order entered August 20, 1971, the district court granted the motion filed by the American Civil Liberties Union, the American Orthopsychiatric Association, the American Psychological Association, and the American Association on Mental Deficiency, for leave to appear as amici. In this Court, these amici have been joined by the National Association for Mental Health, the American Psychiatric Association and the National Association for Retarded Children. The seven have filed a joint brief in this Court.

The district court expressed its gratitude to these organizations for their valuable assistance in this difficult and complex case, 344 F.Supp. 375, 390, and we do so, too.

[4] At the conclusion of the Partlow hearing, the district court entered an emergency order requiring the defendants to take certain immediate actions at Partlow. These included the installation of an emergency light system and procedures for emergency evacuation; revision of sanitation measures in the kitchen; revamping of its program for the use of drugs; conducting appropriate immunizations; and employing t[illegible] hundred additional resident care workers. In its order filed March 2, 1972, the court said it was taking these steps "to protect the lives and well-being of the residents", because it found Partlow to be a "warehousing institution . . . wholly incapable of furnishing treatment to the mentally retarded and and . . . conducive only to the deterioration and debilitation of the residents", and because it found conditions at Partlow "substandard to the point of endangering the health and lives of the residents".

The district court announced its orders granting permanent injunctive relief in two opinions issued April 13, 1972. One of the opinions concerned Partlow, the other, Bryce and Searcy. 344 F.Supp. 373 (Bryce-Searcy), 390 (Partlow). In Partlow, Judge Johnson held that "[b]ecause the only constitutional justification for civilly commiting a mental retardate . . . is habilitation, it follows ineluctably" that civilly committed retardates "have a constitutional right to receive such individual habilitation as will give each of the a realistic opportunity to lead a more useful and meaningful life and to return to society". The Bryce-Searcy opinion summarized the court's earlier opinions, noting its holding that the civilly mentally ill have a constitutional right to treatment. Beyond this, the two opinions were substantially identical. Both ordered the defendants (1) to implement an elaborate set of standards of treatment set forth in appendicies to the opinions; (2) to establish human rights committees at the institutions to review all research and treatment programs "to ensure that the dignity and human rights of the residents are preserved"; (3) to prepare and file reports within six months of the orders on the implementation of the standards; and (4) to pay court costs and a reasonable attorneys' fee to the plaintiffs. The Partlow order also required the defendants to hire a qualified administrator for the School within sixty days.[5]

Governor Wallace and the Mental Health Board filed separate notices of appeal May 12, 1972. On May 22, Governor Wallace filed a motion for modification and for a stay pending appeal. On June 1, the district court issued an opinion fixing the amount due plaintiffs as attorneys' fees at $36,744.62. 344 F.Supp. at 408–411. On June 26, the district court denied the motions for modification and for a stay pending appeal. This Court also denied a motion for a stay pending appeal.

B. The conditions in the Alabama hospitals

There has not been any significant dispute, in this Court or in the district court, about the conditions that prevailed in the Alabama hospitals at the time this suit was instituted. The defendants have pitched their defense on their argument that the Constitution does not guarantee a right to treatment; they have virtually conceded that if such a contitutional right exists, the conditions in the hospitals were such that the state's constitutional obligation to provide adequate treatment could not be met. There is therefore little reason for an extended discussion of the conditions that prevailed at the hospitals. Some discussion, however, is essential to understanding this case. We therefore note briefly how far short the hospitals fell of meeting the three "fundamental conditions of adequate and effective treatment" defined by the district court.

First, it is clear that the environment at the hospitals was a far cry from the "humane psychological and physical environment" the district court envisioned as *sine qua non* of rehabilitative treatment. Bryce Hospital was built in the 1850's; it had 5000 inmates of whom 1500 to 1600 were geriatrics, 1000 were mental retardates, and there were allegedly other non-mentally ill persons. Patients in the hospitals were afforded virtually no privacy: the wards were overcrowded; there was no furniture where patients could keep clothing; there were no partitions between commodes in the bathrooms. There were severe health and safety problems: patients with open wounds and inadequately treated skin diseases were in imminent danger of infection because of the unsanitary conditions existing in the wards, such as permitting urine and feces to remain on the floor; there was evidence of insect infestation in the kitchen and dining areas. Malnutrition was a problem: the United States described the food as "com[ing] closer to 'punishment' by starvation" than nutrition. At Bryce, the food distribution and preparation systems were unsanitary, and less than 50 cents per day per patient was spent on food. Dr. Donald L. Clopper, Associate Commissioner for Mental Retardation for the Alabama Department of Mental

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[5] In both orders, the court refused requests made by plaintiffs and amici to appoint a master and professional advisory committee to oversee implementation of the standards on grounds that "[f]ederal courts are reluctant to assume control of any organization but especially one operated by a state". 344 F.Supp. at 377, 392–393. The court also, in both orders, reserved ruling on various motions by the plaintiffs to ensure adequate financing for the implementation of the standards. These included a motion that the Mental Health Board be directed to sell or encumber its extensive land holdings, and a motion for an injunction against the expenditure of state funds on any "nonessential" functions until the standards were fully implemented.

Health, testified that Partlow was a "stepchild" in the State of Alabama; that the physical environment was inadequate for treating inmates; that "we don't have the staff, we don't have the facilities, nor do we have the financial resources." According to Dr. Clopper, at least 300 Partlow inmates could be discharged immediately, and about 70 percent of the inmates should never have been committed; yet it was 60 percent over-crowded.

Patients at Partlow were forced to perform uncompensated labor. Aides frequently put patients in seclusion or under physical restraints, including straitjackets, without physicians' orders. One resident had been regularly confined in a straitjacket for more than nine years. The Evaluation Report on Partlow by the American Association on Mental Deficiency stated that nine working residents would feed 54 young boys ground food from one very large bowl with nine plates and nine spoons; "since there were no accommodations to even sit down to eat," it was impossible to tell which residents had been fed and which had not been fed with this system. Seclusion rooms were large enough for one bed and a coffee can, which served as a toilet. The patients suffered brutality, both at the hands of the aides and at the hands of their fellow patients; testimony established that four Partlow residents died due to understaffing, lack of supervision, and brutality.[6]

The hospitals failed to meet the second condition, adequate staffing. The defendants' chief witness on standards maintained that treatment could be delivered with the ratio of one psychiatrist, one graduate level psychologist, and one masters level social worker for every 125 patients, and the district court ultimately adopted this recommendation. The organizations appearing as amici had recommended higher ratios—one psychiatrist, one psychologist, and one social worker for every 30–50 patients. But at the time this suit was instituted there were ratios of only one medical doctor with some psychiatric training for 5,000 patients, one Ph.D. psychologist for every 1,670 patients, and one masters level social worker for every 2,500 patients at Bryce. The parties and amici agreed completely on the minimums necessary for treatment of the mentally retarded. They agreed that adequate treatment could be delivered at Partlow with ratios of one masters level psychologist and one masters level social worker for every sixty patients, and one physician for every two hundred patients. Yet at Partlow there were only one psychologist with masters level training or above for every 1,200 patients; one masters level social worker for every 730 patients; and one physician for every 550 patients. Of the four physicians at Partlow, two were not licensed to practice in Alabama.

A severe shortage of nonprofessional staff paralleled the inadequacies of professional staff. After a tour of Bryce, defendants' own consultants noted that:

"Aide staff is spread very thin, creating extreme stresses for individual aides, who at times must cover one or two or three wards, housing as many as 100 or 200 patients. Obviously, it is impossible under such circumstances to provide anything more than a cursory observation and the hope of avoiding disturbing incidents. An aide under these circumstances is hard pressed to meet even minimum patient needs."

The institutional staff was inadequate not only in sheer numbers but also in training; there was no effective "in-service training" program for, or even any regular supervision over, the nonprofessionals.

Finally, the evidence established that the hospitals failed to meet the third condition, individualized treatment programs. According to one consultant's testimony, care of patients at Partlow was not suited to the needs of particular individuals, but was instead "geared primarily to housekeeping functions—cleaning floors, cleaning beds, cleaning patients—and to a continuation of work assignments". Experts testified that the patient records kept at the hospital were wholly inadequate; that they were written in such a way as to be incomprehensible to the aide level staff that had prime responsibility for patient care; and that they were kept where they were not accessible to the direct care staff particularly in need of them.

[6] One of the four died after a garden hose had been inserted into his rectum for five minutes by a working patient who was cleaning him; one died when a fellow patient hosed him with scalding water; another died when soapy water was forced into his mouth; and a fourth died from a self-administered overdose of drugs which had been inadequately secured.

II

[1] The appellants' first and principal contention on appeal is that the Constitution does not guarantee persons civilly committed to state mental institutions a right to treatment.[7] This contention is largely foreclosed by our decision, issued since the institution of this appeal, in *Donaldson* v. *O'Connor*, 1974, 493 F. 2d 507. In *Donaldson*, we held that civilly committed mental patients have a constitutional right to such individual treatment as will help each of them to be cured or to improve his or her mental condition. We reasoned that the only permissible justifications for civil commitment, and for the massive abridgments of constitutionally protected liberties it entails, were the danger posed by the individual committed to himself or to others, or the individual's need for treatment and care. We held that where the justification for commitment was treatment, it offended the fundamentals of due process if treatment were not in fact provided; and we held that where the justification was the danger to self or to others, then treatment had to be provided as the *quid pro quo* society had to pay as the price of the extra safety it derived from the denial of individuals' liberty.

Our discussion in *Donaldson*, briefly summarized here, answers most of the arguments made by the appellants on this appeal against the recognition of a constitutional right to treatment. Governor Wallace, however, makes one argument not answered by our discussion in *Donaldson*, and it is appropriate that we address that argument here. Governor Wallace challenged the assumption, made by the district court in this case and by this Court in *Donaldson*, that the only permissible justification for confinement are danger to self or others or need for treatment. Instead, the Governor suggests, the principal justification for commitment lies in the inability of the mentally ill and mentally retarded to care for themselves. The essence of this argument is that the primary function of civil commitment is to relieve the burden imposed upon the families and friends of the mentally disabled. The families and friends of the disabled, the Governor asserts, are the "true clients" of the institutionalization system.[8]

From this premise the Governor proceeds to the conclusion that is the crux of his argument. If "need for care" is a justification for commitment—or is *the* justification—then it follows that the mere provision of custodial care is constitutionally adequate to justify continued confinement. "[T]he providing of custodial care alone is a tremendously important consideration to patients, their families, and the public-at-large", the Governor writes in his brief.

There are two answers to this line of argument. The first, and more limited, is that even accepting the Governor's premise that "need for care" is a constitutionally adequate justification for confinement, it does not follow that we must accept the conclusion—that *the kind of care that was provided at the Alabama hospitals* is sufficient to make continued confinement constitutional. The assertion that "need for care" justifies confinement implies that the state has an affirmative obligation to provide a certain minimum quality "care", no less than the assertion that "need for treatment" justifies confinement implies that the state has an affirmative obligation to provide a certain minimum quality "treatment". And it is clear that, however that obligation might specifically be de-

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[7] In raising the issue in this Court, the appellants contend that, because there is no constitutional right to treatment, the district court lacked jurisdiction over the suit. In so arguing the issue, the appellants are following, on this point as one the other four of their first five contentions, the decision of the Northern District of Georgia in *Burnham v. Department of Public Health*, 1972, 349 F.Supp. 1335, appeal docketed, No. 72–3110, 5 Cir, Oct. 4, 1972. In *Burnham*, the court held that the Constitution does not guarantee a right to treatment. It then held that the consequence of this conclusion was that it was without jurisdiction over the suit, because 28 U.S.C. § 1343(3), the asserted basis of jurisdiction, confers jurisdiction only over "action[s] . . . to redress the deprivation" of a "right, privilege, or immunity" secured by the Constitution or by an Act of Congress providing for equal rights.

[8] Governor Wallace borrows the term "true clients" from the work of Professor E[illegible]ing Goffman. E. Goffman, Asylums—Essays on the Social Situations of Mental Patie[illegible]nd Other Inmates 384 (1961). Governor Wallace in his brief praises Professo[illegible]an as a "realistic writer". Be that as it may, it is fairly clear that Professor Goffm[illegible]ntent, in calling "relatives, police, and judges" the "true clients of the mental hospitals" was critical, indeed harshly so, and that Professor Goffman was insinuating by that statement an embarrassing, though rarely admitted, truth about the institutionalization system in the United States. What Professor Goffman implied was morally unacceptable—that the convenience of relatives and law enforcers justifies stripping away all of the liberties of the civilly committed—we hold today is constitutionally unacceptable.

fined, it was not being met in the Alabama hospitals. Dr. Gunnar Dybwad, Professor of Human Development at the Graduate School for Advanced Studies in Social Welfare at Brandeis University, and a one time presidential consultant in the field of mental retardation, made essentially this point when he testified about conditions at Alabama's Partlow State School and Hospital:

"The situation which exists and obviously has existed in Partlow for a long time is one of storage, of persons. I am using that word because *I would not use care,* which involves—has a certain qualitative character, and *I would not even use the word 'custodial,' because custody, in my term, means safekeeping.* And, as is visible to the visitor at the present time, employees at Partlow are *not in a position to effect safekeeping,* considering the number of people they have to take care of; so I would say it is a storage problem at the moment." (Emphasis supplied.)

Indeed, many of the standards established by the district court in this case—notably those required for what the district court called a "humane psychological and physical environment"—might have to be met for the state to be able legitimately to claim it was providing adequate "care" to its mental patients. At least where the right to a "humane environment" is concerned, then if it is irrelevant whether the right be viewed as a facet of a "right to treatment", or of a "right to care". It is likewise irrelevant for those purposes whether the state interest imputed to the civil commitment system be called the need "to treat" the mentally ill, or the need "to care" for them.

[2] But beyond this, we find it impossible to accept the Governor's underlying premise that the "need to care" for the mentally ill—and to relieve their families, friends, or guardians of the burdens of doing so—can supply a constitutional justification for civil commitment. At stake in the civi commitment context, as we emphasized in *Donaldson*, see 493 F. 2d at 520, are "massive curtailments" of individual liberty. Against the sweeping personal interests involved, Governor Wallace would have us weigh the state's interest, and the interests of the friends and families of the mentally handicapped in having private parties relieved of the "burden" of caring for the mentally ill. The state interest thus asserted may be, strictly speaking, a "rational" state interest. But we find it so trivial beside the major personal interests against which it is to be weighed that we cannot possibly accept it as a justification for the deprivations of liberty involved.

The other argument against recognition of a constitutional right to treatment for civilly committed mental patients advanced by the appellants are, as we noted above, answered by our discussion in *Donaldson*. Following *Donaldson*, we hold that the district court here did not err in finding that civilly committed mental patients have a constitutional right to treatment. Our express holding in *Donaldson* and here rests on the *quid pro quo* concept of "rehabilitative treatment, or, where rehabilitation is impossible, minimally adequate habilitation and care, beyond the subsistence level custodial care that would be provided in a penitentiary." 493 F. 2d at 522.

III

[3] The second, third, fourth, and fifth issues raised by the appellants are also substantially affected by our decision in *Donaldson*, and present little difficulty except as to some aspects of remedy which will be discussed in Part IV, infra. The argument that this suit is barred by the eleventh amendment is based largely upon Burnham v. Department of Public Health, N.D. Ga. 1972, 349 F. Supp. 1335, appeal docketed, No. 72-3110, 5 Cir., Oct. 4, 1972, a case consolidated for argument on appeal with this case. In *Burnham*, the court held that, because the right to treatment was a right arising only, if at all, under state law, a suit by citizens of the state against state officials to enforce the right was barred by the eleventh amendment. Our holding in *Donaldson*, however, vitiates this argument, of course, for we have now established that the right to treatment arises as a matter of federal constitutional law under the due process clause of the Fourteenth Amendment.

[4] In *Donaldson*, we addressed and rejected the argument that a constitutional right to adequate treatment would present questions not susceptible to "judicially manageable or ascertainable standards". We held that the judiciary was competent to determine, at least in individual cases, whether psychiatric

treatment was medically or constitutionally adequate. And we said in dictum that even in cases such as this one, "when courts are asked to undertake the more difficult task of fashioning institution-wide standards of adequacy", 493 F. 2d at 526, the courts would be able to formulate workable standards. In *Donaldson*, we took note of the substantial agreement reached in this case among parties and *amici* in developing standards during the course of the proceedings in the lower court. We cited that development as evidence supporting our view that workable standards could be fashioned. We remain mindful of that development here, in reaffirming our belief that the right to treatment can be implemented through judicially manageable standards.

[5] The appellants' fourth contention is that the order of the district court invades a province of decision-making exclusively reserved for the state legislature. Governor Wallace argues that the order will require heavy expenditures of state funds; that these funds will have to come from other state programs; and that the duty of compromising and allocating funds among the many programs competing for them is a duty which must be discharged by the state governor and legislature alone. Governor Wallace concedes in his brief that he is not contending that "the financial cost of complying with an established constitutional right is a valid reason for failure to comply". He "suggest[s] that before the Court decides to adopt a new constitutional right it should consider all of the consequences of its action, financial and social, and its effect on our federal form of government". The Mental Health Board makes the point in a related way, by suggesting that the district court's order here is in effect an order requiring the state to furnish a particular service, and by citing cases establishing the general proposition that ordinarily it is not for the federal courts to say whether or in what amounts a state shall provide any particular government benefit or service. *E.g.*, Fullington v. Shea, D. Colo. 1970, 320 F. Supp. 500, aff'd. 404 U.S. 963, 92 S. Ct. 345, 30 L. Ed. 2d 282.

We find these arguments unpersuasive. It goes without saying that state legislatures are ordinarily free to choose among various social services competing for legislative attention and state funds. But that does not mean that a state legislature is free, for budgetary or any other reasons, to provide a social service in a manner which will result in the denial of individuals' constitutional rights. And it is the essence of our holding, here and in *Donaldson*, that the provision of treatment to those the state has involuntarily confined in mental hospitals is necessary to make the state's actions in confining and continuing to confine those individuals constitutional. That being the case, the state may not fail to provide treatment for budgetary reasons alone. "Humane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations". *Jackson* v. *Bishop*, 8 Cir. 1968, 404 F.2d 571, 580 (Blackmun, J.), quoted, *Rozecki* v. *Gaughan*, 1 Cir. 1972, 459 F.2d 6, 8. "Inadequate resources can never be an adequate justification for the state's depriving any person of his constitutional rights." *Hamilton* v. *Love*, E.D.Ark. 1972, 328 F.Supp. 1182, 1194. "[T]he obligation of the Respondents [prison officials] to eliminate unconstitutionalities does not depend upon what the Legislatures may do". *Holt* v. *Sarver*, E.D.Ark.1970, 309 F.Supp. 362, 385, aff'd, 8 Cir. 1971, 442 F.2d 304, See also *Hawkins* v. *Town of Shaw*, 5 Cir. 1971, 437 F.2d 1286, 1292.

This conclusion is not novel. In the context of state penal institutions, the federal courts have repeatedly intervened to assure that the conditions of confinement do not invade the constitutional rights of those confined. *E. g.*, *Cruz* v. *Beto*, 1972, 405 U.S. 319, 92 S. Ct. 1079, 31 L.Ed.2d 263; *Johnson* v. *Avery*, 1968, 393 U.S. 483, 89 S.Ct. 747, 21 L.Ed.2d 718; *Campbell* v. *Beto*, 5 Cir. 1972, 460 F.2d 765; *Laudman* v. *Royster*, E.D.Va.1971, 333 F.Supp. 621; *Holt* v. *Sarver*, E.D.Ark.1970, 309 F.Supp. 362, aff'd, 8 Cir. 1971, 442 F.2d 304. This Court has recognized that "our constitutional duties require that the courts be ever vigilant to assure that the conditions of incarceration do not overstep the bounds of federal constitutional limitations". *Campbell*, 460 F.2d at 767–768. In discharging these duties, the federal courts have in some cases entered decrees requiring substantial restructuring of state prison systems, but the courts have not hesitated to enter such decrees when necessary to safeguard the constitutional rights of prisoners. As the court said in *Holt* v. *Sarver*:

"Let there be no mistake in the matter; the obligation of the Respondents to eliminate existing unconstitutionalities does not depend upon what the Legislature may do, or, indeed, upon what Respondents may actually be able to accom-

plish. If Arkansas is going to operate a Penitentiary System, it is going to have to be a system that is countenanced by the Constitution of the United States." (309 F.Supp. at 385.)

Similar developments have occurred in the field of institutions for the detention of juveniles. *Nelson* v. *Heyne*, 7 Cir. 1974, 491 F.2d 352, aff'g. N.D.Ind. 1972, 355 F.Supp. 451; *Martarella* v. *Kelley*, S.D.N.Y.1972, 359 F.Supp. 479, enforcing, 349 F.Supp. 575; *Inmates of Boys' Training School* v. *Affleck*, D.R.I. 1972, 346 F.Supp. 1354; Morales v. Turman, E.D.Tex.1973, 364 F.Supp. 166.

[6] The appellants' fifth contention, that the plaintiffs had adequate remedies at law, is also unpersuasive. In the *Burnham* case, the court held that the legal remedies of "habeas corpus, medical malpractice, and ordinary tort actions" would supply adequate remedies to mental patients who claimed to have been denied a right to treatment. 349 F.Supp. at 1343. It found the plaintiffs' arguments to the contrary "inconsistent with plaintiffs argument that each individual patient should have his particular therapy or treatment personalized". *Id.* Governor Wallace and the Mental Health Board urge here the argument that damage and habeas corpus actions provide adequate legal remedies to the plaintiffs. They also point to the plaintiffs' argument that treatment must be individualized, and to the tension between that argument and the plaintiffs' insistence that injunctive relief on behalf of the plaintiff class is appropriate in this case.

We are unable to agree that injunctive relief is inappropriate merely because damages or habeas corpus relief may be available to some or all individual plaintiffs. While habeas corpus and tort remedies should play a valuable, indeed essential, role we recognized in *Donaldson*, those remedies are not capable of ensuring what the plaintiffs seek to ensure in this case. In the first place, habeas corpus relief and tort damages are available only after the fact of a failure to provide individual treatment. Here the plaintiffs seek preventive relief, to assure in advance that mental patients will at least have the *chance* to receive adequate treatment by proscribing the maintenance of conditions that foredoom *all* mental patients *inevitably* to inadequate mental treatment. Moreover, there are special reasons why reliance upon individual suits by mental patients would be especially inappropriate. Mental patients are particularly unlikely to be aware of their legal rights. They are likely to have especially limited access to legal assistance. Individual suits may be protracted and expensive, and individual mental patients may therefore be deterred from bringing them. And individual suits may produce distortive therapeutic effects within an institution, since a staff may tend to give especially good—or especially harsh—treatment to patients the staff expects or knows to be litigious.[9]

We see no inconsistency between this conclusion and the position taken by the plaintiffs, and by the district court, that treatment must be individualized. The plaintiffs here do not seek *guarantee* that all patients will receive all the treatment they need or that may be appropriate to them. They seek only to ensure that conditions in the state institutions will be such that the patients confined there will have a *chance* to receive adequate treatment. This requires only the establishment of a program, institution-wide in scope, for developing and formulating individual treatment plans; it of course does not require the formulation, in this suit, of each individual plan. The question of what is necessary to the establishment of such a program is better resolved in a class action brought on behalf of fall patients than it would be in a series of individual suits.

IV

We pretermit decision as to the remedy decreed by the district court to the extent herein stated. As we have held, the legislative power may not be used to deprive appellees of their constitutional right to treatment, but a substantial question is presented as to the scope of judicial power in implementing this right. The ultimate question will be, if all else fails, the method of effecting the financial outlay which will be necessary for the judiciary to give meaning to judicially prescribed minimum constitutional standards for adequate treatment of the mentally ill.

Prior to the entry of the court's orders on April 13, 1972, 344 F.Supp. 373; 344 F.Supp. 387, the patries and amici stipulated to a number of specific condi-

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[9] See 86 Harv.L.Rev. 1282, 1305 (1973).

tions they agreed were necessary for a constitutionally acceptable minimum treatment program.[10] Because of these stipulations, we need not and do not reach decision as to whether the standards prescribed by the district court are constitutionally minimum requirements, or whether it is within the province of a federal district court, three-judge or single judge, to prescribe standards as distinguished from enjoining the operation of such institutions while constitutional rights are being violated.

[7] Governor Wallace contends such stipulations are not binding on him or the Alabama legislature. As a party to the stipulations, through counsel, we hold the Governor has for his part agreed that these standards are minimally acceptable under the Constitution. The Alabama legislature presents a different problem. Clearly the Governor is without authority to agree to the expenditure of funds required to implement such a broad spectrum of standards when such a decision under Alabama law is reserved to the legislature. That the legislature was not a party to the stipulations in question or to this law suit reenforces this manifest principle of governmental organization. It is the Governor's role to propose relief to the legislature and, having stipulated the standards, to use his best efforts to accomplish the relief.

With respect to judicial accomplishment of the remedy, profound questions are presented regarding the scope of substantive due process and the role of federal courts in matters affecting the management of state institutions. Here we are concerned with the operation of state mental institutions within the parameters of substantive due process.[11]

[8] The governor argues that the prescribed remedy will entail the expenditure annually of a sum equal to sixty percent of the state budget excluding school financing, and a capital improvements outlay of $75,000,000. This is contested by appellees. However, that may be, we regard as premature any issue as to whether the district court should appoint a Special Master for the purposes of selling or encumbering state lands to finance these standards, or should enjoin certain state officials from authorizing expenditures for nonessential state functions, and thereby alter the state budget, or by other means order a particular mode of financing the implementation of the stipulated standards.

Such remedial propositions are by the terms of the district court's April 13, 1972 not present orders; they lie in the uncertain future. The district court wrote:

". . . this Court has decided to 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. 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 responsibility for appropriate funding ultimately must fall, of course, upon the State Legisla-

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[10] The parties and amici submitted in two Memoranda of Agreement stipulations of standards of adequate care. Virtually all of the specifics of the district court's April 13. 1972 orders were taken from these stipulations. These standards have not been challenged on appeal. Indeed, Governor Wallace's brief to this court begins with the affirmation: "We wish to emphasize at the outset that this appellant, Governor George C. Wallace, is in full and complete agreement with the ultimate achievement of the standards and goals for mental health facilities which are set forth in the District Court's order[s] of April 13, 1972." Brief of Appellant, p. 1.

[11] As noted, supra, however rare that may be, federal decrees mandating affirmative action expenditures by state governing authorities to ensure constitutional guarantees are not unprecedented in cases involving equal protection and also cruel and unusual punishment. *E.g.,* Griffin v. County School Bd., 1964, 377 U.S. 218, 233, 84 S.Ct. 1226, 12 L.Ed.2d 256, 266; *Swann* v. *Charlotte-Mecklenburg Bd. of Educ.,* N.D.N.C., 1970, 311 F.Supp. 265, 268, vacated and remanded on other grounds, 4 Cir. (en banc), 431 F.2d 138, order reinstated, 1971, 402 U.S. 1, 91 S. St. 1267, 28 L.Ed.2d 554; United States v. Plaquemines Parish School Bd., E.D.La., 1967, 291 F.Supp. 841, aff'd as modified, 5 Cir., 1969, 415 F.2d 817; Cruz v. Beto, 1972, 405 U.S. 319, 92 S.Ct. 1079, 31 L.Ed.2d 263; Holt v. Sarver, 8 Cir., 1971, 442 F.2d 304; Nelson v. Heyne, 7 Cir., 1974, 491 F.2d 352; Gautreaux v. Chicago Housing Auth., N.D.Ill. 1969, 269 F.Supp. 907, aff'd, 7 Cir., 1970, 436 F.2d 306, cert. denied, 1971, 402 U.S. 922, 91 S.Ct. 1378, 28 L.Ed.2d 661. See also cases cited Note, Right To Treatment, 1973, 86 Harv.L.Rev. 1282, 1300, nn. 98–104; Developments in the Law, Civil Commitment of the Mentally Ill, 1974, 87 Harv.L.Rev. 1338, n. 96; Comment, Enforcement of Judicial Financing Order; Constitutional Rights in Search of a Remedy, 1970, 59 Geo.L.J. 393.

ture 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 . . .

"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 and that adequate treatment is available for the mentally ill in Alabama." 344 F.Supp. at 377–378. See also 344 F.Supp. at 393–394." (These separate orders cover the three institutions involved.)

To the latter statement, the district court added in a footnote, 344 F.Supp. at 378, n. 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." See also 344 F.Supp. at 394, n. 14.

The district court ordered that defendants file within six months a detailed report on the implementation of the stipulated standards.

The serious constitutional questions presented by federal judicial action ordering the sale of state lands, or altering the state budget, or which may otherwise arise in the problem of financing, in the event the governing authorities fail to move in good faith to ensure what all parties agree are minimal requirements, should not be adjudicated unnecessarily and prematurely. *See* Ashwander v. Tennessee Valley Authority, 1936, 297 U.S. 288, 346–348, 56 S.Ct. 466, 80 L.Ed. 688, 710–712 (Brandeis, J., concurring); *cf.* Hawkins v. Town of Shaw, 5 Cir. (en banc), 1972, 461 F.2d 1171; Holt v. Sarver, 8 Cir., 1971, 442 F.2d 304, 309. Since we have now affirmed that part of the district court's orders recognizing the constitutional right to treatment, determination of good faith efforts by state authorities to ensure these rights should be made in the first instance in the district court.

[9] In any event, as a jurisdictional matter dictated by federal statute, remedies of the type contemplated in the district court order of April 13, 1972 are required to be determined by a district court of three judges. Any federal decree that state lands be sold or legislative appropriations be reallocated or enjoined would involve state laws of statewide significance within the purview of 28 U.S.C.A. § 2281. The federal injunctive decree which might be entered in such circumstances is required to be that of a three-judge district court. Sands v. Wainwright, *supra*, 491 F.2d 417. We of course make no prejudgment as to the appropriateness of any such remedial order. Moreover, depending on the improvements made or in progress, such remedies may be unnecessary.

This court views as serious a state's failure to ensure the fulfillment of appellees' constitutional rights, but the interests of all concerned, and the sensitivities of our federal system, will be best served by the parties, amici, and court moving together to meet the constitutional requisites. This is the nature of the remedy ordered by this court in Hawkins v. Town of Shaw, *supra*, 461 F.2d at 1174. This appears to be the meaning and intent of the district court's recognition of the function of the Alabama legislature within the Alabama governmental framework, and the court's orders of April 13, 1972 requiring reports on compliance with the stipulated standards.

This approach should hasten the day when the district court can be reasonably assured that appellees' constitutional rights are no longer being violated, and when ultimate control over the institutions in question can be returned to the state. *Cf.* Holt v. Sarver, *supra*, 442 F.2d at 309.

V

We reserve decision on the issue presented by the awards of attorneys' fees to plaintiffs pending decision in No. 73-1790, Gates v. Collier; No. 73-2033, Newman v. State of Alabama; and Named Individual Members of the San Antonio Conservation Society v. Texas Highway Department, en banc, argued and submitted on October 2, 1974. See 28 U.S.C.A. § 2106 for the authority to reserve decision.

Affirmed in part; remanded in part for further proceedings not inconsistent herewith; and decision reserved in part.

[APPENDIX 27]

Cite as 422 U.S. 563 (1975)

Syllabus

O'CONNOR *v.* DONALDSON

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 74-8. Argued January 15, 1975—Decided June 26, 1975

Respondent, who was confined almost 15 years "for care, maintenance, and treatment" as a mental patient in a Florida State Hospital, brought this action for damages under 42 U.S.C. § 1983 against petitioner, the hospital's superintendent, and other staff members, alleging that they had intentionally and maliciously deprived him of his constitutional right to liberty. The evidence showed that respondent, whose frequent requests for release had been rejected by petitioner notwithstanding undertakings by responsible persons to care for him if necessary, was dangerous neither to himself nor others, and, if mentally ill, had not received treatment. Petitioner's principal defense was that he had acted in good faith, since state law, which he believed valid, had authorized indefinite custodial confinement of the "sick," even if they were not treated and their release would not be harmful, and that petitioner was therefore immune from any liability for monetary damages. The jury found for respondent and awarded compensatory and punitive damages against petitioner and a codefendant. The Court of Appeals, on broad Fourteenth Amendment grounds, affirmed the District Court's ensuing judgment entered on the verdict. *Held:*

1. A State cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends, and since the jury found, upon ample evidence, that petitioner did so confine respondent, it properly concluded that petitioner had violated respondent's right to liberty. Pp. 573-576.

2. Since the Court of Appeals did not consider whether the trial judge erred in refusing to give an instruction requested by petitioner concerning his claimed reliance on state law as authorization for respondent's continued confinement, and since neither court below had the benefit of this Court's decision in *Wood* v. *Strickland*, 420 U.S. 308, on the scope of a state official's qualified immunity under 42 U.S.C. § 1983, the case is vacated and remanded for consideration of petitioner's liability *vel non* for monetary damages for violating respondent's constitutional right. Pp. 576-577.

493 F. 2d 507, vacated and remanded.

STEWART, J., delivered the opinion for a unanimous Court. BURGER, C. J., filed a concurring opinion, *post*, p. 578.

Raymond W. Gearey, Assistant Attorney General of Florida, argued the cause for petitioner *pro hac vice*. With him on the briefs were *Robert L. Shevin*, Attorney General, and *Daniel S. Dearing*, Special Assistant Attorney General.

Bruce J. Ennis, Jr., argued the cause for respondent. With him on the brief was *Morton Birnbaum.**

Mr. JUSTICE STEWART delivered the opinion of the Court.

The respondent, Kenneth Donaldson, was civilly committed to confinement as a mental patient in the Florida State Hospital at Chattahoochee in January 1957. He was kept in custody there against his will for nearly 15 years. The petitioner, Dr. J. B. O'Connor, was the hospital's superintendent during most of this period. Throughout his confinement Donaldson repeatedly, but unsuccessfully, demanded his release, claiming that he was dangerous to no one, that he was not mentally ill, and that, at any rate, the hospital was not providing treatment for his supposed illness. Finally, in February 1971, Donaldson brought this lawsuit under 42 U.S.C. § 1983, in the United States District Court for the Northern District of Florida, alleging that O'Conner, and other members of the hospital staff, named as defendants, had intentionally and maliciously deprived him of his constitutional right to liberty.[1] After a four-day trial, the jury returned a verdict assessing both compensatory and punitive damages against O'Conner and a codefendant. The Court of Appeals for the Fifth Circuit affirmed the judgement, 493 F. 2d 507. We granted O'Connor's petition for certiorari, 419 U.S. 894, because of the important constitutional questions seemingly presented.

I

Donaldson's commitment was initiated by his father, who thought that his son was suffering from "delusions." After hearings before a county judge of Pinellas County, Fla., Donaldson was found to be suffering from "paranoid schizophrenia" and was committed for "care, maintenance, and treatment" pursuant to Florida statutory provisions that have since been repealed.[2] The state law was less than clear in specifying the grounds necessary for commitment, and the record is scanty as to Donaldson's condition at the time of the judicial hearing. These matters are, however, irrelevant, for this case involves no challenge to the initial commitment, but is focused, instead upon the nearly 15 years of confinemen that followed.

**William F. Hyland*, Attorney General, *Stephen Skillman*, Assistant Attorney General, and *Joseph T. Maloney*, Deputy Attorney General, filed a brief for the State of New Jersey as *amicus curiae* urging reversal.

Briefs of *amicus curiae* urging affirmance were filed by *E. Barrett Prettyman, Jr.*, for the American Psychiatric Assn.; by *Francis M. Shea, Ralph J. Moore, Jr., John Townsend Rich, James F. Fitzpatrick, Kurt W. Melchior, Harry J. Rubin, Sheridan L. Neimark*, and *A. L. Zwerdling* for the American Association on Mental Deficiency; and by *June Resnick German* and *Alfred Berman* for the Committee on Mental Hygiene of the New York State Bar Assn.

William J. Brown, Attorney General, and *Andrew J. Ruzicho* and *Barbara J. Rouse*, Assistant Attorneys General, filed a brief for the State of Ohio as *Amicus curiae*.

[1] Donaldson's original complaint was filed as a class action on behalf of himself and all of his fellow patients in an entire department of the Florida State Hospital at Chattahoochee. In addition to a damages claim, Donaldson's complaint also asked for habeas corpus relief ordering his release, as well as the release of all members of the class. Donaldson further sought declaratory and injunctive relief requiring the hospital to provide adequate psychiatric treatment.

After Donaldson's release and after the District Court dismissed the action as a class suit, Donaldson filed an amended complaint, repeating his claim for compensatory and punitive damage. Although the amended complaint retained the prayer for declaratory and injunctive relief, that request was eliminated from the case prior to trial. See 493 F. 2d 507, 512–513.

[2] The judicial commitment proceedings were pursuant to § 394.22(11) of the State Public Health Code, which provided:

"Whenever any person who has been adjudged mentally incompetent requires confinement or restraint to prevent self-injury or violence to others, the said judge shall direct that such person be forthwith delivered to a superintendent of a Florida state hospital, for the mentally ill, after admission has been authorized under regulations approved by the board of commissioners of state institutions, for care, maintenance, and treatment, as provided in section 394.09, 394.24, 394.25, 394.26 and 394.27, or make such other disposition of him as he may be permitted by law. . . ." Fla. Laws 1955–1956 Extra. Sess., c. 31403, § 1, p. 62.

Donaldson had been adjudged "incompetent" several days earlier under § 39422(1), which provided for such a finding as to any person who was—

"incompetent by reason of mental illness, sickness, drunkenness, excessive use of drugs, insanity, or other mental or physical condition, so that he is incapable of caring for himself or managing his property, or is likely to dissipate or lose his property or become the victim of designing persons, or inflict harm on himself or others. . . ." Fla. Gen. Laws 1955, c. 29909, § 3, p. 831.

(Continued on page 1026.)

The evidence at the trial showed that the hospital staff had the power to release a patient not dangerous to himself or others, even if he remained mentally ill and had been lawfully committed.[3] Despite many requests, O'Connor refused to allow that power to be exercised in Donaldson's case. At the trial, O'Connor indicated that he had believed that Donaldson would have been unable to make "successful adjustment outside the institution," but could not recall the basis for that conclusion. O'Connor retired as superintendent shortly before this suit was filed. A few months thereafter, and before the trial, Donaldson secured his release and a judical restoration of competency, with the support of the hospital staff.

The testimony at the trial demonstrated, without contradiction, that Donaldson had posed no danger to others during his long confinement, or indeed at any point in his life. O'Connor himself conceded that he had no personal or second-hand knowledge that Donaldson had ever committed a dangerous act. There was no evidence that Donaldson had ever been suicidal or been though likely to inflict injury upon himself. One of O'Connor's codefendants acknowledged that Donaldson could have earned his own living outside the hospital. He had done so for some 14 years before his commitment, and immediately upon his release he secured a responsible job in hotel administration.

Furthermore, Donaldson's frequent requests for release had been supported by responsible persons willing to provide him any care he might need on release. In 1963, for example, a representative of Helping Hands, Inc., a halfway house for mental patients, wrote O'Connor asking him to release Donaldson to its care. The request was accompanied by a supporting letter from the Minneapolis Clinic of Psychiatry and Neurology, which a codefendant conceded was a "good clinic." O'Connor rejected the offer, replying that Donaldson could be released only to his parents. That rule was apparently of O'Connor's own making. At the time, Donaldson was 55 years old, and, as O'Connor knew, Donaldson's parents were too elderly and infirm to take responsibility for him. Moreover in his continuing correspondence with Donaldson's parents, O'Connor never informed them of the Helping Hand offer. In addition, on four separate occasions between 1964 and 1968, John Lembcke, a college classmate of Donaldson's and a longtime family friend, asked O'Connor to release Donaldson to his care. On each occasion O'Connor refused. The record shows that Lembcke was a serious and responsible person, who was willing and able to assume responsibility for Donaldson's welfare.

The evidence showed that Donaldson's confinement was a simple regime of enforced custodial care, not a program designed to alleviate or cure his supposed illness. Numerous witnesses, including one of O'Connor's codefendants, testified

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(Continued from page 1025.)

It would appear that § 394.22(11)(a) contemplated that involuntary commitment would be imposed only on those "incompetent" persons who "require[d] confinement or restraint to prevent self-injury or violence to others." But this is not certain, for § 394.22(11)(c) provided that the judge could adjudicate the person a "harmless incompetent" and release him to a guardian upon a finding that he did "not require confinement or restraint to prevent self-injury or violence to others *and* that treatment in the Florida State Hospital is unnecessary or would be without benefit to such person. . . ." Fla. Gen. Laws 1955, c. 29909, § 3, p. 835 (emphasis added). In this regard, it is noteworthy that Donaldson's "Order for Delivery of Mentally Incompetent" to the Florida State Hospital provided that he required "confinement or restraint to prevent self-injury or violence to others, *or* to insure proper treatment." (Emphasis added.) At any rate, the Florida commitment statute provided no judicial procedure whereby one still incompetent could secure his release on the ground that he was no longer dangerous to himself or others.

Whether the Florida statute provided a "right to treatment" for involuntary committed patients is also open to dispute. Under § 394.22(11)(a), commitment "to prevent self-injury or violence to others" was "for care, maintenance, and treatment." Recently Florida has totally revamped its civil commitment law and now provides a statutory right to receive individual medical treatment. Fla. Stat. Ann. § 394.459 (1973).

[3] The sole *statutory procedure for release required a judicial reinstatement of a patient's* "mental competency." Public Health Code §§ 394.22 (15) and (16), Fla. Gen. Laws 1955, c. 29909, § 3, pp. 838–841. But this procedure could be initiated by the hospital staff. Indeed, it was at the staff's initiative that Donaldson was finally restored to competency, and liberty, almost immediately after O'Connor retired from the superintendency.

In addition, witnesses testified that the hospital had always had its own procedure for releasing patients—for "trial visits," "home visits," "furloughs," or "out of state discharges"—even though the patients had not been judicially restored to competency. Those conditional releases often became permanent, and the hospital merely closed its books on the patient. O'Connor did not deny at trial that he had the power to release patients; he contended that it was his "duty" as superintendent of the hospital "to determine whether that patient having once reached the hospital was in such condition as to request that he be considered for release from the hospital."

that Donaldson had received nothing but custodial care while at the hospital. O'Connor described Donaldson's treatment as "milieu therapy." But witnesses from the hospital staff conceded that, in the context of this case, "milieu therapy" was a euphemism for confinement in the "milieu" of a mental hospital.[4] For substantial periods, Donaldson was simply kept in a large room that housed 60 patients, many of whom were under criminal commitment. Donaldson's requests for ground privileges, occupational training, and an opportunity to discuss his case with O'Connor or other staff members were repeatedly denied.

At the trial, O'Connor's principal defense was that he had acted in good faith and was therefore immune from any liability for monetary damages. His position, in short, was that state law, which he had believed valid, had authorized indefinite custodial confinement of the "sick," even if they were not given treatment and their release could harm no one.[5]

The trial judge instructed the members of the jury that they should find that O'Connor had violated Donaldson's constitutional right to liberty if they found that he had—

"confined [Donaldson] against his will, knowing that he was not mentally ill or dangerous or knowing that if mentally ill he was not receiving treatment for his alleged mental illness.

* * * * * * *

"Now, the purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not a danger to himself or others. Without such treatment there is no justification from a constitutional stand-point for continued confinement unless you should also find that [Donaldson] was dangerous to either himself or others."[6]

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[4] There was some evidence that Donaldson, who is a Christian Scientist, on occasion refused to take medication. The trial judge instructed the jury not to award damages for any period of confinement during which Donaldson had declined treatment.

[5] At the close of Donaldson's case in chief, O'Connor moved for a directed verdict on the ground that state law at the time of Donaldson's confinement authorized institutionalization of the mentally ill even if they posed no danger to themselves or other. This motion was denied. At the close of all the evidence, O'Connor asked that the jury be instructed that "if defendants acted pursuant to a statute which was not declared unconstitutional at the time, they cannot be held accountable for such action." The Disticrict Court declined to give this requested instruction.

[6] The District Court defined treatment as follows:

"You are instructed that a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such treatment as *will give him a realistic opportunity to be cured or to improve his mental condition.*" (Emphasis added.) O'Connor argues that this statement suggests that a mental patient has a right to treatment even if confined by reason of dangerousness to himself or others. But this is to take the above paragraph out of context, for it is bracketed by paragrahs making clear the trial judge's theory that treatment is constitutionally required only if mental illness alone, rather than danger to self or others, is the reason for confinement. If O'Connor had thought the instructions ambiguous on this point, he could have objected to them and requested a clarification. He did not do so. We accordingly have no occasion here to decide whether persons committed on grounds of dangerousness enjoy a "right to treatment."

In pertinent part, the instruction read as follows:

"The Plaintiff calims in brief that throughout the period of his hospitalization he was not mentally ill or dangerous to himself or others, and claims further that if he was mentally ill, or if Defendants believed he was mentally ill, Defendants withheld from him the treatment necessary to improve his mental condition.

"The Defendants claim, in brief, that Plaintiff's detention was legal and proper, or if his detention was not legal and proper, it was the result of mistake, without malicious intent.

* * * * * * *

"In order to prove his claim under the Civil Rights Act, the burden is upon the Plaintiff in this case to establish by a preponderance of the evidence in this case the following facts:

"That the Defendants confined Plaintiff against his will, knowing that he was not mentally ill or dangerous or knowing that if mentally ill he was not receiving treatment for his alleged mental illness.

* * * * * * *

"[T]hat the Defendants' acts and conduct deprived the Plaintiff of his Federal Constitutional right not to be denied or deprived of his liberty without due process of law as that phrase is defined and explained in these instructions. . . .

* * * * * * *

"You are instructed that a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such treatment as will give him a realistic opportunity to be cured or to improve his mental condition.

"Now, the purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not a danger to himself or others. Without such treatment there is no justification from a constitutional stand-point for continued confinement unless you should also find that the Plaintiff was dangerous either to himself or others."

The trial judge further instructed the jury that O'Connor was immune from damages if he—

"reasonably believed in good faith that detention of [Donaldson] was proper for the length of time he was so confined....

"However, mere good intentions which do not give rise to a reasonable belief that detention is lawfully required cannot justify [Donaldson's] confinement in the Florida State Hospital."

The jury returned a verdict for Donaldson against O'Connor and a codefendant, and awarded damages of $38,500, including $10,000 in punitive damages.[7]

The Court of Appeals affirmed the judgment of the District Court in a broad opinion dealing with "the far-reaching question whether the Fourteenth Amendment guarantees a right to treatment to persons involuntarily civilly committed to state mental hospitals." 493 F. 2d, at 509. The appellate court held that when, as in Donaldson's case, the rationale for confinement is that the patient is in need of treatment, the Constitution requires that minimally adequate treatment in fact be provided. *Id.*, at 521. The court further expressed the view that, regardless of the grounds for involuntary civil commitment, a person confined against his will at a state mental institution has "a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition." *Id.*, at 520. Conversely, the court's opinion implied that it is constitutionally permissable for a State to confine a mentally ill person against his will in order to treat his illness, regardless of whether his illness renders him dangerous to himself or others. See *id.*, at 522–527.

II

We have concluded that the difficult issue of constitutional law dealt with by the Court of Appeals are not presented by this case in its present posture. Specifically, there is no reason now to decide whether mentally ill persons dangerous to themselves or to others have a right to treatment upon compulsory confinement by the State, or whether the State may compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment. As we view it, this case raises a single, relatively simple, but nonetheless important question concerning every man's constitutional right to liberty.

The jury found that Donaldson was neither dangerous to himself nor dangerous to others, and also found that, if mentally ill, Donaldson had not received treatment.[8] That verdict, based on abundant evidence, makes the issue before the Court a narrow one. We need not decide whether, when, or by what procedures, a mentally ill person may be confined by the State on any of the grounds which, under contemporary statutes, are generally advanced to justify involuntary confinement of such a person—to prevent injury to the public, to ensure his own survival or safety,[9] or to alleviate or cure his illness. See *Jackson* v. *Indiana*, 406 U.S. 715, 736–737; *Humphrey* v. *Cady*, 405 U.S. 504, 509. For the

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[7] The trial judge had instructed that punitive damages should be awarded only if "the act or omission of the Defendant or Defendants which proximately caused injury to the Plaintiff was maliciously or wantonly or oppressively done."

[8] Given the jury instructions, see n. 6 *supra*, it is possible that the jury went so far as to find that O'Connor knew not only that Donaldson was harmless to himself and others but also that he was not mentally ill at all. If it is so found, the jury was permitted by the instructions to rule against O'Connor regardless of the nature of the "treatment provided. If we were to construe the jury's verdict in that fashion, there would remain no substantial issue in this case: That a wholly sane and innocent person has a constitutional right not to be physically confined by the State when his freedom will pose a danger neither to himself nor to others cannot be seriously doubted.

[9] The judge's instructions used the phrase "dangerous to himself." Of course, even if there is no foreseeable risk of self-injury or suicide, a person is literally "dangerous to himself" if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends. While it might be argued that the judge's instructions could have been more detailed on this point, O'Connor raised no objection to them, presumably because the evidence clearly showed that Donaldson was not "dangerous to himself" however broadly that phrase might be defined.

jury found that none of the above grounds for continued confinement was present in Donaldson's case.[10]

Given the jury's findings, what was left as justification for keeping Donaldson in continued confinement? The fact that state law may have authorized confinement of the harmless mentally ill does not itself establish a constitutionally adequate purpose for the confinement. See *Jackson* v. *Indiana*, *supra*, at 720–723; *McNeil* v. *Director, Patuxent Institution*, 407 U.S. 245, 248–250. Nor is it enough that Donaldson's original confinement was founded upon a constitutionally adequate basis, if in fact it was, because even if his involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed. *Jackson* v. *Indiana*, *supra*, at 738; *McNeil* v. *Patuxent Institution*, *supra*.

A finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.

May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends. See *Shelton* v. *Tucker*, 364 U.S. 479, 488–490.

May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty. See, *e.g.*, *Cohen* v. *California*, 403 U.S. 15, 24–26; *Coates* v. *City of Cincinnati*, 402 U.S. 611, 615; *Street* v. *New York*, 394 U.S. 576, 592; cf. *U.S. Dept. of Agriculture* v. *Moreno*, 413 U.S. 528, 534.

In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. Since the jury found, upon ample evidence, that O'Connor, as an agent of the State, knowingly did so confine Donaldson, it properly concluded that O'Connor violated Donaldson's constitutional right to freedom.

III

O'Connor contends that in any event he should not be held personally liable for monetary damages because his decisions were made in "good faith." Specifically, O'Connor argues that he was acting pursuant to state law which, he believed, authorized confinement of the mentally ill even when their release would not compromise their safety or constitute a danger to others, and that he could not reasonably been expected to know that the state law as he understood it was constitutionally invalid. A proposed instruction to this effect was rejected by the District Court.[11]

[10] O'Connor argues that, despite the jury's verdict, the Court must assume that Donaldson was receiving treatment sufficient to justify his confinement, because the adequacy of treatment is a "nonjusticiable" question that must be left to the discretion of the psychiatric profession. That argument is unpersuasive. Where "treatment" is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present. See *Jackson* v. *Indiana*, 406 U.S. 715. Neither party objected to the jury instruction defining treatment. There is, accordingly, no occasion in this case to decide whether the provision of treatment, standing alone, can ever constitutionally justify involuntary confinement or, if it can, how much or what kind of treatment would suffice for that purpose. In its present posture this case involves not involuntary treatment but simply involuntary custodial confinement.

[11] See n. 5, *supra*. During his years of confinement, Donaldson unsuccessfully petitioned the state and federal courts for release from the Florida State Hospital on a number of occasions. None of these claims was ever resolved on its merits, and no evidentiary hearings were ever held. O'Connor has not contended that he relied on these unsuccessful court actions as an independent intervening reason for continuing Donaldson's confinement, and no instructions on this score were requested.

The District Court did instruct the jury, without objection, that monetary damages could not be assessed against O'Connor if he had believed reasonably and in good faith that Donaldson's continued confinement was "proper," and that punitive damages could be awarded only if O'Connor had acted "maliciously or wantonly or oppressively." The Court of Appeals approved those instructions. But that court did not consider whether it was error for the trial judge to refuse the additional instruction concerning O'Connor's claimed reliance on state law as authorization for Donaldson's continued confinement. Further, neither the District Court nor the Court of Appeals acted with the benefit of this Court's most recent decision on the scope of the qualified immunity possessed by state officials under 42 U.S.C. § 1983. *Wood* v. *Strickland*, 420 U.S. 308.

Under that decision, the relevant question for the jury is whether O'Connor "knew or reasonably should have known that the action he took within his sphere of official responsibility would violate the constitutional rights of [Donaldson], or if he took the action with the malicious intention to cause a deprivation of constitutional rights or other injury to [Donaldson]." *Id.*, at 322. See also *Scheuer* v. *Rhoades*, 416 U.S. 232, 247–248; *Wood* v. *Strickland*, *supra*, at 330 (opinion of POWELL, J.). For purposes of this question, an official has, of course, no duty to anticipate unforeseeable constitutional developments. *Wood* v. *Strickland*, *supra*, at 322.

Accordingly, we vacate the judgment of the Court of Appeals and remand the case to enable that court to consider, in light of *Wood* v. *Strickland*, whether the District Judge's failure to instruct with regard to the effect of O'Connor's claimed reliance on state law rendered inadequate the instructions as to O'Connor's liability for compensatory and punitive damages.[12]

It is so ordered.

MR. CHIEF JUSTICE BURGER, concurring.

Although I join the Court's opinion and judgment in this case, it seems to me that several factors merit more emphasis than it gives them. I therefore add the following remarks.

I

With respect to the remand to the Court of Appeals on the issue of official immunity from liability for monetary damages,[1] it seems to me not entirely irrelevant that there was substantial evidence that Donaldson consistently refused treatment that was offered to him, claiming that he was not mentally ill and needed no treatment.[2]

The Court appropriately takes notice of the uncertainties of psychiatric diagnosis and therapy, and the reported cases are replete with evidence of the divergence of medical opinion in this vexing area. *E.g.*, *Greenwood* v. *United States*, 350 U.S. 366, 375 (1956). See also *Drope* v. *Missouri*, 420 U.S. 162 (1975). Nonetheless, one of the few areas of agreement among behavioral specialists is that an uncooperative patient cannot benefit from therapy and that the first step in effective treatment is acknowledgment by the patient that he is suffering from an abnormal condition. See, *e.g.* Katz, The Right to Treatment—An Enchanting Legal Fiction? 36 U. Chi. L. Rev. 755, 768–769 (1969). Donaldson's adamant refusal to do so should be taken into account in considering petitioner's good-faith defense.

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[12] Upon remand, the Court of Appeals is to consider only the question whether O'Connor is to be held liable for monetary damages for violating Donaldson's constitutional right to liberty. The jury found, on substantial evidence and under adequate instructions, that O'Connor deprived Donaldson, who was dangerous neither to himself nor to others and was provided no treatment, of the constitutional right to liberty. Cf. n. 8, *supra*. That finding needs no further consideration. If the Court of Appeals holds that a remand to the District Court is necessary, the only issue to be determined in that court will be whether O'Connor is immune from liability for monetary damages.

Of necessity our decision vacating the judgment of the Court of Appeals deprives that court's opinion of precedential effect, leaving this Court's opinion and judgment as the sole law of the case. See *United States* v. *Munsingwear*, 340 U.S. 36.

[1] I have difficulty understanding how the issue of immunity can be resolved on this record and hence it is very likely a new trial on this issue may be required; if that is the case I would hope these sensitive and important issues would have the benefit of more effective presentation and articulation on behalf of petitioner.

[2] The Court's reference to "milieu therapy," *ante*, at 569, may be construed as disparaging that concept. True, it is capable of being used simply to cloak official indifference, but the reality is that some mental abnormalities respond to no known treatment. Also some mental patients respond, as do persons suffering from a variety of physiological ailments, to what is loosely called "milieu treatment," *i.e.*, keeping them comfortable, well nourished, and in a protected environment. It is not for us to say in the baffling field of psychiatry that "milieu therapy" is always a pretense.

Perhaps more important to the issue of immunity is a factor referred to only obliquely in the Court's opinion. On numerous occasions during the period of his confinement Donaldson unsuccessfully sought release in the Florida courts; indeed, the last of these proceedings was terminated only a few months prior to the bringing of this action. See 234 So. 2d 114 (1969), cert. denied, 400 U.S. 869 (1970). Whatever the reasons for the state courts' repeated denials of relief, and regardless of whether they correctly resolved the issue tendered to them, petitioner and the other members of the medical staff at Florida State Hospital would surely have been justified in considering each such judicial decision as an approval of continued confinement and an independent intervening reason for continuing Donaldson's custody. Thus, this fact is inescapably related to the issue of immunity and must be considered by the Court of Appeals on remand and, if a new trial on this issue is ordered, by the District Court.[3]

II

As the Court points out, *ante*, at 570 n. 6, the District Court instructed the jury in part that "'a person who is involuntarily civilly committed to a mental hospital does have a *constitutional* right to receive such treatment *as will give him a realistic opportunity to be cured*'" (emphasis added), and the Court of Appeals unequivocally approved this phrase, standing alone, as a correct statement of the law. 493 F. 2d 507, 520 (CA5 1974). The Court's opinion plainly gives no approval to that holding and makes clear that it binds neither the parties to this case nor the courts of the Fifth Circuit. See *ante*, at 577–578, n. 12. Moreover, in light of its importance for future litigation in this area, it should be emphasized that the Court of Appeals' analysis has no basis in the decisions of this Court.

A

There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law. *Specht* v. *Patterson*, 386 U.S. 605, 608 (1967). Cf. *In re Gault*, 387 U.S. 1, 12–13 (1967). Commitment must be justified on the basis of a legitimate state interest, and the reasons for committing a particular individual must be established in an appropriate proceeding. Equally important, confinement must cease when those reasons no longer exist. See *McNeil* v. *Director, Patuxent Institution*, 407 U.S. 245, 249–250 (1972); *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972).

The Court of Appeals purported to be applying these principles in developing the first of its theories supporting a constitutional right to treatment. It first identified what it perceived to be the traditional bases for civil commitment—physical dangerousness to oneself or others, or a need for treatment—and stated:

"[W]here, as in Donaldson's case, the rationale for confinement is the '*parens patriae*' rationale that the patient is in need of treatment, the due process clause requires that minimally adequate treatment be in fact provided. . . . '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.'" 493 F. 2d, at 521.

The Court of Appeals did not explain its conclusion that the rationale for respondent's commitment was that he needed treatment. The Florida statutes in effect during the period of his confinement did not require that a person who had been adjudicated incompetent and ordered committed either be provided with psychiatric treatment or released, and there was no such condition in respondent's order of commitment. Cf. *Rouse* v. *Cameron*, 125 U.S. App. D.C. 366, 373 F. 2d 451 (1967). More important, the instructions which the Court of Appeals read as establishing an absolute constitutional right to treatment did not require the jury to make any findings regarding the specific reasons for respondent's confinement or to focus upon any rights he may have had under state law. Thus, the premise of the Court of Appeals' first theory must have been that, at least with respect to persons who are not physically dangerous, a State has no power to confine the mentally ill except for the purpose of providing them with treatment.

That proposition is surely not descriptive of the power traditionally exercised by the States in this area. Historically, and for a considerable period of time,

[3] That petitioner's counsel failed to raise this issue is not a reason why it should not be considered with respect to immunity in light of the Court's holding that the defense was preserved for appellate review.

subsidized custodial care in private foster homes or boarding-houses was the most benign form of care provided incompetent or mentally ill persons for whom the States assumed responsibility. Until well into the 19th century the vast majority of such persons were simply restrained in poorhouses, almshouses, or jails. See A. Detusch, The Mentally Ill in America 38–54, 114–131 (2d ed. 1949). The few States that established institutions for the mentally ill during this early period were concerned primarily with providing a more humane place of confinement and only secondarily with "curing" the persons sent there. See *id.*, at 98–113.

As the trend toward state care of the mentally ill expanded, eventually leading to the present statutory schemes for protecting such persons, the dual functions of institutionalization continued to be recognized. While one of the goals of this movement was to provide medical treatment to those who could benefit from it, it was acknowledged that this could not be done in all cases and that there was a large range of mental illness for which no known "cure" existed. In time, providing places for the custodial confinement of the so-called "dependent insane" again emerged as the major goal of the State's programs in this area and remained so well into this century. See *id.*, at 228–271; D. Rothman, The Discovery of the Asylum 264–295 (1971).

In short, the idea that States may not confine the mentally ill except for the purpose of providing them with treatment is of very recent origin,[4] and there is no historical basis for imposing such a limitation on state power. Analysis of the sources of the civil commitment power likewise lends no support to that notion. There can be little doubt that in the exercise of its police power a State may confine individuals solely to protect society from the dangers of significant antisocial acts or communicable disease. Cf. *Minnesota ex rel. Pearson* v. *Probate Court*, 309 U.S. 270 (1940); *Jacobson* v. *Massachusetts*, 197 U.S. 11, 25–29 (1905). Additionally, the States are vested with the historic *parens patriae power*, including the duty to protect "persons under legal disabilities to act for themselves." *Hawaii* v. *Standard Oil Co.*, 405 U.S. 251, 257 (1972). See also *Mormon Church* v. *United States*, 136 U.S. 1, 56–58 (1890). The classic example of this role is when a State undertakkes to act as " 'the general guardian of all infants, idiots, and lunatics.' " *Hawaii* v. *Standard Oil Co., supra*, at 257, quoting 3 W. Blackstone, Commentaries *47.

Of course, an inevitable consequence of exercising the *parens patriae* power is that the ward's personal freedom will be substantially restrained, whether a guardian is appointed to control his property, he is placed in the custody of a private third party, or committed to an institution. Thus, however the power is implemented, due process requires that it not be invoked indiscriminately. At a minimum, a particular scheme for protection of the mentally ill must rest upon a legislative determination that it is compatible with the best interests of the affected class and that its members are unable to act for themselves. Cf. *Mormon Church* v. *United States, supra*. Moreover, the use of alternative forms of protection may be motivated by different considerations, and the justifications for one may not be invoked to rationalize another. Cf. *Jackson* v. *Indiana*, 406 U.S., at 737–738. See also American Bar Foundation, The Mentally Disabled and the Law 254–255 (S. Brakel & R. Rock ed. 1971).

However, the existence of some due process limitations on the *parens patriae* power does not justify the further conclusion that it may be exercised to confine a mentally ill person only if the purpose of the confinement is treatment. Despite many recent advances in medical knowledge, it remains a stubborn fact that there are many forms of mental illness which are not understood, some which are untreatable in the sense that no effective therapy has yet been discovered for them, and that rates of "cure" are generally low. See Schwitzgebel, The Right to Effective Mental Treatment, 62 Calif. L. Rev. 936, 941–948 (1974). There can be little responsible debate regarding "the uncertainty of diagnosis in this field and the tentativeness of professional judgment." *Greenwood* v. *United States*, 350 U.S. at 375. See also Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Calif. L. Rev. 693, 697–719 (1974).[5] Similarly, as previously observed, it is universally recognized as fundamental to effective therapy that the patient acknowledge his illness and cooperate with

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[4] See Editorial, A New Right, 46 A.B.A.J. 516 (1960).

[5] Indeed, there is considerable debate concerning the threshold questions of what constitutes "mental disease" and "treatment." See Szasz, The Right to Health, 57 Geo. L. J. 734 (1969).

those attempting to give treatment; yet the failure of a large proportion of mentally ill persons to do so is a common phenomenon. See Katz, *supra*, 36 U. Chi. L. Rev., at 768–769. It may be that some persons in either of these categories,[6] and there may be others, are unable to function in society and will suffer real harm to themselves unless provided with care in a sheltered environment. See, *e.g.*, *Lake* v. *Cameron*, 124 U.S. App. D.C. 264, 270–271, 364 F. 2d 657, 663–664 (1966) (dissenting opinion). At the very least, I am not able to say that a state legislature is powerless to make that kind of judgment. See *Greenwood* v. *United States*, *supra*.

B

Alternatively, it has been argued that a Fourteenth Amendment right to treatment for involuntarily confined mental patients derives from the fact that many of the safeguards of the criminal process are not present in civil commitment. The Court of Appeals described this theory as follows:

"[A] due process right to treatment is based on the principle that when the three central limitations on the government's power to detain—that detention be in retribution for a specific offense; that it be limited to a fixed term; and that it be permitted after a proceeding where the fundamental procedural safeguards are observed—are absent, there must be a *quid pro quo* extended by the government to justify confinement. And the *quid pro quo* most commonly recognized is the provision of rehabilitative treatment." 493 F. 2d, at 522.

To the extent that this theory may be read to permit a State to confine an individual simply because it is willing to provide treatment, regardless of the subject's ability to function in society, it raises the gravest of constitutional problems, and I have no doubt the Court of Appeals would agree on this score. As a justification for a constitutional right to such treatment, the *quid pro quo* theory suffers from equally serious defects.

It is too well established to require extended discussion that due process is not an inflexible concept. Rather, its requirements are determined in particular instances by identifying and accommodating the interests of the individual and society. See, *e.g.*, *Morrissey* v. *Brewer*, 408 U.S. 471, 480–484 (1972); *McNeil* v. *Director, Patuxent Institutions*, 407 U.S., at 249–250; *McKeiver* v. *Pennsylvania*, 403 U.S. 528, 545–555 (1971) (plurality opinion). Where claims that the State is acting in the best interests of an individual are said to justify reduced procedural and substantive safeguards, this Court's decisions require that they be "candidly appraised." *In re Gault*, 387 U.S., at 21, 27–29. However, in so doing judges are not free to read their private notions of public policy or public health into the Constitution. *Olsen* v. *Nebraska*, 313 U.S. 236, 246–247 (1941).

The *quid pro quo* theory is a sharp departure from, and cannot coexist with, due process principles. As an initial matter, the theory presupposes that essentially the same interests are involved in every situation where a State seeks to confine an individual; that assumption, however, is incorrect. It is elementary that the justification for the criminal process and the unique deprivation of liberty which it can impose requires that it be invoked only for commission of a specific offense prohibited by legislative enactment. See *Powell* v. *Texas*, 392 U.S. 514, 541–544 (1968) (opinion of Black, J.).[7] But it would be incongruous, for example, to apply the same limitation when quarantine is imposed by the State to protect the public from a highly communicable disease. See *Jacobson* v. *Massachusetts*, 197 U.S., at 29–30.

A more troublesome feature of the *quid pro quo* theory is that it would elevate a concern for essentially procedural safeguards into a new substantive constitutional right.[8] Rather than inquiring whether strict standards of proof or periodic redetermination of a patient's condition are required in civil confinement, the theory accepts the absence of such safeguards but insists that the State provide benefits which, in the view of a court, are adequate "compensation" for

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[6] Indeed, respondent may have shared both of these characteristics. His illness, paranoid schizophrenia, is notoriously unsusceptible to treatment, see Livermore, Malmquist, & Meehl, On the Justifications for Civil Commitment, 117 U. Pa. L. Rev. 75, 93 and n. 52 (1968), and the reports of the Florida State Hospital staff which were introduced into evidence expressed the view that he was unwilling to acknowledge his illness and was generally uncooperative.

[7] This is not imply that I accept all of the Court of Appeals' conclusions regarding the limitations upon the States' power to detain persons who commit crimes. For example, the notion that confinement must be "for a fixed term" is difficult to square with the widespread practice of indeterminate sentencing, at least where the upper limit is a life sentence.

[8] Even advocates of a right to treatment have criticized the *quid pro quo* theory on this ground. *E.g.*, Developments in the Law—Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1325 n. 39 (1974).

confinement. In light of the wide divergence of medical opinion regarding the diagnosis of and proper therapy for mental abnormalities, that prospect is especially troubling in this area and cannot be squared with the principle that "courts may not substitute for the judgments of legislators their own understanding of the public welfare, but must instead concern themselves with the validity under the Constitution of the methods which the legislature has selected." *In re Gault*, 387 U.S., at 71 (Harlan, J., concurring and dissenting). Of course, questions regarding theadequacy of procedure and the power of a State to continue particular confinements are ultimately for the courts, aided by expert opinion to the extent that is found helpful. But I am not persuaded that we should abandon the traditional limitations on the scope of judicial review.

In sum, I cannot accept the reasoning of the Court of Appeals and can discern no basis for equating an involuntarily committed mental patient's unquestioned constitutional right not to be confined without due process of law with a constitutional right to *treatment*.[9] Given the present state of medical knowledge regarding abnormal human behavior and its treatment, few things would be more fraught with peril than to irrevocably condition a State's power to protect the mentally ill upon the providing of "such treatment as will give [them] a realistic opportunity to be cured." Nor can I accept the theory that a State may lawfully confine an individual thought to need treatment and justify that deprivation of liberty solely by providing some treatment. Our concepts of due process would not tolerate such a "trade-off." Because the Court of Appeals' analysis could be read as authorizing those results, it should not be followed.

[APPENDIX 28]

Cite as 357 F. Supp. 752 (E.D. N.Y. 1973)

NEW YORK STATE ASSOCIATION FOR RETARDED CHILDREN, INC., et al.

and

Patricia Parisi, by mother Lena Steuernagel, et al., Plaintiffs,

v.

Nelson A. Rockefeller, Individually and as Governor of the State of New York, et al., Defendants.

Nos. 73-C-55, 73-C-113.

United States District Court, E. D. New York

April 10, 1973

Action was brought on behalf of residents of New York institution for the mentally retarded against certain New York officials for equitable relief relating

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[9] It should be pointed out that several issues which the Court has touched upon in other contexts are not involved here. As the Court's opinion makes plain, this is not a case of a person seeking release because he has been confined "without ever obtaining a judicial determination that such confinement is warranted." *McNeil* v. *Director, Patuxent Institution* 407 U.S. 245, 249 (1972). Although respondent's amended complaint alleged that his 1956 hearing before the Pinellas County Court was procedurally defective and ignored various factors relating to the necessity for commitment, the persons to whom those allegations applied were either not served with process or dismissed by the District Court prior to trial. Respondent has not sought review of the latter rulings, and this case does not involve the rights of a person in an initial competency or commitment proceeding. Cf. *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972); *Specht* v. *Patterson*, 386 U.S. 605 (1967); *Minnesota ex rel. Pearson* v. *Probate Court*; 309 U.S. 270 (1940).

Further, it was not alleged that respondent was singled out for discriminatory treatment by the staff of Florida State Hospital or that patients at that institution were denied privileges generally available to other persons under commitment in Florida. Thus, the question whether different bases for commitment justify differences in conditions of confinement is not involved in this litigation. Cf. *Jackson* v. *Indiana*, *supra*, at 723–730; *Baxerom* v. *Herold*, 383 U.S. 107 (1966).

Finally, there was no evidence whatever that respondent was abused or mistreated at Florida State Hospital or that the failure to provide him with treatment aggravated his condition. There was testimony regarding the general quality of life at the hospital, but the jury was not asked to consider whether respondent's confinement was in effect "punishment" for being mentally ill. The record provides no basis for concluding, therefore, that respondent was denied rights secured by the Eighth and Fourteenth Amendments. Cf. *Robinson* v. *California*, 370 U.S. 660 (1962).

to the treatment and care of residents. On motion for preliminary injunction the District Court, Judd, J., held, inter alia, that federal court could not in fairness direct that any of the residents be released before they had been habilitated as far as possible and could not direct the closing of the state institution or impose all of the national accreditation standards but court would grant enumerated items as preliminary relief in an attempt to correct deficiencies affecting physical safety and risk of physical deterioration to inmates such as a prohibition against seclusion and the immediate hiring of additional personnel.

Preliminary injunction granted.

1. Mental Health ⇨439

Justification for holding man acquitted of crime by reason of insanity and keeping him beyond maximum possible sentence must be either treatment or protection of public or himself. U.S.C.A.Const. Amends. 8, 14.

2. Constitutional Law ⇨81

There is no constitutional provision which imposes a duty on a state to provide services to its citizens.

3. Mental Health ⇨51, 59

While residents of state hospital for mentally retarded and their parents or guardians might be entitled to enforce fulfilment of the statutory purpose of care and treatment in the New York courts, in federal court a failure to accomplish original purpose gives right only to release or to what anyone is entitled to receive when confined in a state institution. Mental Hygiene Law N.Y. §§ 33.15, 33.25, 33.27.

4. Constitutional Law ⇨83(1)

Procedural safeguards are necessary before citizen can be deprived of liberty even when state's purpose is benign.

5. Mental Health ⇨6

To extent that characterization of person as mentally retarded may involve a public stigma, initial determination cannot be made without notice and hearing.

6. Constitutional Law ⇨251

What constitutes due process under any given set of circumstances must depend on nature of proceeding involved and rights that may possibly be affected by that proceeding.

7. Constitutional Law ⇨255(5)

Due process may be an element in the right of mentally retarded person in state institution to protection from harm, but it does not establish a right to treatment.

8. Constitutional Law ⇨209

Equal protection clause of Fourteenth Amendment gives no substantive rights, with possible exceptions of the one-man, one-vote rule, but rather mandates that state law not discriminating against classes of similarly situated persons without having a rational basis for so doing. U.S.C.A.Const. Amend. 14.

9. Constitutional Law ⇨211, 215

If classification is suspect, such as one based on race, or if it infringes fundamental constitutional rights, such as freedom of speech, there must be strict judicial scrutiny under the equal protection clause, and the scheme may be justified only by state showing a compelling interest in maintaining it. U.S.C.A.Const. Amend. 14.

10. Constitutional Law ⇨85

Alleged denial of a public education does not infringe a fundamental right guaranteed by Constitution. U.S.C.A. Const. Amend. 14.

11. Schools and School Districts ⇨148

State is not constitutionally required to provide mentally retarded with a certain level of special education. U.S.C.A.Const. Amend. 14.

12. Schools and School Districts ⇨148

New York, which was required to allocate finite resources among many worthwhile and necessary programs and had done so in a rational manner including

provision for education to children of the state both normal and handicapped, had no constitutional duty to supply the full need for education of mentally retarded children in state institutions.

13. Constitutional Law ⚷70.1(1)

Allocation of state resources among conflicting needs is a matter for the State Legislature if there is a rational basis and other constitutional rights are not violated.

14. Prisons ⚷17

Federal Constitution does not cease to protect man when he enters prison, and a tolerable living environment is guaranteed by law with respect to persons confined under criminal law.

15. States ⚷112

Since persons residing in state institutions other than prisons may not be constitutionally punished, some conditions tolerated in prisons may not be permissible in other institutions.

16. Mental Health ⚷51

Because residents of state home for the mentally retarded were for the most part confined behind locked gates and held without possibility of a meaningful waiver of right to freedom, residents must be entitled to at least same living conditions as prisoners. Mental Hygiene Law N.Y. §§ 33.15, 33.25, 33.27.

17. Mental Health ⚷51

Residents of state institution for mentally retarded were entitled to certain basic rights including protection from assault by fellow residents or staff, correction of conditions violating basic standards of human decency, medical care, opportunity for exercise and outdoor recreation, adequate heat and necessary elements of basic hygiene.

18. Courts ⚷303(2)

Eleventh Amendment to Federal Constitution did not constitute a jurisdictional impediment to suit by and on behalf of inmates of New York institution for the mentally retarded against New York officials for equitable relief to require the officials to institute programs which will raise conditions at institution, although the Amendment might affect the scope of relief granted. U.S.C.A.Const. Amend. 11.

19. Federal Civil Procedure ⚷219

Since there were provisions for federal policing of programs aided by federal funds, any consideration of federal statutory rights of residents of New York institution for mentally retarded, on behalf of whom suit was brought to compel the institution to institute programs to raise standards, should await either a joinder of United States Department of Health, Education and Welfare as a party or at least some opportunity for Department to participate. Social Security Act, § 1901 et seq., 42 U.S.C.A. § 1396 et seq.; Mental Retardation Facilities Construction Act, §§ 130–140 as amended 42 U.S.C.A. §§ 2670–2677c.

20. Courts ⚷260.4

Federal court of equity should abstain from adjudicating constitutionality of state statute when state court, given chance, might so construe statute as to avoid constitutional question, and doctrine of abstention calls for a judicious exercise of discretion enabling federal courts to restrain their authority because of scrupulous regard for rightful independence of state governments and for smooth working of federal judiciary.

21. Courts ⚷260.4

In determining applicability of doctrine of abstention, among interests to be weighed against impinging on the federal-state relation is the importance of right alleged to be impaired and harm inflicted by delay attendant on postponing adjudication while state courts consider same matter.

22. Courts ⚷260.4

Abstention by federal court is not justified simply because a federal claim might be presented to state courts.

23. Courts ⟹260.4

Where state claim and federal claim are not the same so that determination of state claim may obviate necessity of deciding federal claim, abstention by federal court may be appropriate, but the state remedy must be available in practice, not only in theory, to justify abstention.

24. Courts ⟹260.4

Where there is real probability of serious physical harm to residents of state institution, abstention by federal court is not required, and federal intervention should not be delayed.

25. Courts ⟹260.4

Although plaintiffs bringing suit on behalf of residents of New York institution for mentally retarded seeking to compel institution of new programs to raise the level of care and treatment had significant state claims and New York courts had granted relief to individuals in certain prior cases, federal court would not abstain and remit plaintiffs to questionable state court remedy, but would restrict its preliminary relief to steps which appeared essential for physical safety of residents and their protection from gross deterioration. Mental Hygiene Law N.Y. §§ 33.15, 33.25, 33.27.

26. Mental Health ⟹51, 59

Federal court in which suit was instituted on behalf of residents of state institution for mentally retarded against state officials could not in fairness direct that any of the residents be released before they had been habilitated as far as possible and could not direct the closing of the state institution or impose all of the national accreditation standards, but court would grant enumerated items as preliminary relief in an attempt to correct deficiency affecting physical safety and risk of physical deterioration to inmates such as prohibition against seclusion and immediate hiring of additional personnel.

Louis J. Lefkowitz, Atty. Gen., State of New York, New York City, by Brenda Soloff, Judith Gordon, Asst. Attys. Gen., for defendants; and Judith T. Kramer, Deputy Asst. Atty. Gen., of counsel.

Bruce J. Ennis and Burt Neuborne, New York Civil Liberties Union, New York City, Julian Tepper, Stanley Herr, Washington, D.C., Charles R. Halpern, Eugene Z. DuBose, Mental Health Law Project, Washington, D.C., for plaintiffs in case No. 72–C–356.

Kalman Finkel, John E. Kirklin, Anita Fisher Barrett, Legal Aid Society, Civil Appeals Bureau, New York City, Robert L. Feldt, Legal Aid Society, Staten Island, N.Y., for plaintiffs in case No. 72–C–357.

Leonard B. Pack, New York City, for American Association on Mental Deficiency, New York City Chapter of the National Association of Social Workers, Federation of Parents Organizations for the New York State Mental Institutions, and New York State Federation of Chapters of the Council for Exceptional Children, amici curiae for plaintiffs.

JUDD, District Judge.

MEMORANDUM

Willowbrook State School for the Mentally Retarded has been characterized by Dr. Herbert J. Grossman, expert consultant for the defendants, as "based on the wrong concept in the wrong place with the wrong plan." Plaintiffs, representing the residents of Willowbrook, have asked this court to require the defendants to institute programs which will raise the conditions at Willowbrook to a level approaching the ideals stated in recently formulated national accreditation standards. The official defendants question the power of a federal court and also the necessity of any action, in the light of the efforts which are currently being made to improve the conditions at Willowbrook.

The present state of the case requires the court's decision on a motion for a preliminary injunction, after a week of hearings. A federal court, as will appear, cannot grant relief to the extent requested by the plaintiffs.

Dr. Grossman in the final affidavit submitted by the defendants stated that "from a professional point of view, improvement is necessary in every aspect of care and in every building which I visited." However, he identified overcrowding

as the most critical problem, and endorsed the plans of the Department of Mental Hygiene as a logical and systematic way to deal with problems which "are longstanding and enormously complex."

Summary of Facts

From the testimony received at five days of hearings, a sheaf of exhibits, a folder of photographs, and hundreds of pages of affidavits considered as part of the record, plus this court's visit to the Willowbrook State School for the Mentally Retarded, it appears and the court finds that:

Willowbrook consists of approximately 43 buildings with a resident population of 4,727 on December 10, 1972, reduced from a high of 6,200 in 1969 and from a total population of approximately 5,700 at the beginning of this action. Over three-quarters of the residents are profoundly or severely retarded with intelligence quotients below 35, approximately one-third suffer from epileptic seizures, and over half have been in Willowbrook over 20 years.

In spite of legislative reports dating from 1964, which complained of overcrowding and inadequate staffing at Willowbrook, conditions are still inhumane. The institution has not yet recovered from a hiring freeze which prevented even the replacement of departing staff members from December 1970 until November 1971 and prevented the hiring of any additional staff until January 1972.

Only 27 percent of the residents at Willowbrook are there on voluntary application. These are not treated any differently from those who are there under court order. Even those who are there on voluntary application (usually of their parents or guardians) have no other place to go.

Testimony of ten parents, plus affidavits of others, showed failure to protect the physical safety of their children, and deterioration rather than improvement after they were placed in Willowbrook School. The loss of an eye, the breaking of teeth, the loss of part of an ear bitten off by another resident, and frequent bruises and scalp wounds were typical of the testimony. During eight months of 1972 there were over 1,300 reported incidents of injury, patient assaults, or patient fights.

The number of ward attendants is below the level which even the Director of Willowbrook thinks proper, and unauthorized absences worsen the shortage. There are only half the number of doctors that are needed, and nurses, physical therapists, recreation therapists, and other professional staff are in short supply. For many of the professional groups, the salaries offered are not competitive with those available in other more desirable places of employment in the community. The turnover of present staff is almost 40 percent a year for ward attendants and 18 percent a year for the rest of the staff.

Physical maintenance is poor, with a backlog of 750 work orders and at least one toilet inoperative in every battery of toilets.

These conditions are hazardous to the health, safety, and sanity of the residents. They do not conform with the standards published by the American Association on Mental Deficiency in 1964, or with the proposed standards published on March 5, 1973 by the United States Department of Health, Education, and Welfare. A most striking deficiency is the inadequate coverage of dayrooms, where the ratio is frequently 15 or more residents per attendant on duty even for profoundly or severely retarded residents.

Over three-fourths of the residents of Willowbrook are profoundly or severely retarded, and would require resident care personnel in the ratio of 1:5 for the first shift, 1:7 for the second shift, and 1:15 for the third shift, to comply with the 1964 A.A.M.D. Standards.

More detailed standards, set forth as optimum goals, were prepared in 1971 by the Accreditation Council for Facilities for the Mentally Retarded (A.C.F.M.R. Standards), but at the time of the hearings only one facility had been accredited as meeting these standards.

Defendants have taken significant steps during 1972, by closing admission to Willowbrook, by appointing a qualified new Director and a highly experienced new Deputy Director for Institutional Administration, by creating a ward service career ladder, and by plans to subdivide the institution into manageable units, among other things. These steps have been inadequate, however, to assure the safety of the residents up to the present time. Efforts to reduce the population and to increase the staff are continuing, but the number of new professionals hired during 1972 has been minimal, largely because of the inadequacy of salaries in relation to the problems facing the staff.

The Legislature has now provided additional funds, and the Director and Deputy Director have been assured that there will be money to pay for anyone that they can hire and to purchase a reasonable amount of necessary equipment.

Approximately half the budget of Willowbrook is reimbursed by the United States Department of Health, Education, and Welfare, which rates Willowbrook as an intermediate care institution.

Requests for Relief

In their post-trial memorandum, plaintiffs suggest 26 appropriate forms of relief:

1. Immediate steps to employ 134 more nurses, 125 mid-level supervisors, 25 more maintenance workers, and more personnel employees.
2. Employment of enough attendants within 30 days to provide at least one for every 10 residents during the first and second shifts.
3. Immediate steps to employ enough attendants (after 30 days) to have one for every 8 or 9 residents on the first and second shifts.
4. Notices to forbid the use of seclusion.
5. Preparation of evacuation plans and conducting a fire drill within 30 days.
6. Subsequent employment of enough attendants to assure a 3-shift ratio of 1:6, 1:6, and 1:12.
7. Steps to recruit a total of 422 English speaking nurses.
8. Immediate steps to recruit a physical therapy staff of 50 to 60 persons.
9. All steps necessary to hire an additional 21 full-time M.D. physicians.
10. Immediate steps to develop an orientation program for resident-care attendants.
11. Immediate steps to assign named residents to named resident-care attendants.
12. Immediate steps to subdivide large dayroom areas into smaller sections.
13. Immediate steps to make maximum use of presently unused space.
14. Repair of all defective toilets, health and safety hazards, etc.
15. Immediate provision of adequate cleaning equipment, etc.
16. Immediate steps to hire sufficient maintenance personnel.
17. All steps necessary to eliminate improper physical and chemical restraints.
18. All steps necessary to eliminate cockroaches, rodents, and other pests.
19. All steps necessary to provide adequate clothing and bedding.
20. All steps necessary to provide adequate toilet and person hygiene supplies.
21. Immediate steps to provide regular outdoor exercise.
22. Immediate steps to initiate completion of medical screening of all residents by July 31, 1973.
23. Immediate steps to contract for acute medical and surgical services from a fully accredited hospital within 60 days.
24. In the alternative, immediate steps to implement each of the recommendations of Dr. Clements and Dr. Roos.
25. Immediate submission to the Legislature of a supplemental budget request, if necessary.
26. Direction to request any necessary exemptions from the state Civil Service law in respect of salary levels, fringe benefits, and recruitment.

Discussion

Plaintiffs ground their claim on a constitutional right to treatment, which would require the court to impose a large portion of the A.C.F.M.R. Standards upon the defendants.

Defendants dispute the jurisdiction of the federal court, assert that relief is barred by the Eleventh Amendment, and that in any event, the facts do not justify the issuance of a preliminary injunction. They further ask the court to abstain, even if it has jurisdiction, in deference to the efforts which they are making to remedy any existing deficiencies.

The court concludes (a) that the plaintiffs' class has no constitutional right to treatmetnt either independently or on due process or equal protection grounds, but (b) that they have a right to reasonable protection from harm; that appropriate relief is not barred (c) by the Eleventh Amendment or (d) by any duty of abstention, and (e) that the court should give specific directions to prevent seclusion and to effect, among other things, a prompt increase in the number of ward attendants, doctors, nurses, physical therapists and recreation therapists,

CONTINUED

11 OF 12

with salary limits fixed by the court if those offered by the defendants are inadequate to attract the necessary staff.

(a) The right to treatment

Of the many complex issues of law presented, the most difficult involves the newly developing "right to treatment," its scope, and the extent to which it embodies a federal constitutional principle.

The right to treatment as a constitutional concept has its beginnings in Judge Bazelon's opinion in *Rouse* v. *Cameron*, 125 U.S.App.D.C. 366, 373 F. 2d 451 (1966), though it was really announced only as a statutory right.

Prior to *Rouse* v. *Cameron*, *supra*, dicta in two D.C. Court of Appeals opinions touched on a constitutional right to treatment. In *Ragsdale* v. *Overholser*, 108 U.S.App.D.C. 308, 281 F.2d 943 (1960), a habeas corpus proceeding by a mental patient, Judge Fahy (concurring) questioned a statement by the majority that it was permissible to confine a person acquitted by reason of insanity for a period considerably in excess of the possible penalty for the crime charged. He thought that the mandatory commitment provision would run afoul of the due process clause 'unless qualified by an obligation for treatment of the mental condition which led to the acquittal. To fail to provide treatment would transform the hospital into a penitentiary where one could be held indefinitely for no convicted offense.

281 F.2d at 950. Ragsdale, after a charge of robbery, and acquittal because of insanity, had escaped from confinement in St. Elizabeth's Hospital. He brought his petition shortly after he had been returned to the hospital as a fugitive. There was some evidence that he was still mentally ill and Judge (now Chief Justice) Burger in the majority opinion (281 F.2d at 947) held that reasonable medical doubts should be resolved in favor of the public.

Judge Bazelon, in Darnell v. Cameron, 121 U.S.App.D.C. 58, 348 F.2d 64 (1965), like *Ragsdale* an appeal from the denial of a petition for habeas corpus by an inmate of St. Elizabeth's Hospital, noted (pp. 67–68) that the petitioner had received little treatment although he had been confined for more than four years after acquittal by reason of insanity of a charge with only a possible one-year sentence. Darnell had been originally convicted of indecent exposure, and was returned to the hospital after being released on parole and arrested again for a similar offense. The precise holding was that he was entitled to a hearing on the revocation of parole, but Judge Bazelon suggested that the hearing on remand should also consider the issue of treatment, in order to meet the question of the constitutionality of the mandatory commitment statute.

Armed with the *Ragsdale* and *Darnell* cases, and supported by a law review article entitled The Right to Treatment, 46 A.B.A.J. 499 (1960) by Dr. Morton Birnbaum, Judge Bazelon again considered the right to treatment in the seminal case of *Rouse* v. *Cameron*, cited above, 373 F.2d 451. *Rouse* is important because all the recent cases supporting a constitutional right to treatment are traceable to it.

As the touchstone for the constitutional right to treatment, *Rouse* merits scrutiny. Procedurally, *Rouse*, like *Ragsdale*, was an appeal from the denial of a habeas corpus petition. The petitioner was confined in St. Elizabeth's Hospital after acquittal, by reason of insanity, of a misdemeanor. The lower court judge refused to consider the claim that petitioner had not received adequate treatment, stating that his jurisdiction on habeas corpus was limited to a consideration of whether petitioner had regained his sanity. The Court of Appeals reversed and remanded for a hearing and findings on the adequacy of treatment. Judge Bazelon's majority opinion notes (373 F.2d at 453) that civil confinement without treatment might draw into question the constitutionality of the statute requiring commitment in all cases where criminal defendants are acquitted by reason of insanity. He cited three bases of possible constitutional violation (*ibid.*): (1) that summary commitment, without a finding of present incapacity, might violate procedural due process in the absence of treatment, being justified only "because of its humane therapeutic goals"; (2) that a person convicted of a crime could be sentenced to prison only for a finite period, while a person acquitted by reason of insanity might be confined indefinitely; and (3) that indefinite confinement without treatment of one who is not criminally responsible may be so inhumane as to violate the Eighth Amendment's proscription of cruel and unusual punishment.

These constitutional issues were not, however, the basis of decision. Rather the court decided that Congress had established a statutory right to treatment

by its enactment of the 1964 Hospitalization of the Mentally Ill Act. D.C. Code § 21-562. Although Judge Bazelon suggested that the constitutional problem discussed in the opinion motivated Congress to pass the law, he based his decision on the statute, saying (373 F.2d at 455):

"Because we hold that the right to treatment provision applies to appellant, we need not resolve the serious constitutional questions that Congress avoided by prescribing this right."

On remand, the district court found that *Rouse* was receiving adequate treatment, but the Court of Appeals reversed for errors in the original commitment, without reaching the treatment issue. 128 U.S.App.D.C. 283, 387 F.2d 241 (1967).

Rouse v. *Cameron* is noteworthy in other respects in relation to the right to treatment. First, the court suggests methods by which a judge can weigh the adequacy of treatment, including (373 F.2d at 456) periodic assessments of each individual's needs and progress. Second, the court states (373 F.2d at 458) that the alternative to providing adequate treatment is release. In this second respect, the decision applies the rule of *Robinson* v. *California*, 370 U.S. 660, 82 S.Ct. 1417, 8 L.Ed.2d 758 (1962), that mere status (Robinson was a narcotic addict) does not justify imprisonment in the absence of treatment to remedy the condition. *Cf.* United States ex rel. *Schuster* v. *Herold*, 410 F.2d 1071 (2d Cir. 1969).

The proposition that the *quid pro quo* for commitment in lieu of criminal incarceration must be treatmen is not really radical. Expanding that proposition, however, to a constitutional right of habilitation owed by the State of New York to mentally retarded children resident at Willowbrook is more than the next logical step in an inexorable sequence. At the outset, there is a difference in the nature of the commitment. In *Rouse*, the commitment of persons acquitted by reason of insanity was not only involuntary but mandatory. On the other hand, a large part of the residents of Willowbrook entered because they had no alternative, and none have been denied a right to release. There is a significant difference between the state requiring commitment as an alternative to criminal incarceration and the state providing a residence for the mentally retarded. The residents of Willowbrook are for the most part incapable of existing independently unless successfully habilitated. See Murdock, Civil Rights of the Mentally Retarded: Some Critical Issues, 48 Notre Dame Lawyer, 133, 160 (1971). Moreover, there is a great difference between a federal judge giving directions about care in a federal hospital, involving no federal-state relations, and a federal court judge radically restructuring New York's treatment of mentally retarded children.

Recent cases have expanded the purview of the right to treatment, without analyzing the basis for *Rouse* v. *Cameron*. In *Wyatt* v. *Stickney*, D.C., 325 F.Supp. 781 (1971), Judge Frank Johnson's case in the Middle District of Alabama, the initial challenge was to the conditions to which all involuntarily committed mental patients in state hospitals were subjected. Later the case was expanded to include the mentally retarded committed to a state school. Judge Johnson relied on the D.C. Circuit cases. He did not elaborate on the constitutional underpinnings but rather accepted Judge Bazelon's due process theory as self-evident, saying in 325 F.Supp. at 784:

"Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transferred "into a penitentiary where one could be held indefinitely for no convicted offense," *Ragsdale* v. *Overholser*, 108 U.S.App. D.C. 308 [315], 281 F.2d 943, 950 (1960). The 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 . . ." (emphasis from original).

When Judge Johnson later held that the right was applicable to the residents of the Partlow State School and Hospital, he stated (344 F.Supp. 373, 390), that the legal principles, "clear beyond cavil," supported plaintiff's position that "people involuntarily committed 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."

His use of the word "habilitation" represented a step beyond his earlier opinion on the mental hospitals, where he had found only a right to "individual treatment." 325 F.Supp. at 784. Judge Johnson ordered compliance at the Partlow School with some 49 paragraphs of standards, including staff ratios based largely on the A.C.F.M.R. Standards, 344 F.Supp. at 395-407. The defendants in that

case, however, had offered no rebuttal to the plaintiff's claims of inadequate treatment. To some extent the case represented a joint effort by the Partlow residents and the Partlow administration to bring pressure on the Alabama Legislature. Alabama ranked 50th among the states in expenditures per patient and had not qualified for any federal funds. 325 F.Supp. at 784.

A federal district judge in Georgia refused to follow Judge Johnson's decision in an action alleging inadequate diagnoses and treatment at state mental institutions. *Burnham* v. *Department of Public Health*, 349 F.Supp. 1335 (N.D. Ga. 1972). He called attention to substantial increases in the state funds provided for mental hygiene (p. 1337), to the statutory basis of the D.C. Circuit cases (p. 1339), and (p. 1340) to Judge Burger's caution, in his dissent in *Lake* v. *Cameron*, 124 U.S. App. D.C. 264, 364 F.2d 657, 663 (1966), that a district court was not equipped to resolve the social and economic interests involved.

The *Wyatt* and *Burnham* cases are both under appeal to the Fifth Circuit Court of Appeals, where they have been argued and await decision.

In other cases the right to treatment has been applied to training schools for juveniles. Inmates of Boys' Training School v. Affleck, 346 F.Supp. 1354 (D. R.I. 1972); Matarella v. Kelley, 349 F.Supp. 575 (S.D. N.Y. 1972). In both *Affleck* and *Martarella*, many of the plaintiff class had not been committed in lieu of criminal prosecution or incarceration. Some of the plaintiffs in *Affleck* had been voluntarily committed by their parents. 346 F.Supp. at 1363. The class of plaintiffs in *Martarella* were PINS (persons in needs of supervision), none of whom had committed crimes. With a minimum of discussion, and without citation of *Rousse*, the Court in *Affleck* held that the right to rehabilitation was grounded in due process. The Court reasoned that since juveniles were entitled to strict compliance with procedural due process under the decision in In re Gault, 387 U.S. 1, 87 S.Ct. 1428, 12 L.Ed.2d 527 (1967), any deviation from strict procedures before commitment could be justified only by the promise to rehabilitate.

Judge Lasker in *Martarella* recognized that the right to treatment presented the "most difficult legal issue in this case. . . ." He summarizes his discussion of the law with the assertion (349 F.Supp. at 599) that:

"[T]here can be no doubt that the right to treatment, generally, for those held in non-criminal custody (whether based on due process, equal protection or the Eighth Amendment, or a combination of them) has by now been recognized by the Supreme Court, the lower federal courts and the courts of New York."

The rationale is based on the *quid pro quo* approach of due process adapted from *Rouse* and *Wyatt* v. *Stickney* and the proposition that commitment without treatment becomes punishment for status in violation of the Eighth Amendment as interpreted in *Robinson* v. *California*.

In considering whether there is a federal right to treatment here, it is necessary to face the constitutional questions which Judge Bazelon elided in Rouse v. Cameron. The first two questions are not presented. (1) The summary nature of the original commitment in *Rouse* v. *Cameron* is not involved here, since there has been no refusal to release any resident. (2) The extended period of confinment is not an issue, for the same reason. (3) The Eighth Amendment protection against "cruel and unusual punishments" is presented. The court must also consider Judge Lasker's statement that due process or equal protection may support the right to treatment.

Due process

The due process basis for the right to treatment for the mentally retarded is not as self-evident as Judge Johnson found in Wyatt v. Stickney. As noted above, the extension of the right from situations involving the mentally ill to situations involving the mentally retarded is not ineluctable. Even those commentators who strongly support the rights of the mentally retarded recognize that there are significant difficulties in such an extension. See Murdock, *supra*, 48 Notre Dame Lawyer at 153.

[1] The justification for holding a man acquitted of crime by reason of insanity and keeping him beyond the maximum possible sentence, must be either treatment or protection of the public or himself. In *Rouse*, where there was no finding of danger to the public or to the petitioner, the Court could impose a duty either to treat or to release. This equation is not so easily balanced on the Willowbrook facts, where release is not the alternative.

[2] There is no constitutional provision which imposes a duty on a state to provide services to its citizens. *Cf. Dandridge* v. *Williams*, 397 U.S. 471, 487, 90 S.Ct. 1153, 1163, 25 L.Ed.2d 491 (1970):

"[T]he Constitution does not empower this Court to second-guess state officials charged with the difficult responsibility of allocating limited public welfare funds among the myriad of potential recipients."

[3] It may be argued that the state has reneged on a statutory promise of treatment. Both the old and new Mental Hygiene laws specify that the purpose for admission to a state school is care and treatment (Sections 122–124 of the old law and Sections 33.15, 33.25, and 33.27 of the new law, McKinney's Consol. Laws, c. 27). Residents of Willowbrook and their parents or guardians may be entitled to enforce the fulfillment of this purpose in the state courts. In a federal court, the holding should be that failure to accomplish the original purpose gives only a right to release or to what anyone is entitled to receive when confined in a state institution.

There may be a fundamental conflict of interest between a parent who is ready to avoid the responsibility of caring for an abnormal child, and the best interests of the child. Murdock, *supra*, 48 Notre Dame Lawyer at 139–143. A "voluntary admission" on the petition of parents may quite properly be treated in the same category as an "involuntary admission," in the absence of evidence that the child's interests have been fully considered. There may be occasions where a court should appoint a law guardian or a special guardian to represent a child before institutionalization. That issue need not be decided at this stage, however.

[4, 5] There is no doubt that procedural safeguards are necessary before a citizen can be deprived of liberty even when the state's purpose is benign. In re Gault, 387 U.S. 1, 87 S.Ct. 1428, 18 L.Ed.2d 527 (1967). To the extent that the characterization of a person as mentally retarded may involve a public stigma, the initial determination cannot be made without notice and hearing. *Wisconsin* v. *Constantineau*, 400 U.S. 433, 91 S.Ct. 507, 27 L.Ed.2d 515 (1971); *Pennsylvania Association for Retarded Children* v. *Pennsylvania*, 343 F.Supp. 279, 293–295 (E.D. Pa. 1972).

[6] What constitutes due process under any given set of circumstances must depend upon the nature of the proceeding involved and the rights that may possibly by affected by that proceeding. *Cafeteria and Restaurant Workers Union* v. *McElroy*, 367 U.S. 886, 895, 81 S.Ct. 1743, 1748–1749, 6 L.Ed.2d 1230 (1961). The Supreme Court has not required the full panoply of criminal due process rights in juvenile adjudications because the state's purpose is treatment, not punishment. In re Gault, *supra*; In re Winship, 397 U.S. 358, 90 S.Ct. 1068, 25 L.Ed.2d 368 (1970); *McKeiver* v. *Pennsylvania*, 403 U.S. 528, 91 S.Ct. 1976, 29 L.Ed.2d 647 (1971).

[7] Due process may be an element in the right to protection from harm, but it does not establish a right to treatment.

Equal protection

The plaintiffs assert that they have not been provided with a free public education suited to their needs and capabilities, although their need for such an education is no different from that of other children who are given such an education. This disparate treatment, state the plaintiffs, denies them the equal protection of the law guaranteed by the Fourteenth Amendment.

[8, 9] The Equal Protection clause of the Fourteenth Amendment gives no substantive rights (with the possible exception of the one man-one vote rule). Rather, it mandates that state law not discriminate against classes of similarly situated persons without having a rational basis for so doing. In recent years the Supreme Court has added a refinement to the scrutiny of equal protection claims. If the classification is suspect (*e. g.*, based on race) or if it infringes fundamental rights (*e. g.*, freedom of speech), there must be strict judicial scrutiny and the scheme may be justified only by the state showing a compelling interest in maintaining it.

[10] The plaintiff class has not been singled out by use of suspect criteria. Nor does the alleged denial of a public education infringe a fundamental right. Until recently the question whether education was a fundamental constitutional right was unsettled. Some lower court decisions supported the plaintiffs' argument that it was. *Serrano* v. *Priest*, 5 Cal.3d 584, 96 Cal. Rptr. 601, 487, P.2d 1241 (1971); Rodriguez v. San Antonio Independent School District, 337 F.Supp. 280 (3-judge court) (W.D.Tex.1971). However, the Supreme Court, on March 21, 1973, reversed the three-judge court in *San Antonio Independent School District*, holding that although education is one of the most important functions of state and local governments, it is neither explicitly nor implicitly guaranteed by the Constitution. 411 U.S. 1, 93 S.Ct. 1278, 36 L.Ed.2d 16.

The *San Antonio Independent School District* case involved a constitutional challenge to the method of financing public education in Texas which is based on local *ad valorem* real property taxes. The system of financing permitted a large per pupil expenditure discrepancy between a wealthy district which spent $594 and a poor district which spent $356. At 93 S.Ct. 1285–1286. The plaintiff class argued that the system denied it equal protection of the law because its members, largely Mexican-American and black who came from disadvantaged backgrounds, were not provided with an education equal in quality to that available in more wealthy school districts. The Supreme Court held that the challenged Texas system of school finance was not so irrational as to be invidiously discriminatory. At 93 S.Ct. 1308.

[11] It would appear that if there is no constitutional infirmity in a system in which the state permits children of normal mental ability to receive a varying quality of education, a state is not constitutionally required to provide the mentally retarded with a certain level of special education. Furthermore, even in a case which found the Minnesota property tax system of financing public education to be unconstitutional, it was recognized that the state had no duty to respond to the needs of individual pupils. Van Dusartz v. Hatfield, 334 F.Supp. 870, 877 (D.Minn.1971), citing *McInnis* v. *Shapiro*, 293 F.Supp. 327, 336 (N.D. Ill. 1968) (3-judge court), aff'd sub nom., *McInnis* v. *Oglivie*, 394 U.S. 322, 89 S.Ct. 1197, 22 L.Ed.2d 308 (1969).

That plaintiffs have not been unconstitutionally discriminated against is supported by several other cases. In McMillan v. Board of Education, 430 F. 2d 1145, 1149 (2d Cir. 1970), Judge Friendly stated that:

[I]f New York had determined to limit its financing of educational activities at the elementary level to maintaining public schools and to make no grants to further the education of children whose handicaps prevented them from participating in classes there, we would perceive no substantial basis for a claim of denial of equal protection."

A recent Ninth Circuit case held that the City of San Francisco did not violate the Equal Protection clause by failing to provide students of Chinese ancestry with compensatory instruction in English. *Lau* v. *Nichols*, 472 F.2d 909 (decided Jan. 8, 1973). To the same effect is Morales v. Shannon (W.D.Tex.1973, 41 L.W. 2452).

Mills v. Board of Education of District of Columbia, 348 F.Supp. 866 (D.D.C. 1972) supports plaintiffs' position. However, the *Mills* case was based on the District of Columbia Code and the Board of Education regulations as well as the due process clause. Moreover, Judge Waddy there relied on *Hobson* v. *Hansen*, 269 F.Supp. 401 (D.D.C.1968), which involved the desegregation of district schools. To the extent that *Hobson* went beyond discrimination against blacks, it is at odds with *San Antonio Independent School District, supra.* Lastly, the defendants in *Mills* admitted (348 F.Supp. at 871) that they were under a duty to provide the mentally handicapped plaintiff class with a public education suited to their needs, but asserted that they would need additional funds from Congress. In *The Pennsylvania Assoc. for Retarded Children* v. *Pennsylvania*, 343 F.Supp. 279, 290 (E.D.Pa. 1972), likewise all the defendents except one school district consented to a settlement stipulation.

[12] New York has a complicated statutory framework for providing education to the children of the state—both normal and handicapped. The level and quality of education provided to the mentally retarded does not approach what the plaintiffs assert is necessary. To meet the varying demands, New York must allocate finite resources among many worthwhile and necessary programs. It has done so in a rational manner. Having recognized a need, there is no constitutional duty to supply the need in full. Dandridge v. Williams, *supra*, 397 U.S. 471, 90 S.Ct. 1153, 25 L. Ed. 2d 491.

[13] The allocation of state resources among conflicting needs is a matter for the state legislature, if there is a rational basis and other constitutional rights are not violated. Jefferson v. Hackney, 406 U.S. 535, 92 S.Ct. 1724, 32 L.Ed2d 285 (1972); *Fullington* v. *Shea*, 320 F.Supp. 500 (D.Colo.1970), aff'd, 404 U.S. 963, 92 S.Ct. 345, 30 L.Ed.2d 282 (1971).

Plaintiffs' constitutional rights must rest on protection from harm and not on a right to treatment or habilitation.

(b) *The right to protection from harm*

[14] Persons who live in state custodial institutions are owed certain constitutional duties by the state and its officials. In recent years there has been a great increase in the number of federal court cases involving inquiries into the

conditions in state penal institutions and recognition that the federal Constitution does not cease to protect a man when he enters prison. See generally Turner, Establishing the Rule of Law in Prisons: A Manual for Prisoners' Rights Litigation, 23 Stan.L.Rev. 473 (1971); Hirschkop and Milemann. The Unconstitutionality of Prison Life, 55 U.Va.L. Rev. 795 (1969).

With respect to persons confined under the criminal law, the standard has been succinctly stated by Circuit Judge Kaufman that:

"A tolerable living environment is now guaranteed by law."

Book Review, 86 Harv.L.Rev. 637, 639 (1973), citing *Wright* v. *McMann*, 387 F.2d 519 (2d Cir. 1967), on remand, 321 F.Supp. 127 (N.D.N.Y.1970), aff'd in part and rev'd in part, 460 F.2d 126 (2d Cir.), cert. denied, 409 U.S. 885, 93 S.Ct. 115, 34 L.Ed.2d 141 (1972).

[15] The cases dealing with prison conditions reflect a balance between the requirements of humane treatment and the necessary loss of rights which follows incarceration for a criminal offense. *E. g., Wright* v. *McMann, supra*. Institutionalization for any reason involves some restrictions. However, since persons residing in state institutions other than prisons may not be constitutional "punished" (*Robinson* v. *California, supra*), some conditions tolerated in prisons may not be permissible in other institutions. *Lollis* v. *New York State Dept. of Social Services*, 328 F.Supp. 1115, 1118 (D.C.1971), *modifying*, 322 F.Supp. 473 (S.D.N.Y.1970).

[16] Since Willowbrook residents are for the most part confined behind locked gates, and are held without the possibility of a meaningful waiver of their right to freedom, they must be entitled to at least the same living conditions as prisoners. The rights of Willowbrook residents may rest on the Eighth Amendment, the due process clause of the Fourteenth Amendment or the equal protection clause of the Fourteenth Amendment (based on irrational discrimination between prisoners and innocent mentally retarded persons). It is not necessary now to determine which source of rights is controlling.

[17] One of the basic rights of a person in confinement is protection from assaults by fellow inmates or by staff. *Gates* v. *Collier*, 349 F.Supp. 881 (N.D. Miss.1972); *Hamilton* v. *Love*, 328 F. Supp. 1182 (E.D.Ark.1971); *Holt* v. *Sarver*, 309 F.Supp. 362, 384 (E.D.Ark.1970), aff'd 442 F.2d 304 (8th Cir. 1971). Another is the correction of conditions which violate "basic standards of human decency." *Brenneman* v. *Madigan*, 343 F.Supp. 128, 13 (N.D. Cal.1972).

Prisoners may not be denied medical care, although mere negligence in treatment or differences of individual opinion do not give rise to a federal civil rights claim. *Corby v. Conboy*, 457 F.2d 251 (2d Cir. 1972). They are entitled to an opportunity to exercise and to have outdoor recreation. *Hamilton* v. *Schiro*, 338 F.Supp. 1016, 1017 (E.D.La.1970); Brenneman v. Madigan, *supra*, 343 F. Supp. at 133. As indicated above, they are entitled to adequate heat during cold weather, and to the necessary elements of basic hygiene. *LaReau* v. *MacDougall*, 473 F.2d 974 (2d Cir. 1972); Campbell v. Beto, 460 F.2d 765, 768 (5th Cir. 1972).

The reaction above may not exhaust the rights to which the federal constitution entitles residents of a place like Willowbrook. At the present time it is not necessary to set forth a full catalogue of rights, but only to hold that there is support for the extent of relief hereinafter described.

There is some imprecision in a test which requires a determination of the harm against which an inmate must be protected, or "civilized standards of humane decency" or the level of a "tolerable living environment" or the conditions which "shock the conscience" of the court. However, these are the standards that have been applied in determining constitutional rights.

(c) *Eleventh amendment*

[18] The point at which an action against a state official for failure to conform to federal law [Ex Parte Young, 209 U.S. 123, 28 S.Ct. 441, 52 L. Ed. 714 (1908)], becomes a suit against the state is imprecise. Although the state is not formal party to these actions, the bar posed by the Eleventh Amendment may still apply. *Ford Motor Co.* v. *Dep't. of Treasury of Indiana*, 323 U.S. 459, 464, 65 S.Ct. 347, 350, 89 L.Ed. 389 (1945). In practical terms, the Eleventh Amendment is not a jurisdictional impediment here, but it may affect the scope of relief. However, under the facts in this case, money is not an obstacle to the defendants doing what the court intends to direct. For this reason, defendants' citation of *Rothstein* v. *Wyman*, 467 F.2d 226 (2d cir. 1972) is inapposite.

At this stage, it is not necessary to meet the problem recently discussed by Judge Friendly, whether allocation of limited public funds among retarded children and other children involves an essentially political question. Friendly, "The

Law of the Circuit" and All That, 46 St.John's L.Rev. 406, 410 (1972). Likewise, it is unnecessary to consider the scope of federal court decisions which impose additional expenditures on state agencies in order to remedy unconstitutional activities. *Swann* v. *Charlotte-Mecklenburg Board of Education*, 402 U.S. 1, 91 S.Ct. 1267, 28 L.Ed.2d 554 (1971); *Holt* v. *Sarver*, 442 F.2d 304, 306–307 (8th Cir. 1971); *Rozecki* v. *Gaughan*, 459 F.2d 6, 8 (1st Cir. 1972).

For all practical purposes, the state must ultimately meet the requirements of the Department of Health, Education, and Welfare or lose the substantial federal assistance which is granted for the care of the mentally retarded. The relief granted here is substantially less than what the HEW regulations will ultimately require.

Federal statutory rights

[19] Plaintiffs assert that there is a federal interest in the case because of Congressional programs to return retarded persons to useful lives in the community (42 U.S.C. §§ 2670–2677c), and because of provisions in Title XIX of the Social Security Act concerning grants to states for medical assistance programs (42 U.S.C. § 1396 et seq.).

Since there are provisions for federal policing of programs aided by federal funds, any consideration of statutory rights should await either the joinder of the United States Department of Health, Education, and Welfare as a party, or at least some opportunity to the Department to participate. Catholic Medical Center v. Rockefeller, 305 F.Supp. 1256, 1268 (E.D.N.Y. 1969), vacated, 397 U.S. 820, 90 S.Ct. 1517, 25 L.Ed.2d 806 (1970), aff'd, 430 F.2d 1297 (2d Cir. 1970), app. dism., 400 U.S. 931, 91 S.Ct. 246, 27 L.Ed.2d 262 (1970).

(d) Abstention

Almost all discussions of the abstention doctrine begin by referring to Chief Justice Marshall's *obiter dictum in Cohens* v. *Virginia*, 19 U.S. (6 wheat.) 264, 404, 5 L.Ed. 257 (1821), that a federal court may not constitutionally decline to exercise jurisdiction if jurisdiction exists. The commentaries then uniformly state that even if Chief Justice Marshall was correct in 1821, no such rule exists today.

[20] The modern exposition of the doctrines is found in Justice Frankfurter's opinion for the Court in Railroad Commission of *Texas* v. *Pullman Co.*, 312 U.S. 496, 61 S.Ct. 643, 85 L.Ed. 971 (1941). Simply stated, a federal court of equity, according to the doctrine, should abstain from adjudicating the constitutionality of a state statute when a state court, given the chance, might so construe the statute as to avoid the constitutional question. The doctrine calls for a judicious exercise of discretion, enabling the federal courts to "restrain their authority because of "scrupulous regard for the rightful independence of the state governments" and for the smooth working of the federal judiciary. (Citations omitted). This use of equitable powers is a contribution of the courts in furthering the harmonious relation between state and federal authority without the need of rigorous congressional restriction of those powers." (312 U.S. at 501 61 S.Ct. at 645.)

The doctrine seeks to supply two demands: (1) harmonious federal-state relationships and (2) economical employment of federal court resources. Its vitality over the years has been subject to ebb and flow. Judge Kaufman in *Reid* v. *Board of Education* 453 F.2d 238 (2d Cir. 1971), suggests that while abstention by the federal courts was confined within narrow limits during the two decades of the Warren Court the tide moved the other way during 1970 and 1971. The two late cases cited in *Reid* were *Reetz* v. *Bozanich* 397 U.S. 82 90 S.Ct. 788 25 L.Ed.2d 68 (1970), and *Askew* v. *Hargrave*, 401 U.S. 476, 91 S.Ct. 856, 28 L.Ed.2d 196 (1971). A case decided last term, *Lake Carriers' Assoc.* v. *MacMullan*, 406 U.S. 498, 92 S.Ct. 1749, 32 L.Ed.2d 257 (1972), must also be considered. Those three cases restate the principles which must be applied in deciding whether abstention is proper.

[21–23] Abstention is still described in *Lake Carriers* as appropriate only in narrowly limited special circumstances. 406 U.S. at 509, 92 S.Ct. at 1756. Abstention is an equitable doctrine requiring the balancing of various factors and the exercise of sound discretion. Among the interests to be weighed against impinging on the federal-state relation are the importance of the right alleged to be impaired and the harm inflicted by delay attendant on postponing adjudication while state courts consider the same matter. *Harman* v. *Forssenius*, 380 U.S. 528, at 537, 85 S.Ct. 1177 at 1183, 14 L.Ed.2d 50 (1965). *Harman* v. *Forssenius* was

cited with approval in the *Lake Carriers* case, 406 U.S. at 511, 92 S.Ct. at 1757. Abstention is not justified simply because the federal claim might be presented to the state courts. *Zwickler* v. *Koota*, 389 U.S. 241, 251, 88 S.Ct. 391, 397, 19 L.Ed.2d 444 (1967). But where the state claim and federal claim are not the same, so that determination of the state claim may obviate the necessity of deciding the federal claim, abstention may be appropriate. *Askew* v. *Hargrave*, 401 U.S. 476, 91 S.Ct. 856, 28 L.Ed.2d 196 (1971). However, the state remedy must be available in practice, not only in theory, to justify abstention. *Monroe* v. *Pape*, 365 U.S. 167, 174, 81 S.Ct. 473, 477, 5 L.Ed2d 492 (1961); *Askew* v. *Hargrave*, *supra*, 401 U.S. at 478, 91 S.Ct. at 858.

This case differs from the *Pullman* case and most cases where abstention has been ordered, in that it does not involve the constitutionality of a state statute, but only practices by state officials and employees alleged to violate plaintiffs' civil rights. It differs from the *Reid* case in at least two major respects. *Reid* involved the question whether a district judge had properly exercised his discretion in abstaining from a decision. The plaintiffs in *Reid* were at home, and seeking the right to placement in special classes for brain-injured children; they were not in a state institution suffering physical abuse and deprivation.

The defendants state that the instant case presents the paradigm for abstention. They argue that the plaintiffs have significant state court remedies under applicable statutes; that state courts have granted relief; and that the novel federal constitutional questions and the scope of requested relief involve serious encroachment on state functions which should be avoided.

It is clear that the plaintiffs have significant state claims, under both the old and new Mental Hygiene Laws. Justice Titone in *Renelli* v. *Department of Mental Hygiene*, Sup. 1973, 340 N.Y.S.2d 498, granted relief to a resident of Willowbrook State School in an Article 78 proceeding and directed the entry of an order containing "a specific program of what the respondents are to do in the way of giving Adrienne the treatment and care needed to afford her the opportunity to be taught the elementary functions that she is capable of."

He said that placing a person like Adrienne in an institution and then forgetting her with no attempt at treatment was the same as imprisonment. He found that she had deteriorated and become anti-social and withdrawn during her period at Willowbrook, that the changes made at Willowbrook after the press first called attention to its conditions "can best be described as cosmetic, a sop for the press" and that there was "no change of substance," but that the wards were still overcrowded and understaffed.

In Usen v. Sipprell, 71 Misc.2d 633, 336 N.Y.S.2d 848 (Sup.Ct.Erie Co. 1972), Justice Walter J. Mahoney directed the Commissioner of Mental Hygiene, the State Commissioner of Education, and the Erie County Commissioner of Social Services to prepare plans for the temporary care and treatment and provisions for education and mental health services over a five-year period for two children who had been denied admission to the West Seneca State School. He declared that the proceeding might proceed as a class action, without citing any of the New York cases on the limitation of class actions.

The New York Court of Appeals has refused to grant class action status where there are individual differences among members of the class, as exist here. Gaynor v. Rockefeller, 15 N.Y.2d 120, 256 N.Y.S.2d 584 (1965); Hall v. Coburn Corp., 26 N.Y.2d 396, 311 N.Y.S.2d 281, 259 N.E.2d 720 (1970).

[24] Where there is a real probability of serious physical harm to residents of a state institution, abstention is not required, and federal intervention should not be delayed. Inmates of Attica Correctional Facility v. Rockefeller, 453 F.2d 12 (2d Cir. 1971); Maxwell v. Wyman, 458 F.2d 1146, 1151, n. 9 (2d Cir. 1972).

[25] The extended time and tremendous effort which have gone into this case should not be wasted by remitting plaintiffs to a questionable state court remedy.

On the other hand, the circumstances justify this court in restricting its preliminary relief to the steps which appear essential for the physical safety of the residents and their protection from gross deterioration. The defendants appear to be making a substantial effort to comply with the requirements of the new Mental Hygiene Law which first became effective on January 1, 1973.

The proposed regulations of HEW, when they become effective, will necessitate a substantial raising of standards, since the state cannot afford to lose the federal funding which is available to an intermediate care facility.

For these reasons, the court will not abstain, but will restrict its relief to the extent indicated below.

Types of relief

[26] The court cannot in fairness direct that any of the residents be released before they have been habilitated so far as possible. In fact, none of the plaintiffs have urged this. Nor can the court direct the closing of Willowbrook. As was stated in Employees of Department of Public Health and Welfare, State of Missouri v. Department of Public Health and Welfare, 452 F.2d 820, 827 (8 Cir. 1971), cert. granted, 405 U.S. 1016, 92 S.Ct. 1294, 31 L.Ed.2d 478 (1972):

"The State has no realistic option open to it to discontinue its mental hospitals and training schools forthwith."

The court deems it inappropriate to impose the A.C.F.M.R. Standards or to require all the detailed steps requested by plaintiffs, for the reasons stated above.

It does not follow that the court should avoid imposing detailed requirements, as the defendants assert. Quite apart from the Wyatt v. Stickney cases, federal courts in other situations have found it necessary to prescribe quite detailed provisions for the correction of inadequacies in custodial institutions. *E.g.*, Jones v. Wittenberg, 330 F.Supp. 707, at 714–721; Inmates of Boys' Training School v. Affleck, *supra*, 346 F.Supp. at 1368–1374.

The basic problems that must be dealt with are the shortage of ward attendants and supervisors, the shortage of physical therapists and recreation staff, the shortage of nurses and doctors, the need for a hospital contract, and the repair of toilets, since these deficiencies affect physical safety and the risk of physical deterioration.

To this end, the court has determined that the following items of relief are appropriate:

1. *A prohibition against seclusion.* The fact that seclusion continued after the Director ordered its termination requires that future violations of his directions be punishable by contempt and not simply by civil service disciplinary procedures.

2. *Immediate hiring of additional ward attendants*, sufficient to assure that during waking hours there will be a 1:9 ratio of staff to residents or better in all facilities housing severely or profoundly retarded or emotionally disturbed residents—the court finding that this is the ratio necessary to provide the degree of care required under the standards set forth above. The court recognizes that addition of numbers does not necessarily assure better treatment, but it relies on the defendants to see that necessary training and supervision is provided, as is likely under the present program of reducing population and providing qualified team leaders.

Defendants argue that additional hiring cannot avoid the results of unauthorized absences. The court cannot accept such a confession of administrative failure. The duty is to protect residents from harm at all times, including weekends, even if it requires the creation of a pool of substitutes or weekend differentials or other innovative practices.

The court recognizes also that a period of training and orientation is necessary for new employees and therefore will grant a little time for this purpose.

3. *Immediate hiring of at least 85 more nurses*, representing about half of the vacant positions—the court finding that this is the minimum number of additional nurses necessary to conform to the standards set forth above. The mix between registered nurses and licensed practical nurses may be determined by the Director.

4. *Immediate hiring of 30 more physical therapy personnel*, to be recruited with a starting salary of at least $12,000—the court finding that this is the minimum number of additional physical therapy staff necessary to prevent physical deterioration of the residents. The salary is fixed at about 10 percent above the figure which the court has been informed is the level at which present unsuccessful recruiting efforts are proceeding.

The court has been cited to no cases dealing specifically with the power of a federal court to adjust state salaries, but this is a necessary part of the power of an equity court to fashion an effective decree. Otherwise bureaucratic regulations might frustrate the protection of constitutional rights. If salaries which are sufficient to staff institutions off Staten Island are insufficient to bring personnel into Willowbrook, then, as long as Willowbrook remains open, the salaries must be set at a level which will enable the state to fulfil its constitutional obligations.

5. *Immediate hiring of 15 additional physicians*—the court finding that this is the minimum number necessary to conform with the standards set forth above.

6. *Immediate hiring of sufficient recreation staff* to assure that residents will receive an opportunity for indoor and outdoor recreation so far as they are

capable of it—the court finding that provision for recreation is necessary to conform to the standards set forth above.

7. *Immediate and continuing repair of all inoperable toilets*—the court finding that this item of basic hygiene is fundamental and is at present not met. With respect to other items of maintenance, the court relies for the present on the evidence of energetic efforts of Deputy Director Eliazarian to meet the needs of the institution, and the hope that other state officials will cooperate with his efforts.

8. *Consummation within a reasonable time of a contract with an accredited hospital* for the care of acutely ill Willowbrook residents—the court finding that Building No. 2 at Willowbrook does not meet the standards of medical care which are required for that purpose and that a contract with an outside institution is the only way to satisfy this portion of the standards set forth above.

9. *Periodic reports* must be made concerning the progress of the defendants in meeting these requirements, and implementing the plans which they have described to the court, and concerning any hindrances by other state officials to their efforts.

Salaries attractive enough to bring people to an institution with the reputation and character of Willowbrook may need general adjustment. The need is clearest with respect to physical therapists. With respect to nurses, there may have been inept recruitment policies in the past rather than salary problems. The court will defer action on the starting salaries of staff other than physical therapists until after the first of the reports from the defendants.

The court has considered the fact that reduction in population at willowbrook has proceeded at a fairly rapid pace (an additional 122 residents were transferred during the last half of March 1973), and has made its findings with that fact in mind.

The court will not include medical screening in the order, since this relates to the right to treatment rather than to the right to protection from harm. Provision of the traditional staff mentioned above, and a contract with an accredited hospital are deemed to meet the requirements of protection from harm.

The court has been informed that Commissioner Grunberg terminated his state service in March 31, 1973. The order to be entered herein will be binding on his successor. In order to be sure that the successor will carry out the policies which Commissioner Grunberg has outlined, it may be hoped that he will read the affidavits submitted in this case so that he may be aware of the inhumane and shocking conditions which have heretofore existed at Willowbrook.

An appropriate order embodying these provisions will be entered shortly. The parties will be free to apply to the court for the correction of any statements in this Memorandum or for modification or clarification of any provisions of the Order.

[APPENDIX 29]

Cite as 364 F. Supp. 166 (E.D. Tex. 1973)

Alicia Morales et al.

v.

James Turman, Individually and in his official capacity as Executive Director of the Texas Youth Council, et al.

Civ. A. No. 1948.

United States District Court, E. D. Texas, Sherman Division. Aug. 31, 1973.

Class action wherein plaintiffs alleged that certain practices of Texas Youth Council were violative of their constitutional and civil rights. The District Court, Justice, J., held that widespread practice of beating, slapping, kicking, and otherwise physically abusing juvenile inmates, in absence of any exigent circumstances, violated state law, avowed policies of Council, and prohibition of Eighth Amendment against cruel and unusual punishment, and that it was appropriate to enter a preliminary injunction to enjoin such practices where their continuation would work irreparable injuries, both physical and psychological, upon members of plaintiffs' class and where plaintiffs were without adequate remedy at law that would protect them against such injury.

Judgment for plaintiffs.

See also, D.C., 59 F.R.D. 157.

1. Courts ⚷263(5), 284(4)

District court had jurisdiction of action wherein it was alleged that operation of facilities of Texas Youth Council by defendants was violative of plaintiffs' constitutional and civil rights, and court also had pendent jurisdiction to decide questions arising from alleged violations of rights secured by state statutes in context of lawsuit. U.S.C.A. Const. Amends. 1, 8, 14; 28 U.S.C.A. §§ 1331, 1343, 2201, 2202; 42 U.S.C.A. § 1983.

2. Criminal Law ⚷1213

Prohibition of Eighth Amendment against cruel and unusual punishment applies to state as well as to federal government. U.S.C.A. Const. Amend. 8.

3. Criminal Law ⚷1213

Protection of Eighth Amendment applies not only to convicted persons but also to nonconvicted persons held in custody. U.S.C.A. Const. Amend. 8.

4. Criminal Law ⚷1213

Juveniles held in state institutions are protected by Eighth Amendment, U.S.C.A. Const. Amend. 8.

5. Criminal Law ⚷1213
Infants ⚷69

Widespread practice of beating, slapping, kicking, and otherwise particularly abusing juvenile inmates, in absence of any exigent circumstances, in many of Texas Youth Council facilities was violative of state statutes, avowed policies of Council, and prohibition of Eighth Amendment against cruel and unusual punishment, Vernon's Ann. Tex.Civ.St. arts. 5130, 5143d, § 1; U.S.C.A.Const. Amend. 8.

6. Criminal Law ⚷1213

Use of tear gas and other chemical crowd control devices in many of Texas Youth Council facilities in situations not posing an imminent threat to human life or an imminent and substantial threat to property, but merely as a form of punishment, Constituted cruel and unusual punishment in violation of Eighth Amendment. Vernon's Ann.Tex.Civ.St. arts. 5130, 5143d, § 1; U.S.C.A.Const. Amend. 8.

7. Criminal Law ⚷1213

Placing inmates confined to facilities of Texas Youth Council in solitary confinement or secured facilities, in absence of any legislative or administrative limitation on duration and intensity of confinement and subject only to unfettered discretion of constitutional officers, constituted cruel and unsual punishment in violation of Eighth Amendment. Vernon's Ann.Tex.Civ.St. arts. 5130, 5143d, §1; U.S.C.A. Const. Amend. 8.

8. Criminal Law ⚷1213

Requiring inmates confined to facilities of Texas Youth Council to maintain silence during periods of day merely for purposes of punishment and to perform repetitive, nonfunctional, degrading, and unnecessary "make-work" tasks for many hours constituted cruel and unusual punishment in violation of the Eighth Amendment. Vernon's Ann. Tex. Civ. St. arts. 5130, 5143d, § 1; U.S.C.A. Const. Amend. 8.

9. Constitutional Law ⚷223

Racial segregation in correctional facilities of Texas Youth Council is unconstitutional. Vernon's Ann.Tex.Civ.St. arts, 5130, 5143d, § 1; U.S.C.A. Const. Amend. 14.

10. Constitutional Law ⚷272

Initial placement or subsequent transfer of inmates to maximum security unit of Texas Youth Council, absent any attempt through a hearing that comported with minimal due process requirements to determine which of juvenile offenders posed a danger to society, constituted a violation of Fourteenth Amendment. Vernon's Ann.Tex.Civ.St. arts. 5130, 5143d, § 1; U.S.C.A.Const. Amend. 14.

11. Constitutional Law ⚷90(3)

Any restrictions upon important First Amendment freedom of communication must bear, at the very least, a rational relationship to advancement of a legitimate state interest. U.S.C.A.Const. Amend. 1.

12. Reformatories ⚷7

Legitimate state interest of preventing flow of contraband into facilities of Texas Youth Council justified only the least restrictive practices adequate to achieve that interest, namely, opening of incoming mail in presence of inmate to whom it was addressed for sole purpose of examining it for contraband; interest was not served by reading or censoring of incoming or outgoing mail or by limitation of persons with whom inmates could correspond. Vernon's Ann.Tex.Civ.St. arts. 5130, 5143d, § 1; U.S.C.A.Const. Amend. 1.

13. Constitutional Law ⚷90.1(1)

Practice of prohibiting or discouraging juveniles confined to facilities of Texas Youth Council from conversing in languages other than English, under circumstances that did not give rise to similar prohibitions on speaking of English, was violative of First Amendment. Vernon's Ann.Tex.Civ.St. arts. 5130, 5143d, § 1; U.S.C.A.Const. Amend. 1.

14. Infants ⚷16.12

Law of Texas requiring that Texas Youth Council adhere to its statutory duty to provide a program of constructive training aimed at rehabilitation and reestablishment in society of children adjudged deliquent confers upon each juvenile committed to custody of Council a right to humane and rehabilitative treatment directed toward ultimate purpose of reintegrating child into society. Vernon's Ann. Tex. Civ.St. trt. 5143d, § 1.

15. Constitutional Law ⚷255(4)

The "right to treatment" doctrine, which holds that commitment of juveniles to institutions under conditions and procedures much less rigorous than those required for conviction and imprisonment of an adult offender gives rise to certain limitations upon conditions under which state may confine juveniles, finds its basis in due process clause of Fourteenth Amendment. U.S.C.A.Const. Amend. 14.

16. Infants ⚷69

Juveniles committed to custody of Texas Youth Council enjoy both a state statutory and a federal constitutional "right to treatment." Vernon's Ann.Tex. Civ.St. arts. 5130, 5143d, § 1; U.S.C.A.Const. Amend. 14.

17. Infants ⚷69

Segregation by untrained correctional officers of some inmates from general population in facilities operated by Texas Youth Council on basis of suspected homosexuality constituted a violation of their state and federal rights to treatment. Vernon's Ann.Tex.Civ.St. art. 5143d, § 1; U.S.C.A.Const. Amend. 14.

18. Infants ⚷69

Failure to allow and encourage full participation of family and interested friends in program of youthful offender constituted a violation of juvenile's state and federal rights to treatment. Vernon's Ann.Tex.Civ.St. art. 5143d, § 1; U.S.C.A. Const. Amend. 14.

19. Infants ⚷69

Practice of withholding or neglecting to provide case work, nursing, and psychological or psychiatric services to juveniles confined in solitary confinement or security facilities of Texas Youth Council constituted a violation of their state and federal rights to treatment. Vernon's Ann.Tex.Civ.St. art. 5143d, § 1; U.S. C.A.Const. Amend. 14.

20. Infants ⚷69

Failure to provide juveniles confined to a maximum security institution, which had a history of brutality, neglect, and intimidation, with access to a person who could head their complaints and seek administrative redress for their grievances without fear of reprisals constituted a violation of state and federal rights of juveniles to treatment. Vernon's Ann.Tex.Civ.St. art. 5143d, § 1; U.S.C.A.Const. Amend. 14.

21. Infants ⚷69

Confinement of juveniles in facilities of Texas Youth Council which did not have a nurse available on premises 24 hours a day constituted a violation of state and federal rights of juveniles to treatment. Vernon's Ann.Tex.Civ.St. art. 5143d, § 1; U.S.C.A.Const. Amend. 14.

22. Infants ⚷69

Employment by Texas Youth Council of persons whose personalities, backgrounds, or lack of qualifications rendered them likely to harm juveniles in their care either physically or psychologically, absent any attempt to administer appropriate psychological testing or psychiatric interviews, constituted a violation of juveniles' state and federal rights to treatment. Vernon's Ann.Tex.Civ.St. art. 5143d, § 1; U.S.C.A.Const. Amend. 14.

23. Injunction ⚷136(2, 3)

It was appropriate to enter a preliminary injunction to enjoin certain practices of Texas Youth Council where their continuation would work irreparable injury, both physical and psychological, upon members of plaintiffs' class and where plaintiffs were without an adequate remedy at law that would protect them against such injury.

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Louis M. Thrasher, Michael Lottman, William Malcolm Logan, Jr., Daniel E. Maeso, and Michelle White, Attys., Civil Rights Div., Dept. of Justice, Washington, D.C., for the United States, amicus curiae.

Larry A. Schwartz, Patricia Wald, Attys., Mental Health Law Project, Washington, D.C., for American Orthopsychiatric Assn., American Psychological Assn., and American Assn. on Mental Deficiency, amici curiae.

JUSTICE, District Judge.

FINDINGS OF FACT

1. Plaintiffs are minor children who represent a class consisting of all juveniles (hereinafter juveniles or TYC inmates) who are presently, have been in the past, or may be in the future adjudicated delinquent pursuant to Vernon's Tex.Rev.Civ.Stat.Ann. art. 2338–1, involuntarily committed to the custody of the Texas Youth Council(hereinafter the TYC), pursuant to Tex.Rev.Civ.Stat.Ann. art. 5143d, and assigned to one of the six schools under the jurisdiction of the TYC: Mountain View, Gatesville, Giddings, Gainesville, Crockett, and Brownwood. (The names of these schools correspond to the names of the Texas cities in which they are located, except for Mountain View, which is located near Gatesville, Texas.)

2. Defendants are Dr. Jamec A. Turman, Executive Director of the TYC, members of the TYC appointed by the Governor with the consent of the Senate, and various employees of the TYC responsible for the supervision of the above-described schools (hereinafter TYC personnel).

3. The Mountain View State School for Boys is a maximum security facility operated by the TYC. It is surrounded by two fences, both of which are topped with barbed wire. A juvenile may be initially assigned to Mountain View as a result of a staff determination that his pre-commitment conduct evinces dangerous propensities or he may be transferred there from one of the other TYC institutions for boys, usually Gatesville, as a result of a decision that his conduct is unsatisfactory. Thus, there are at least some boys incarcerated at Mountain View whose delinquent behavior consists of such "status" offenses as truancy, incorrigibility, or running away from home. There are also some boys at Mountain View who were transferred there from other schools for such essentially nonviolent, uncooperative behavior as swearing at correctional officers, refusing to work, or running away.

4. The decision whether to initially assign a boy to Mountain View or to transfer him to Mountain View from one of the other institutions for boys is made by a classfication committee. Many of the persons on the committee have no knowledge of Mountain View, and no firm criteria exists to guide their decision. Time limitations make adequate psychiatric examination difficult, if not impossible; deliberations are carried on in the boys' absence; and boys are not in formed of the committees decision prior to the actual assignment or transfer.

5. Correctional officers at Mountain View presently administer, or have in the past administered, various forms of physical abuse, including slapping,

punching, and kicking. One form of this physical abuse, referred to as "racking," consists of requiring the inmate to stand against the wall with his hands in his pockets while he is struck a number of times by blows from the fists of correctional officers. Other abuse consists of correctional officers administering blows to the face with both open and closed hands.

No testimony was adduced to justify this punishment on the grounds of protecting persons or property. Certain employees of the TYC have consistently engaged in this abuse of the juveniles in their care. As a result of these practices, the climate at Mountain View is one of repression and fear. The administrative staff of Mountain View and the central office of the TYC have been less than diligent in their efforts to eradicate these practices at Mountain View, with the result that inmates of Mountain View do not feel secure in reporting brutal conduct on the part of correctional officers to higher authorities.

6. Tear gas and similar chemical substances have been used by agents or employees of the defendants on Mountain View inmates in situations in which no riot or other disturbance was imminent. One inmate, for example, was tear-gassed while locked in his cell for failure to work; another was gassed for fleeing from a beating he was receiving; and another was gassed by a correctional officer supervisor while he was being held by two 200-pound correctional officers.

7. Mountain View's history, well-known to the inmates of both Mountain View and Gatesville, has been one of brutality and repression. Its reputation has in no small part been a function of ineffective leadership and a staff unqualified by education, experience, or personality to effect the rehabilitation of delinquents. Mountain View cannot be operated as a minimally adequate facility without a competent and sensitive Superintendent.

8. Correctional officers at institutions other than Mountain View, primarily Gatesville, presently administer, or have in the past administered, various forms of physical abuse to TYC inmates, including slapping, punching, and kicking.

9. Complaints regarding physical abuse of TYC inmates at Mountain View and other institutions are supposed to be the subject of "incident reports," filed by all TYC inmates and personnel involved. Specific procedures vary from one institution to another, however, and falsification of reports by correctional officers particularly at Mountain View, and by inmates, under duress of the correctional officers, is widespread. Many correctional officers force an inmate to file a report that reflects that an injury was caused by a football game, for example, rather than by the use of force by the correctional officer. Moreover, many inmates testified to fear of reprisals by correctional officers for the truthful reporting of instances of physical abuse.

10. Some Mountain View inmates are segregated from the general population on the basis of purported homosexuality and race. Two dormitories, referred to by TYC inmates and personnel as "punk dorms," are set aside for the smaller boys and for those determined by the custodial staff, on the basis of nonclinical standards, to be homosexuals. One dormitory is for black inmates, and the other is for Anglo and Mexican-American inmates. Experts testifying for both the plaintiffs and the defendants and the various amici groups were unanimous in concluding that the permanent segregation of inmates on the basis of purported homosexuality was psychologically damaging. Some juveniles, however, have already been stigmatized and identified as purported homosexuals by being placed in one of the so-called "punk dorms." It is apparent that immediate and indiscriminate return of those juveniles to the general population would pose a danger to their safety.

11. The average length of stay for TYC inmates at Mountain View is approximately a year and a half, at least fifty percent longer than the average length of stay for inmates at either of the other boys' institutions.

12. Experts testifying for the plaintiffs, the various amici groups, and the defendants, except for certain TYC personnel, were unanimous in concluding that only a very small percentage of juveniles adjudged delinquent should be placed in a maximum security facility.

13. In order that the provisions of this order be understood and observed by all persons employed at Mountain View, which institution has the worst history of brutality and repression of any TYC facility, it is necessary that a person trusted by Mountain View inmates be appointed to serve as an Ombudsman to whom inmates and staff may go with grievances and to whom all meetings and records touching upon the operation of Mountain View or the assignment of juveniles to Mountain View are open. It is necessary that this Ombudsman be empowered to report directly to the court any violations of its order and to make recommendations to TYC concerning compliance with the order.

14. Mr. Charles Derrick, presently Chief of Casework Services at Mountain View, enjoys the confidence of both administration and inmates, as evidenced by the agreement of all the parties in this civil action that he serve during the course of litigation as an Ombudsman to protect the rights of juveniles who were witnesses in the case.

15. Juveniles at many or all of the TYC institutions are subject to placement in security facilities, variously called "Security Treatment Center," "Special Treatment Cottage," "STC," or similar designations. In at least some of the institutions, the infirmary is used occasionally as a security facility.

16. Juveniles are, or have been in the past, confined to security facilities for conduct that is not seriously disruptive of the institution's program and for conduct that poses no threat to the safety of any person or to the preservation of valuable property.

17. Most or all of these security facilities contain single rooms or cells in which juveniles are, or have been in the past, locked for periods of time as long as a month or more, with no opportunity to leave the cell except for daily bathing, hygiene, and eating. Many juveniles so confined have little or no contact with casework, medical, or psychological staff during the period of their confinement.

18. In some institutions, inmates are locked into cells to which no person in the immediate vicinity has a key; in the event of an emergency, the key to the cell must be secured from a person who is not in the building and who may not arrive with the key for a period of several minutes.

19. In some institutions, inmates confined to a security facility or placed in solitary confinement receive very little or no educational instruction during the period of their confinement. They are ordinarily not allowed to attend regular school classes, but may receive instruction from special tutors who visit the facility or may work independently on assigned material. Sometimes they are not even permitted access to school materials.

20. Inmates in some security facilities have been forced to perform repetitive, make-work tasks, such as pulling up grass without bending their knees or buffing a floor for hours with a rag. During the pendency of this lawsuit, inmates were permitted to adopt a kneeling posture, rather than a bending posture with unbent knees, for the performance of the grass-pulling.

21. Inmates in some security facilities are forbidden to sleep except during certain hours, and are penalized by longer confinement or physical punishment if they fall asleep during hours when sleeping is not permitted. This rule is enforced even against inmates who are taking regular doses of medication that induces drowsiness.

22. Some inmates are, or have been in the past, confined to cells that are almost bare of furnishing and do not contain the minimum bedding necessary for comfortable and healthful sleep.

23. Inmates in some security facilities are, or have been in the past, instructed that they may not speak for the duration of their confinement except to answer when spoken to.

24. Experts were unanimous in their opinion that solitary confinement of a child in a small cell is an extreme measure that should be used only in emergency situations to calm uncontrollably violent behavior, and should not last longer than necessary to calm the child. Experts also agreed that the child should not be left entirely alone for long periods, but that some person should check on the child at frequent intervals and be responsible for making the solitary confinement a constructive rather than a punitive effort. Experts also testified that often confinement of a child to his own dormitory room for a short period succeeds in calming him and restoring order to the environment.

25. Experts testified that prolonged confinement of a child to a single building can be harmful unless the child is receiving a great deal of attention during the time of confinement. Experiments in sensory deprivation have shown that the absence of many and varied stimuli may have a serious detrimental effect upon the mental health of a child.

26. In some institutions, doors to the dormitory rooms are either locked or chained as a matter of course during certain hours of the day and throughout the night. Sometimes inmates are not permitted access to regular bathroom facilities but must use a chamber pot in their rooms if they cannot wait until the designated hour for use of the bathroom.

27. Experts testified that denying a child access to a regular bathroom whenever he needs it is demeaning and unnecessary. Experts also testified that the practice of confining inmates to their dormitory rooms as a matter of course is damaging to a child's self-respect and physical development.

28. The incoming and outgoing mail of inmates, except that to or from attorneys, is subject to being read or censored, in one form or another, in at least some of the TYC institutions. Similarly, many of the institutions retain policies in one form or another regarding the number and length of letters that inmates may write and limitations on the persons to whom they may write.

29. The speaking of Spanish by inmates is, or has been in the past, discouraged and has been in the past the subject of disciplinary action by TYC personnel. Approximately 23.9 percent of the inmates in the six TYC facilities involved in this civil action are Mexican-American. Some can speak little or no English.

30. Visitation policies regarding the number of visits, the length of visits, and the number of visitors permitted vary from one institution to another. At most of the institutions, however, families of inmates are encouraged to visit on only one Sunday a month and are permitted to visit at other times only after prior arrangements are made. At the Mountain View School STC, visitation is limited to ten or fifteen minutes a month by the parents.

31. None of the six schools under the jurisdiction of TYC (excepting only Giddings, as to which no evidence was offered) has available a registered nurse available on the premises on a 24-hour basis.

32. TYC institutions have no system to screen psychologically prospective employees to determine their suitability for working with children. Former Mountain View correctional officers testified that they were hired after only a ten-minute interview with the assistant superintendent and no further screening. A psychologist at the Gatesville Reception Center and a psychological consultant to the Gatesville State School for Boys testified that testing techniques exist to screen out potentially abusive prospective employees and that psychologists at Gatesville are equipped to administer such testing.

CONCLUSIONS OF LAW

[1] 1. This court has jurisdiction of this civil action under the first, eighth, and fourteenth amendments to the United States Constitution, 42 U.S.C.A. § 1983, and 28 U.S.C.A. §§ 1331, 1343, and 2201–2202. Pendent jurisdiction also exists to decide questions arising from alleged violations of rights secured by state statutes in the context of this lawsuit. *United Mine Workers* v. *Gibbs*, 383 U.S. 715, 86 S.Ct. 1130, 16 L.Ed.2d 218 (1966). *See generally* Tex. Rev.Civ.Stat.Ann. art. 5119 et seq. (197).

[2–4] 2. The eighth amendment's prohibition against cruel and unusual punishment applies to state as well as federal government. *Robinson* v. *California*, 370 U.S. 660, 82 S.Ct. 1417, 8 L.Ed.2d 758 (1962). The protection applies not only to convicted persons but also to non-convicted persons held in custody. *Hamilton* v. *Love*, 328 F.Supp. 1182 (E.D.Ark.1971). Juveniles held in state institutions are protected by the eighth amendment. Lollis v. New York State Department of Social Services, 322 F.Supp. 473 (S.D.N.Y.1970).

[5] 3. The widespread practice of beating, slapping, kicking, and otherwise physically abusing juvenile inmates, in the absence of any exigent circumstances, in many of the Texas Youth Council facilities, particularly the Mountain View and Gatesville schools, violates state law, Tex.Rev.Civ.Stat.Ann. art. 5130 (1971), the avowed policies of the Texas Youth Council, Tex.Rev.Civ.Stat. art. 5143d §1 (1971), and the eighth amendment to the United States Constitution. This kind of punishment, which is administered not merely in the absence of legislative authorization, whether express or implied, but rather in express derogation of state law, violates the eighth amendment because it is so severe as to degrade human dignity; is inflicted in a wholly arbitrary fashion; is so severe as to be unacceptable to contemporary society; and finally, is not justified as serving any necessary purposes. *See Furman* v. *Georgia*, 408 U.S 238, 257–306, 92 S.Ct. 2726, 33 L.Ed.2d 346 (1972) (Brennan, J.); *see also Jackson* v. *Bishop*, 404 F.2d 511 (8th Cir. 1968).

[6] 4. The use of tear gas and other chemical crowd-control devices in situations not posing an imminent threat to human life or an imminent and substantial threat to property—but merely as a form of punishment—constitutes cruel and unusual punishment in violation of the eighth amendment. Landman v. Royster, 333 F.Supp. 621, 649 (E.D.Va.1971).

[7] 5. Placing inmates in solitary confinement or secured facilities, in the absence of any legislative or administrative limitation on the duration and intensity of the confinement and subject only to the unfettered discretion of correctional officers, constitutes cruel and unusual punishment in violation of the

eighth amendment. *See Furman* v. *Georgia*, *supra* at 257–306 of 408 U.S., 92 S.Ct. 2726; *see also Inmates* v. *Affleck*, 346 F. Supp. 1354 (D.R.I.1972).

[8] 6. Requiring inmates to maintain silence during periods of the day merely for purposes of punishment, and to perform repetitive, nonfunctional, degrading, and unnecessary tasks for many hours—the so-called make-work, such as pulling grass without bending the knees on a large tract of ground not intended for cultivation or any other purpose, or moving dirt with a shovel from one place on the ground to another and then back again many times, or buffing a small area of the floor for a period of time exceeding that in which any reasonable person would conclude that the floor was long since sufficiently buffed—constitutes cruel and unusual punishment in violation of the eighth amendment. See *Furman* v. *Georgia*, supra at 257–306 of 408 U.S., 92 S.Ct. 2726.

[9] 7. Racial segregation of any state-operated facility is unconstitutional. Brown v. Board of Education, 347 U.S. 483, 74 S.Ct. 686, 98 L.Ed. 873 (1954); Washington v. Lee, 263 F.Supp. 327 (M.D.Ala.1966).

[10] 8. The initial placement or subsequent transfer of inmates to Mountain View, the maximum security unit, absent any attempt through a hearing that comports with minimal due process requirements to determine which of the juvenile offenders pose a danger to society, constitutes a violation of the fourteenth amendment. *See e.g., Goldberg* v. *Kelly*, 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970); Clutchette v. Procunier, 328 F.Supp. 767 (N.D.Cal.1971).

[11, 12] 9. Although the limitation on permissible censorship of the mail of adult prisoners remains uncertain, it is clear that any restrictions upon the important first amendment freedom of communication must bear, at the very least, a rational relationship to the advancement of a legitimate state interest. *See e.g., Nelson* v. *Heyne*, 355 F.Supp. 451, 457–58 (N.D.Ind. 1972); *Palmigiano* v. *Travisono*, 317 F.Supp. 776 (D.R.I.1970). The defendants have advanced no legitimate state interest, much less a compelling interest, that is served by the reading or censoring of incoming or outgoing mail or by limitation of the persons with whom inmates may correspond. A legitimate state interest in preventing the flow of contraband into Texas Youth Council institutions justifies only the least restrictive practices adequate to achieve that interest—in this case, the opening of incoming mail in the presence of the inmate to whom it is addressed for the sole purpose of examining it for contraband. *Nelson* v. *Heyne*, *supra*.

[13] 10. The practice of prohibiting or discouraging juveniles in TYC institutions from conversing in languages other than English, under circumstances that would not give rise to similar prohibitions on the speaking of English, is a violation of the first amendment to the Constitution.

[14] 11. The law of the state of Texas requires that the TYC adhere to its statutory duty to provide "a program of constructive training aimed at rehabilitation and reestablishment in society of children adjudged delinquent." Tex. Rev. Civ. Stat. Ann. art. 5143d § 1 (1971). This law confers upon each juvenile committed to the custody of the Texas Youth Council a right to humane and rehabilitative treatment directed toward the ultimate purpose of reintegrating the child into society. *See Smith* v. *State*, 444 S.W.2d 941, 948 (Tex. Civ. App.—San Antonio 1969, writ ref. n.r.e); In re Gonzalez, 328 S.W.2d 475 (Tex.Civ. App.—El Paso 1959, writ ref. n.r.e.).

[15, 16] In addition to this state statutory right, the commitment of juveniles to institutions under conditions and procedures much less rigorous than those required for the conviction and imprisonment of an adult offender gives rise to certain limitations upon the conditions under which the state may confine the juveniles. This doctrine has been labelled the "right to treatment," and finds its basis in the due process clause of the fourteenth amendment. *See, e.g., Nelson* v. *Heyne*, *supra* at 459 of 355 F.Supp.; *Inmates* v. *Affleck*, *supra; see also Wyatt* v. *Stickney*, 325 F. Supp. 781 (M.D.Ala.1971) (mental institutions), discussed in 86 Harv.L.Rev. 1287 (1973). Thus juveniles committed to the custody of the Texas Youth Council enjoy both a state statutory and a federal constitutional "right to treatment."

[17] 12. The segregation by untrained correctional officers of some inmates from the general population on the basis of suspected homosexuality constitutes a violation of their state and federal right to treatment.

[18] 13. Failure to allow and encourage full participation of family and interested friends in the program of a youthful offender constitutes a violation of the juvenile's state and federal right to treatment.

[19] 14. The practice of withholding or neglecting to provide casework, nursing, and psychological or psychiatric services to juveniles confined in solitary confinement or security facilities constitutes a violation of their state and federal right to treatment.

[20] 15. Failure to provide inmates of a maximum security institution such as Mountain View, which has a history of brutality, neglect, and intimidation, with access to a person who can hear their complaints and seek administrative redress for their grievances without fear of reprisals, constitutes a violation of their state and federal right to treatment.

[21] 16. Confinement of juveniles in an institution in which a nurse is not available on the premises twenty-four hours a day constitutes a violation of their state and federal right to treatment.

[22] 17. The employment by the TYC of persons whose personalities, backgrounds, or lack of qualifications render them likely to harm the juveniles in their care either physically or psychologically, absent any attempt to administer the appropriate psychological testing or psychiatric interviews, constitutes a violation of the juveniles' state and federal right to treatment. In particular, failure to employ an individual who is qualified by education, experience, and personal attributes to superintend the rehabilitation of juveniles who have engaged in seriously delinquent behavior constitutes a violation of those juveniles' state and federal right to treatment.

18. The plaintiffs are without an adequate remedy at law that would protect them against the wrongs described in the foregoing findings of fact.

[23] 19. It is appropriate at this time for the court to enter a preliminary injunction to enjoin certain of the practices complained of by the plaintiffs, because their continuation would work irreparable injury, both physical and psychological, upon members of the plaintiff class.[1] *See, e.g. Nelson* v. *Heyne, supra; Inmates* v. *Affleck, supra.*

EMERGENCY INTERIM RELIEF

In accordance with the findings of fact and conclusions of law set out above, which are preliminary only and made solely for the purpose of responding to the plaintiffs' motion for emergency interim relief (joined in by the United States and the other *amici* group) it is

Ordered that the defendants, their officers, agents, servants, and employees, and those persons in active concert or participation with them who receive actual notice of this order by personal service or as otherwise hereinafter provided, are hereby enjoined, pending final order of this court, from operating the facilities of the TYC in any way inconsistent with the following provisions of this order:

USE OF PHYSICAL FORCE

1. Except to the extent that the use of corporal punishment is governed by Tex.Rev.Stat.Ann. art. 5130,[2] the use of physical force of any kind of any TYC personnel on any TYC inmates shall not be permitted except to the extent reasonably necessary (i) in self-defense, (ii) in defense of third persons, whether TYC inmates or TYC personnel or others, (iii) in effecting restraint on TYC inmates in the act of escaping, or (iv) to prevent substantial destruction of property.

(*a*) In defending persons or property, the threat to persons must be imminent, and the threat to property must be both imminent and substantial.

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[1] In other matters arising from this civil action, this court has issued a preliminary injunction regarding the rights of inmates to confer privately with their attorneys and to correspond with them without interference, *see* 326 F. Supp. 670; and has issued a discovery order permitting four experts trained in sociology and psychology to live in the institution for four weeks under conditions experienced by the inmates and to report to the court at the conclusion of the study, *see* 59 F.R.D. 157.

[2] Although the portion of this statute permitting the use of a leather strap to administer up to ten lashes under certain conditions was not the subject of any testimony or request for relief, Jackson v. Bishop, 404 F.2d 571 (8th Cir. 1968), casts considerable doubt upon its constitutionality. Writing for a unanimous Eighth Circuit panel prior to his elevation to the United States Supreme Court, Judge Blackmun concluded "that the use of the strap in the penitentiaries of Arkansas is punishment which, in this last third of the 20th century, runs afoul of the Eighth Amendment: that the strap's use, *irrespective of any precautionary conditions which may be imposed,* offends contemporary concepts of decency and human dignity and precepts of civilization which we profess to possess; and that it also violates those standards of good conscience and fundamental fairness enunciated by this court in the *Carey*" [Carey 1. Settle, 351 F.2d 483 (8th Cir. 1965)] and *Lee* [Lee v. Tahash, 352 F.2d 970 (8th Cir. 1965)] cases. Id. at 579 [emphasis added.]

(b) The use of physical force must never exceed that reasonably necessary to effect the purposes permitted in (1) above. In effecting restraint on TYC inmates in the act of escaping, the force reasonably necessary does not include striking or beating.

2. The use of Mace is prohibited.

3. The use of tear gas or any other crowd-control chemical substance is prohibited except to the extent reasonably necessary to bring under control a riot that threatens imminent harm to human life or imminent and substantial destruction of property.

4. Any TYC inmate who considers that he has been the victim of any use of force by a TYC employee that is prohibited by this order may file with his caseworker (or in the absence of his caseworker, some other caseworker) a report setting out the allegations. This report shall be forwarded forthwith to the superintendent of the institution concerned. Within ten days of the date of the alleged incident, the superintendent shall investigate the alleged incident and file a written report detailing his findings and conclusions with all counsel in this civil action and with this court.

SEGREGATION

1. Effective immediately, no TYC inmates shall be segregated or assigned to dormitories or other facilities on the basis of race, color, or national origin.

2. No TYC inmates not now residing in a dormitory designed to segregate inmates suspected of homosexuality from the rest of the TYC inmate population shall be assigned to such a dormitory; *provided, however*, that the removal of inmates who now reside in such a dormitory back to the general population shall not be required, nor shall it be prohibited.

SOLITARY CONFINEMENT, SECURITY, AND DORMITORY CONFINEMENT

A. DEFINITIONS

"Solitary confinement" is defined as the placing of a TYC inmate alone in a other than a room in the inmate's own locked or otherwise secured room or cell dormitory.

"Security" is defined as the placing of a TYC inmate in a locked or otherwise secured building, which may contain one or more solitary confinement rooms or cells. The definition includes, but is not limited to, a Security Treatment Cottage or infirmary.

"Dormitory confinement" is defined as the placing of a TYC inmate alone in a locked or otherwise secured room in his own dormitory.

B. DECISION TO PLACE IN SOLITARY CONFINEMENT OR SECURITY

1. No TYC inmate shall be placed in solitary confinement, security, or dormitory confinement, or otherwise confined in a room or building, except in conformance with this order; *provided, however*, that nothing herein shall be construed to prohibit locking the outer doors of dormitory buildings during normal sleeping hours. This provision does prohibit, however, the confinement of juveniles in individual dormitory rooms or cells by chaining or night-latching their doors, except in conformance to section E herein.

2. No TYC inmate shall be placed in solitary confinement or security by any TYC personnel for longer than one hour in the absence of a written statement, signed by the inmate's caseworker (or, in his absence, by some other caseworker), declaring that the caseworker has talked to or visited with the inmate and has concluded that such confinement meets the standards set out hereafter in (C) (1) or (D) (1), whichever is applicable.

C. SOLITARY CONFINEMENT

1. No TYC inmates shall be placed in solitary confinement unless such confinement is clearly necessary to prevent imminent physical harm to the inmate or to other persons or clearly necessary to prevent imminent and substantial destruction of property.

2. While confined in solitary confinement, the inmate shall be visited by his caseworker (or, in his absence, by some other caseworker) for a period of ten minutes each hour until his release from solitary confinement, excepting only the

hours between 10:00 p.m. and 7:00 a.m. The inmate shall be visited by a registered nurse at least once a day; if he is confined for longer than one day, a psychiatrist or a psychologist shall consult with the inmate and afford him such treatment as is indicated on a daily basis beginning no later than the second day of such confinement.

In no event shall an inmate be placed in solitary confinement for longer than three consecutive days in the absence of a written report prepared and signed by the inmate's caseworker, detailed the justification for such confinement. Copies of this report shall be forwarded forthwith to the Executive Director of TYC, all counsel in this civil action, and to this court. If such confinement exceeds five consecutive days, the burden of preparing and filing these written reports shall shift to the Executive Director of TYC.

3. No TYC inmate shall be placed in solitary confinement unless a person within calling distance of the inmate is at all times in possession of a key to the isolation room or cell.

D. SECURITY

1. No TYC inmate shall be confined in security unless such confinment is clearly necessary to prevent escape or clearly necessary to restrain behavior that creates substantial disruption of the routine of the institution.

2. While confined to security, the inmate shall be visited at least once a day by his caseworker (or, in his absence, some other caseworker) and by a registered nurse. If he is confined for longer than one day, a psychiatrist or a psychologist shall consult with the inmate and afford him such treatment as is indicated no later than the second day of such confinement.

In no event shall an inmate be confined to security for longer than three consecutive days in the absence of a written report prepared and signed by the inmate's caseworker, detailing the reasons for such confinement. Copies of these reports shall be forwarded forthwith to the Executive Director of the TYC, all counsel in this civil action, and to this court. If such confinement exceeds ten consecutive days, the burden of preparing and filing these reports shall shift to the Executive Director of TYC.

E. DORMITORY CONFINEMENT

1. As an alternative to placement in solitary confinement or security, a TYC inmate may be placed in dormitory confinement.

2. No TYC inmate shall be placed in dormitory confinement unless such confinement meets the standards prescribed for solitary confinement in C(1) or for security in D(1). In no event shall dormitory confinement exceed fifty minutes.

F. CONDITIONS OF SOLITARY CONFINEMENT, SECURITY, AND DORMITORY CONFINEMENT.

The following provisions shall apply to all TYC inmates (whether placed in solitary confinement, security, domitory confinement, or otherwise):

1. A bed, mattress, appropriate bedding, and access to a toilet (not a chamber pot) shall be provided for all TYC inmates in the place where they sleep.

2. The so-called "silence rule," requiring that confined inmates sometimes maintain silence during periods of the day other than those that reasonably require some order (such as academic or vocational classes) shall not be enforced.

3. All TYC inmates shall enjoy the opportunity for at least one hour of large-muscle exercise or recreation on a daily basis, unless dispensed with by a physician (in the case of bodily infirmities) or a psychiatrist (in the case of mental conditions) in writing.

4. School books and daily lesson plans that reflect an amount of daily instruction consistent with the educational practices of the school program in the institution as a whole shall be provided all TYC inmates, unless a psychiatrist otherwise directs in writing.

5. Repetitive, nonfunctional, degrading, and unnecessary tasks (so-called "make work," such as buffing a waxed floor that has already been sufficiently buffed or pulling grass in an open field not intended for cultivation or any other purpose) are prohibited.

6. No TYC inmate shall be disciplined for sleeping during periods of the day other than those that reasonably require some attention by the inmate (such as academic or vocational classes or work other than the so-called "make work," referred to in (5) above.) In no event, however, shall any discipline be administered that is inconsistent with other part of this order.

MAXIMUM SECURITY CONFINEMENT: MOUNTAIN VIEW

1. No juvenile committed to the custody of the Texas Youth Council and not now assigned to Mountain View State Schools for Boys (hereinafter referred to as Mountain View) shall be assigned or transferred to Mountain View after the date of this order except upon a written finding by the classification committee that the juvenile has in the past, either prior to or subsequent to commitment, committed acts that, if committed by an adult, would constitute the offense of murder, voluntary manslaughter, kidnapping, aggravated kidnapping, rape, aggravated rape, sexual abuse, aggravated sexual abuse, sexual abuse of a child, aggravated assault, deadly assault on a peace officer, arson, robbery, or aggravated robbery, as defined in the Texas Penal Code (approved June 14, 1973; effective January 1, 1974), Tex.Laws 1973, ch. 399. Definitions of all terms relevant to these crimes shall be governed by the new Texas Penal Code.

2. Any juvenile that the classification committee considers a candidate for assignment or transfer to Mountain View shall be present at the committee meeting during all deliberations about his assignment. He shall be given an opportunity to make any statements and ask any questions that he desires. If the committee decides to assign or transfer the juvenile to Mountain View it must prepare written reasons justifying the assignment or transfer and furnish forthwith a copy thereof to all counsel in this civil action and to this court.

3. Mountain View shall be administered in accordance with all other applicable provisions of the court's order, including but not limited to those provisions concerning use of physical force and tear gas and the employment of solitary confinement, security, and dormitory confinement.

OMBUDSMAN

1. Mr. Charles L. Derrick shall serve during the pendency of this interim order as Ombudsman for the juvenile inmates of the Mountain View State School for Boys. He shall have the duty of reporting to this court any matters concerning the operation of the Mountain View facility that should be brought to the court's attention, especially any violations of this court's order. He may, if he wishes, forward a copy of his reports to any other interested party, but he shall not be required to do so.

2. All inmates and staff members of Mountain View shall have free access to Mr. Derrick, and no person shall interfere with Mr. Derrick's performance of his duties as Ombudsman or with any person who wishes to consult with him in that capacity.

3. Mr. Derrick shall receive notice of and be permitted to attend any meeting of TYC staff, formal or information, at which policies or procedures affecting Mountain View are discussed. Notice to Mr. Derrick of such a meeting shall be in writing and shall be delivered to him at least twenty-four hours before the meeting, except in the case of an emergency meeting, of which notice shall be given him at the earliest possible time.

4. Mr. Derrick's present salary shall continue to be paid by TYC, and may not be reduced during his occupation of the position of Ombudsman. TYC may, if it so desires, continue to employ Mr. Derrick in his present position as Chief of Casework Services at Mountain View, provided that the performance of his duties as Chief of Casework Services shall not interfere with his duties as Ombudsman.

5. Mr. Derrick shall be provided with office space, secretarial assistance, office supplies, and all other facilities necessary to the performance of his duties as Ombudsman.

6. Mr. Derrick shall have free access to all records kept in the course of the regular business of Mountain View, and all records of TYC kept in the regular course of its business that relate to matters affecting Mountain View.

7. Mr. Derrick shall make to TYC such recommendations as are appropriate concerning the operation of Mountain View or any matters affecting the operation of Mountain View, especially recommendations concerning compliance with this court's order. A copy of all such recommendations shall be provided to the Executive Director of TYC, the Superintendent of Mountain View, the court and all counsel in this civil action.

COMMUNICATION: MAIL; NONENGLISH LANGUAGES

A. MAIL

1. Outgoing or incoming mail shall not be opened, read, censored, or tampered with in any other manner; *provided, however*, that TYC personnel, in order to search for and seize contraband, may open but not read incoming mail in the presence of the TYC inmate to whom the particular piece of mail is addressed. Contraband shall consist of any object or substance the knowing possession of which constitutes a crime under the laws of the State of Texas or the United States or any other object or substance that would clearly pose a danger to human life or property within the TYC facilities.

2. The number of persons with whom TYC inmates may correspond by mail shall not be limited. Writing paper, envelopes, pencils or pens, and at least three 8-cent stamps per week shall be provided at reasonable times and places each day.

B. NONENGLISH LANGUAGES

The speaking or writing of non-English languages shall not be prohibited or discouraged under circumstances that would not give rise to similar prohibitions regarding the English language.

VISITATION RIGHTS

Visitation by family and friends of TYC inmates shall be permitted (1) for at least two hours a day on at least two separate days between Monday and Friday, inclusive, except holidays; (2) on Saturdays, Sundays, and holidays between 9:00 a.m. and 5:00 p.m.

NURSING CARE

At least one registered nurse shall be available on the premises of each of the six TYC institutions on a 24-hour basis.

SCREENING OF PROSPECTIVE TYC PERSONNEL

1. All TYC personnel hired, rehired, or promoted after the date of this order to any position shall meet the qualifications for that position set forth in the Texas Position Classification Plan, as established for the TYC by the Texas State Auditor (United States Exhibit No. 20).

2. All TYC personnel who apply after the date of this order for a position bringing them into contact with juveniles on a regular basis shall be required to submit to psychological testing and psychiatric interviews. TYC shall not hire any employee the results of whose testing casts doubt upon his psychological fitness to work with children.

3. Upon the rehiring of any former TYC personnel during the period of this interim relief, defendants in this civil action shall give notice forthwith of such rehiring to all counsel and to this court.

It is further Ordered that copies of this order shall be sent by certified mail, return receipt requested, to the three appointed members of the TYC, to the Executive Director of the TYC, and the Superintendents of the Mountain View, Gatesville, Giddings, Gainesville, Crockett and Brownwood institutions under the jurisdiction of the TYC. It is further

Ordered that the Executive Director of the TYC instruct each of the Superintendents of the above-named schools to hold meetings of all employees, full time. part time, or consulting, of their respective schools, in order that the Superintendent may read and discuss this order with them. At the conclusion of these meetings, every employee shall sign a form indicating that he or she understands every provision in the order. Forms containing these signatures shall be forwarded forthwith to the Executive Director of TYC. These meetings may be conducted in shifts; *provided, however*, that these meetings with all employees shall be completed and forms containing employee signatures shall be completed and placed in the mail to the Director of TYC no later than seven days from the date of his receipt of this court's order. It is further

Ordered that three (3) copies of this order be posted within four days of the receipt of this court's order by the Executive Director of TYC in every facility located within the six above-named institutions in which TYC inmates sleep, including dormitories, the infirmary, or any of the facilities described in this order as constituting security. The order shall be posted in a conspicuous place, preferably a bulletin board near the entrance of the building.

[APPENDIX 30]

Cite as 349 F. Supp. 278 (M.D. Ala. 1972)

N. H. Newman, and others, Plaintiffs,

v.

State of Alabama et al., Defendants, United States of America, Amicus Curiae.
Civ. A. No. 3501–N.

United States District Court,
M. D. Alabama, N. D.
Oct. 4, 1972.

Class action brought by state prisoners contending that they were deprived of proper and adequate medical treatment in violation of their rights guaranteed under Eighth and Fourteenth Amendments to United States Constitution and seeking declaratory and injunctive relief. The District Court, Johnson, Chief Judge, held that failure of board of corrections to provide sufficient medical facilities and staff to afford inmates basic elements of adequate medical care constituted willful and intentional violation of rights of prisoners guaranteed under Eighth and Fourteenth Amendments and intentional refusal by correctional officers to allow inmates access to medical personnel and to provide prescribed medicines and other treatment was cruel and unusual punishment in violation of the Constitution.

Injunction granted.

1. Constitutional Law ⚷272

Prisoners do not lose all their constitutional rights and, among other safeguards, Eighth Amendment's prohibition against cruel and unusual punishment incorporated into due process clause of Fourteenth Amendment protects prisoners from unconstitutional conditions of treatment imposed by prison authorities under color of state law. U.S.C.A. Const. Amends. 8, 14.

2. Criminal Law ⚷1213

Adequacy of medical treatment provided prison inmates is a condition subject to scrutiny under Eighth Amendment prohibiting cruel and unusual punishment. U.S.C.A. Const. Amend. 8.

3. Prisons ⚷4

While federal courts will not hesitate to intervene when action is clearly necessary to protect a prisoner's constitutional rights, courts traditionally have been reluctant to interfere in normal processes of state prison administration.

4. Prisons ⚷17

Cours should not inquire into adequacy or sufficiency of medical care of state prison inmates unless there appears to be an abuse of the broad discretion which prison officials possess in that area.

5. Prisons ⚷17

When practices within prison system result in deprivation of basic elements of adequate medical treatment, such practices violate constitutional guarantees and federal courts must act to provide relief, specially when deprivation immediately *threatens* life and limb.

6. Constitutional Law ⚷272
Criminal Law ⚷1213

Failure of board of corrections to provide sufficient medical facilities and staff to afford inmates basic elements of adequate medical care constituted willful and intentional violation of rights of prisoners guaranteed under Eighth and Fourteenth Amendments and intentional refusal by correctional officers to allow inmates access to medical personnel and to provide prescribed medicines and other treatment was cruel and unusual punishment in violation of the Constitution. U.S.C.A. Const. Amends. 8, 14.

7. Federal Civil Procedure ⚷2737

In class action brought by state prisoners representing themselves and others similarly situated contending that they were deprived of proper and adequate

medical treatment in violation of their rights guaranteed under Eighth and Fourteenth Amendments and seeking declaratory and injunctive relief, attorney's fee was to be awarded because of positive benefit resulting to plaintiffs and members of plaintiffs' class. U.S.C.A. Const. Amends. 8, 14; 28 U.S.C.A. §1343; Fed. Rules Civ.Proc. rule 23, 28 U.S.C.A.

8. Federal Civil Procedure ⚿2737

In class action brought by state prisoners contending that they were deprived of proper and adequate medical treatment and seeking declaratory and injunctive relief, where actual time spent by plaintiffs' appointed attorney in investigation, preparation, trial and briefing was approximately 400 hours and in addition he actually expended from his own funds for deposition expenses, marshal's services and photostating of records the sum of $2483.42 and those expenditures were reasonably necessary to proper investigation and preparation of the case, $12,000 was reasonable fee to be awarded attorney in addition to reimbursement of his actual expenditures. 28 U.S.C.A. §1343; Fed.Rules Civ.Proc. rule 23, 28 U.S.C.A.

Joseph D. Phelps, of Hill, Robison, Belser, Brewer & Phelps, Montgomery, Ala., for plaintiffs.

William J Baxley, Atty Gen., and Herbert H. Henry, Asst. Atty Gen., State of Ala., Montgomery, Ala., for defendants.

David L. Norman, Asst. Atty. Gen., and Louis H. Thrasher, Patricia G. Littlefield and Philip Fuoco, Attys., Civil Rights Div., Dept. of Justice, Washington, D.C., and Ira DeMent, U.S. Atty., M. D. Ala., Montgomery, Ala., for the United States as amicus curiae.

OPINION

JOHNSON, Chief Judge.

This is a class action brought by prisoners within the Alabama Penal System who represent themselves and others similarly situated. Plaintiffs contend that as prisoners they are deprived of proper and adequate medical treatment in violation of their rights guaranteed under the Eighth and Fourteenth Amendments to the United States Constitution. They seek declaratory and injunctive relief. Defendants are the Attorney General of the State of Alabama, the Commissioner, the chairman, and other members of the Alabama Board of Corrections, and the warden, the hospital administrator and the hospital staff of the Medical and Diagnostic Center, Mt. Meigs, Alabama, the general hospital for the Alabama prison system. The case is now submitted upon the pleadings, motions, depositions, testimony taken at trial, and briefs of the parties. Jurisdiction is founded upon 28 U.S.C. §1343.

[1-5] As this Court has stated before, it is well established that prisoners do not lose all their constitutional rights. *Washington* v. *Lee*, 263 F. Supp. 327, 331 (M. D. Ala. 1966), aff'd per curiam, 390 U.S. 333, 88 S. Ct. 994, 19 L. Ed. 2d 1212 (1968). *See Cruz* v. *Beto*, 405 U.S. 319, 92 S. Ct. 1079, 31 L. Ed. 2d 263 (March 20, 1972). Among other safeguards, the Eighth Amendment's prohibition against cruel and unusual punishment, incorporated into the due process clause of the Fourteenth Amendment, protects prisoners from unconstitutional conditions of treatment imposed by prison authorities under color of state law. *See Robinson* v. *California*, 370 U.S. 660, 82 S. Ct. 1417, 8 L. Ed. 2d 758 (1962). The adequacy of medical treatment provided prison inmates is a condition subject to Eighth Amendment scrutiny. *See, e.g., Hutchens* v. *State of Alabama*, 466 F. 2d 507 (5th Cir. August 15, 1972); *Campbell* v. *Beto*, 460 F 2d 765 (5th Cir., April 18, 1972).

While federal courts will not hesitate to intervene when action is clearly necessary to protect a prisoner's constitutional rights, the courts traditionally have been reluctant to interfere in the normal processes of state prison administration. Consistent with this policy, the Fifth Circuit has narrowly limited the scope of review under the Eighth Amendment. Courts should not inquire into the adequacy or sufficiency of medical care of state prison inmates unless there appears to be an abuse of the broad discretion which prison officials possess in this area. *See, e.g., Haskew* v. *Wainwright*, 429 F. 2d 525 (5th Cir. 1970); *Roy* v. *Wainwright*, 418 F. 2d 231 (5th Cir. 1969); *Granville* v. *Hunt*, 411 F. 2d 9 (5th Cir. 1969); *Thompson* v. *Blackwell*, 374 F. 2d 945 (5th Cir. 1967). The Fifth Circuit has repeatedly stated, however, that there may be cases in which the deprivation of medical care will warrant judicial inquiry and action. *See e.g., Woolsey* v. *Beto*, 450 F. 2d 321 (5th Cir. 1971); Sanders v. United States, 438 F. 2d 918 (5th Cir. 1971); *Schack* v. *Florida*, 391 F. 2d 593 (5th Cir. 1968). *See also*, *Burroughs* v. *Wainwright*, 464 F. 2d 1027 (5th Cir., July 28, 1972); *Bowman* v. *Hale*, 464 F. 2d

1032 (5th Cir., July 28, 1972). When practices within a prison system result in the deprivation of basic elements of adequate medical treatment, then such practices violate constitutional guarantees and federal courts must act to provide relief. This is especially true when deprivation immediately threatens life and limb. *Campbell* v. *Beto*, *supra*.

Plaintiffs in this case have shown by substantial evidence that the Alabama prison authorities have clearly abused their discretion in providing medical treatment to inmates. Defendants, in administering the Medical and Diagnostic Center (M&DC) and other prison medical facilities, and in otherwise performing the duty of providing for the medical needs of inmates, have fallen far short of supplying the constitutionally required level of adequate medical treatment. The medical facilities of the Alabama prison system are grossly understaffed. In addition, with the exception of the M&DC, which is recently built and generally well equipped, the physical plant and equipment provided for the care of prisoners are totally inadequate. Compounding the lack of staff and facilities, and resulting in part therefrom, is the poor administration of the medical treatment program, including the procurement and distribution of drugs and other medical supplies. Further, the record is filled with examples of correctional staff members intentionally denying inmates the right to be examined and treated by trained medical personnel, and further refusing to provide medicine and other treatment prescribed by a physician. The result is a degree of neglect of basic medical needs of prisoners that could justly be called "barbarous" and "shocking to the conscience." *See, Novak* v. *Beto*, 453 F. 2d 661, 671 (5th Cir. 1971).

The almost 4000 prisoners within the Alabama Penal System are housed in five major prisons—Atmore, Holman (maximum security unit), Draper, Tutwiler (women) and the M&DC—a minimum security facility for the young, an honor farm, a pre-release center, and 13 road camps. M&DC, where the prison general hospital is located, also serves as the receiving center for approximately 175 new inmates each month as well as the permanent assignment for some 175 inmates. The hospital, whose main ward is frequently filled nearly to capacity, contains approximately 80 beds, including a tuberculosis ward and a hepatitis ward. At any given time, some 100 additional inmates will be temporarily assigned to the center from other facilities, awaiting diagnosis or treatment by a physician, or receiving treatment on an outpatient basis.

The medical staff at M&DC, in addition to providing treatment for hospital patients, must attend to the medical needs of the inmates permanently and temporarily assigned to the center. This includes the routine physical examination of all new prisoners. To provide this care, there is no full-time physician presently employed at M&DC. Services are provided by three doctors in private practice who are employed on a salary basis to work at the center for a short time each week. Services are also provided on a part-time basis by the Medical Director of the prison system who, in addition, has responsibility for the entire medical care program within the system and further maintains his own very extensive private practice. Three registered nurses, the only ones employed anywhere in the system, cover the hospital on staggered shifts during the week. There is no registered nurse on duty at night or on weekends. While nurses and doctors can be called if needed, it often takes several hours to locate them, and at least one doctor refuses to take night calls.

Most of the daily care at the M&DC is provided by nine medical technical assistants (MTA's) who received their training as medics in the armed services and who perform as licensed practical nurses, although not licensed by the state. They are responsible for providing 24-hour coverage, seven days a week. At night, and frequently during the day, only one MTA is on duty to serve the entire center. A dentist provides services to inmates during part of the day, three days a week. The M&DC has no hospital administrator, no dietician, no registered X-ray technician, no medical records librarian and no civilian records clerk.[1]

The record is clear, from the testimony of outside experts, of physicians who have attended patients at the M&DC, and of others, that the present level of staffing at the Center is simply insufficient to provide even minimally adequate care to inmates. The case histories of inmates, described below, attest graphically to this conclusion.

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[1] A pharmacist was recently employed to work full time at the center. Prior to his employment, responsibility for procuring and maintaining the drug supply was divided among several employees at the M & DC.

The totally inadequate medical care at the M&DC is remarkably good compared with that available in other prisons within the system. The Atmore-Holman complex, located some 150 miles from the M&DC, contains approximately 1700 inmates, or almost half the state prison population. Only one part-time, retired physician is employed to treat these inmates. He conducts sick call at both Atmore and Holman for a few hours, three times a week. The evidence shows that at Atmore alone as many as 150 inmates may attend sick call on a single day. Of these, only a handful can be selected to see the doctor that day. If the regular physician becomes ill or is otherwise unable to treat the inmates, the chances of obtaining even emergency treatment are even less, since a week or more sometimes passes during which no doctor visits either prison. Dental care at Holman and Atmore is provided by one part-time dentist.

Both Atmore and Holman maintain small, overcrowded infirmaries with only rudimentary laboratory facilities. Atmore has an old X-ray machine, not recently tested for leakage, operated by an unsupervised inmate. The minor surgery room is poorly equipped (there is no sterilizer for example) and unsanitary. Neither Holman nor Atmore has means to safely restrain patients or to isolate contagious diseases. Holman has no oxygen unit and otherwise lacks equipment necessary for emergencies. The only full-time medical personnel employed to staff these facilities are MTA's, two at Atmore and three at Holman, although the budget includes slots for five MTA's at each prison—slots which were requested and justified by the Board of Corrections as being essential to provide minimal care to inmates.

Draper prison, where approximately 850 inmates are assigned, has no full-time physician. The Medical Director, in addition to his private practice and numerous other duties already described, conducts sick call five mornings a week. A dentist is available only one-half day per week. Again, although budgeted slots have been approved for five MTA's, only one is employed to maintain the small infirmary at Draper and otherwise are for the inmates.[2] The medical staff at Tutwiler, which houses 120 women prisoners, likewise consists of only one MTA. A physician conducts sick call five times a week. While the more serious illnesses or injuries are treated outside the prison, either at the doctor's office or at a private hospital, an average of seven or eight babies are delivered at Tutwiler each year under conditions which endanger the lives of both mother and infant. The delivery table has no restraints, paint is peeling from the ceiling above it, and large segments of the linoleum floor around the table are missing. There are no facilities to resuscitate the newborn or otherwise provide adequate care should any complications arise during delivery.

There are no medical personnel assigned to any of the remaining prison facilities which together house more than 800 prisoners.[3] If an inmate becomes ill or is injured, he is supposed to be taken to a local physician, who is paid on a contract basis, or to the M&DC. In practice, however, the wardens of these facilities, because of the inconvenience and because they are not trained to screen medical complaints, many times refuse to provide needed medical attention. If an inmate does see a doctor, it is frequently impossible in these small, outlying prison facilities to obtain prescribed medicine or other treatment.

The effects of inadequate facilities and an overworked staff appear throughout the system. Medical organization is informal and ineffective. For example, at the M&DC there are no hospital bylaws, and no regular staff meetings or medical committee meetings. The duties and responsibilities of medical personnel are not set out in writing. Consequently, lines of supervision are vague. Untrained inmates provide many of the support services as janitors, ward attendants, records clerks, and X-ray, laboratory and dental technicians, yet few checks are made to see that they properly complete their tasks. As a result, patients are neglected and doctors' orders are rarely carried out. There is no standard sanitary procedure followed in the hospital or the infirmaries, and there is no fire or disaster plan for evacuation of any of the facilities. Moreover, no one, inside or outside the prison system, conducts periodic health inspections, fire and safety inspections, or audits to check the quality of care being provided. It is no surprise, therefore, that hazardous and substandard conditions, ranging from improperly stored oxygen to unsanitary kitchen facilities, are found throughout the system.

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[2] When this case went to trial, there were plans to transfer a member of the correctional staff who had some medical training in the medical staff as an MTA.

[3] The physicians employed for Tutwiler does provide some services to the youth center.

Medical records, including those within the hospital, are not standardized, are inaccurate and incomplete. Strict control of narcotics is thereby hampered, leading to drug abuse. In addition, because of poor records it is frequently impossible for medical personnel at outlying prisons to tell what treatment, if any, a patient returning from the M&DC has received and what course is indicated for his future care. Further, records of inmates are sometimes lost or misplaced. This is especially true of medication cards for outpatients, without which prescribed medication cannot be administered.

There is a chronic shortage of medical supplies throughout the system. Not only are prescription drugs frequently unavailable, especially those for relieving pain, but simple items such as aspirin and antacids have been lacking in some prisons for weeks at a time. Rags have been used as a substitute for gauze sponges, out-of-date drugs have been administered, and oxygen tanks in a prison ambulance have remained empty and unusable for more than a month. Patients must routinely wait months, and on occasion more than a year, to be fitted with prosthetic devices and eye glasses.

Because the medical facilities are understaffed, medical personnel are continually called upon to perform services for which they have not been trained and for which they are not qualified. While this occurs among the civilian staff, the worst abuse is found among inmate personnel. Unsupervised prisoners, without formal training, regularly pull teeth, screen sick call patients, dispense as well as administer medication, including dangerous drugs, give injections, take X-rays, suture, and perform minor surgery.

The cumulative effect of the above-described deficiencies on the quality of care provided inmates is profound. An inmate whose condition, while not an emergency, is serious enough to warrant care by a physician may be diagnosed and treated entirely by other inmates who have had no special training, or by an MTA, whose training is limited. Those prisoners who eventually see a doctor may have waited weeks and sometimes months for an appointment. Inmates examined at infirmaries often must be transferred to the better equipped M&DC for further diagnosis and treatment. Although an immediate request is made, approval for this transfer can take anywhere from a few days (emergencies can be sent immediately) to well over a month. Patients arriving at the M&DC from Holman and Atmore are routinely placed in lockup, even though they were previously in general population. Lockup is segregated confinement in a small two-man cell which the prisoner is allowed to leave, briefly, only once each day. Inmates may remain there a few days, a few weeks or even months before they are taken to sick call or allowed to see a doctor. Some are returned to Atmore or Holman never having been examined by any member of the medical staff at the M&DC. Such delay in providing care has brought needless and untold suffering to countless inmates. Serious diseases are advanced beyond repair before they have been diagnosed and treatment has begun. The result is frequently permanent injury and even death.

If an inmate is cared for by a physician, the physician frequently does not have time to give more than cursory attention to the patient's medical needs. If medicine or other treatment, such as a special diet, is prescribed on an outpatient basis, an inmate may never receive it, or at best receive it sporadically. Compliance with doctors' orders within the hospital is similarly lacking. Medicine is not adminstered on schedule, bandages are not changed, and there is a general lack of personal care to the point that worsening conditions of patients go unnoticed and unattended.

Perhaps the most deplorable deprivation is that which is the product of the knowing and intentional mistreatment of sick and injured inmates. Inmates held in lockup at the M&DC, sent there for the purpose of treatment, are arbitrarily denied by correctional staff the right even to attend sick call. At the M&DC and elsewhere, correctional personnel, well knowing that an inmate has been prescribed medicine which he is entitled to receive, deliberately refuse it.

The fate of those many prisoners who are mentally ill or retarded deserves special mention. Mental illness and mental retardation are the most prevalent medical problems in the Alabama prison system. It is estimated that approximately 10 percent of the inmates are psychotic and another 60 percent are disturbed enough to require treatment. To diagnose and treat these almost 2400 inmates, the Board of Corrections employs one clinical psychologist, who works one afternoon each week at the M&DC. There are no psychiatrists, social workers, or counsellors on the staff.[4] Severe, and sometimes dangerous, psychotics

[4] At least one psychiatrist is employed on a contract basis to diagnose a limited number of the worst cases.

are regularly placed in the general population. If they become violent, they are removed to lockup cells which are not equipped with restraints or padding and where they are unattended. While some do obtain interviews with qualified medical personnel and a few are eventually transferred for treatment to a state mental hospital,[5] the large majority of mentally disturbed prisoners receive no treatment whatsoever. It is tautological that such care is constitutionally inadequate. *See Flint* v. *Wainwright*, 433 F. 2d 961 (5th Cir. 1970).

Several individual cases will illustrate the pervasive and gross neglect of prisoners' medical needs which prevails within the Alabama Penal System. A nineteen-year-old epileptic inmate assigned to the Holman unit tried unsuccessfully for several weeks to obtain medical treatment. An untrained and unsupervised inmate on the medical staff took his blood pressure and temperature and, finding neither abnormal, refused to allow him to see the doctor. When he was finally admitted to the infirmary at Holman, he was immediately placed in an ambulance and sent to the M&DC as an emergency.[6] He arrived at the M&DC on a Thursday, but did not see a doctor until Friday. The preliminary diagnosis was pneumonia, and intravenous antibiotics were begun. The patient, however, his reason and control impaired by a high fever, refused to stay in bed. No medical restraints could be found, and he was finally handcuffed to the bed by the attending MTA. Subsequently, the business manager of the hospital, who had no medical training, ordered the handcuffs removed, and from then until his death on Sunday the inmate was allowed to leave his bed and take cold showers at will. When he died, the only person in attendance was another inmate who shared the room.

A quadriplegic, who spent many months in the hospital at the M&DC, suffered from bedsores which had developed into open wounds because of lack of care and which eventually became infested with maggots. Days would pass without his bandages being changed, until the stench pervaded the entire ward. The records show that in the month before his death, he was bathed and is dressings were changed only once. Equally neglected was another patient at the M&DC who could not eat. Although intravenous feeding was ordered, it was not administered, and no other form of nourishment was received for the three days prior to his death.

Another hospital patient, a geriatric who had suffered a stroke and was partially incontinent, was made to sit day after day on a wooden bench beside his bed so that the bed would be kept clean. He frequently fell from the bench, and his legs became blue and swollen. One leg was later amputated, and he died the following day.

Emergency care is sometimes undeserving of the name. One inmate, severely injured in a stabbing incident, was transported from Atmore prison to a private hospital in the city of Atmore, and finally to the M&DC which had been notified to expect his arrival. No doctor was there to attend him, however, and after waiting for more than an hour, he was transported again to a private hospital where he was operated on some six hours after being wounded. Another inmate was sent to the M&DC by ambulance from Holman as an emergency. Two days passed before he was seen by a physician. He died a few hours later of lung cancer, as the autopsy subsequently revealed.

A number of inmates each year are severely injured while performing jobs for the state. The record documents several instances in which these inmates have been denied surgery which, although expensive, is necessary to restore the use of arms or legs, or otherwise return the patient to good health.

While this list is far from exhaustive, it accurately reflects the scope and extent of the deficiencies in medical treatment which exist in the Alabama correctional system. These case histories do not show isolated instances of mere negligence or malpractice on the part of prison employees. Rather they illustrate what can and does occur when too few reasonable men, functioning with too little supportive facilities, undertake what is, in effect, an impossible task.

[6] It is the holding of this Court that failure of the Board of Corrections to provide sufficient medical facilities and staff to afford inmates basic elements of adequate medical care constitutes a willful and intentional violation of the rights of prisoners guaranteed under the Eighth and Fourteenth Amendments.

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[5] The inadequacy of the treatment available at the mental hospitals within the state was the subject of the Court's opinion in Wyatt v. Stickney, 325 F. Supp. 781 (1971), and subsequent orders in that case. 344 F.Supp 373, 344 F. Supp. 387 (1972).

[6] Normally inmates requiring treatment are transferred to the M&DC on a bus which makes regularly scheduled trips.

Further, the intentional refusal by correctional officers to allow inmates access to medical personnel and to provide prescribed medicines and other treatment is cruel and unusual punishment in violation of the Constitution.

[7, 8] When plaintiffs as a class, representing all prisoners in the Alabama Penal System, filed this action pursuant to Rule 23, Federal Rules of Civil Procedure, seeking declaratory and injunctive relief and when, in response to a show cause order of this Court, the defendants in a formal answer to the complaint categorically denied the plaintiffs' contentions, it was determined that the plaintiffs were entitled to be represented by competent legal counsel in this proceeding. Accordingly, the Honorable Joseph D. Phelps, Attorney at Law, Montgomery, Alabama, was appointed to represent plaintiffs in this case and in the order of appointment the defendants were put on notice "that a reasonable attorney's fee, to be determined by the Court at the conclusion of this cause", was to be taxed as a part of the court costs in this proceeding. This action is a classic one requiring the granting of any attorney's fee. Here an attorney's fee is to be awarded because of the positive benefit resulting to the plaintiffs and the members of plaintiffs' class. In this connection see Newman v. *Piggy Park Enterprises, Inc.*, 390 U.S. 400, 88 S.Ct. 964, 19 L.Ed.2d 1263 (1968); Mills v. Electric Auto-Lite Company, 396 U.S. 375, 90 S.Ct. 616, 24 L.Ed.2d 593 (1970); Miller v. Amusement Enterprises, 426 F.2d 534 (5th Cir. 1970); Lee v. Southern Home Sites Corporation, 444 F.2d 143 (5th Cir. 1971) and Callahan, et al. v. Wallace as Governor of Alabama, etc., et al., 466 F.2d 59 (5th Cir., September 11, 1972). These cases clearly require an award of attorneys' fees since, by pursuing a private remedy in this Court, plaintiffs clearly have benefited substantially a large class of others in the same manner as they have benefited themselves. The evidence in this case reflects that the actual time spent by plaintiffs' attorney in the investigation, preparation, trial, and briefing was approximately 400 hours. Additionally, plaintiffs' attorney actually expended from his own funds for deposition expenses, marshal's services and photostating of records, the sum of $2,483,42. It appears that these expenditures were reasonably necessary to the proper investigation and preparation of this case. It further appears that the sum of $12,000 is a reasonable fee to be awarded the Honorable Joseph D. Phelps for the services rendered plaintiffs and the members of their class. Reimbursement of his actual expenditures will be in addition thereto.

An appropriate order will be entered accordingly.

DECREE

Pursant to the findings of fact and conclusions of law made and entered in an opinion of this Court filed this date, it is ordered, adjudged and decreed that the defendants, their agents, successors in office, and all persons acting in concert or in participation with them be and they are hereby enjoined:

1. From refusing or failing to provide adequate medical care to each inmate of the correctional system operated pursuant to the authority of the Alabama Board of Corrections, including but not limited to all inmates of all prisons, road camps and medical centers.

2. From failing to bring the general hospital at the Medical and Diagnostic Center up to the standards provided in the United States Department of Health, Education and Welfare Proposed Revised Regulations for Participation of Hospitals in Medicare Program of January 17, 1972.

3. From failing to comply in every respect with applicable regulations of the Federal Bureau of Narcotics and Dangerous Drugs and to limit access to all drugs to physicians, registered nurses and non-inmate medical technical assistants on a physician's orders. No unqualified personnel shall prescribe, dispense, or administer prescription drugs.

4. From failing to establish within 90 days from the date of this decree an emergency evacuation plan for each medical facility, including written instructions to employees and periodic fire drills, said plan to be approved by the Alabama Fire Marshal.

5. From failing to provide that the Alabama Fire Marshal conduct regular and periodic inspections of all medical facilities and to comply with any recommendations made by the Fire Marshal pursuant to these inspections.

6. From failing to ensure that each medical facility shall have written sanitation procedures approved by the medical director.

7. From failing to arrange with and provide for the Alabama State Board of Health to make regular and periodic inspetcion for general sanitation in all medical facilities operated by defendants; this inspection is to include but not be limited to all food processing facilities.

8. From failing to develop a plan within 90 days of this decree setting forth in detail the type and extent of care which is to be provided in each infirmary facility and, in conjunction with this, instituting a systematic program of evaluating and updating all medical equipment at these facilities so as to ensure that each facility has the equipment necessary to provide the type of care set forth in the plan. Within 90 days of this decree the defendants shall file a report with this Court reflecting the status of all equipment and the steps being taken to correct the inadequacies.

9. From failing to conduct a survey of the entire correctional system operated by defendants within 90 days from the date of this decree and to file with this Court within said 90 days proposed minimum staffing for each of the medical facilities operated by the defendants, this survey and staffing proposal to include but not be limited to physicians, psychiatrists, psychologists, medical technical assistants, statewide officers such as directors and assistant directors, dentists, pharmacists, registered nurses, x-ray technicians, hospital administrators and physician consultants.

10. From failing to ensure that every inmate who is in need of medical attention, either for diagnostic or treatment purposes, is seen by a qualified medical attendant when required and by a physician when necessary.

11. From failing to provide, or discontinuing, any medication or other reasonable treatment prescribed by a physician unless on the order of a physician.

12. From failing to ensure that each medical facility maintain at all times a medically acceptable minimum level of drugs and supplies.

13. From failing to provide eye glasses and dentures, or other prosthetic devices, within a reasonable time to those inmates who require them.

14. From failing to place geriatric inmates in separate, uncrowded quarters and to ensure that said geriatric inmates are checked periodically by medical personnel.

It is further ordered:

1. That defendants maintain a record system throughout the Alabama Penal System which will ensure that a complete medical record is available for each prisoner at the facility to which the prison is currently assigned.

2. That no inmate shall be punished or placed in a situation of greater security because of seeking medical diagnosis or treatment.

3. That defendants provide physical examinations by a physician for all inmates at regular intervals of not more than two years.

4. That the defendants shall provide ambulances or other suitable emergency transportation vehicles at each medical facility and shall maintain a medically adequate supply of emergency equipment and supplies at each medical facility.

5. That all medical technical assistants employed by the defendants shall as a minimum meet the same standards required of licensed practical nurses in the State of Alabama.

6. That defendants maintain under the supervision of the medical director written job descriptions for each medical staff member, including medical technical assistants and inmates.

7. That defendants cease the practice of using inmates to deliver medical treatment which under the laws of the state only a licensed physician or nurse is permitted to deliver unless such inmates meet the standards required of a licensed professional in the State of Alabama, and that defendants ensure that inmates who provide direct patient care such as bathing and feeding are adequately trained and supervised.

8. That each inmate sent from another institution to the Medical and Diagnostic Center for medical reasons shall be seen on arrival by either a medical technical assistant or a registered nurse and by a physician within 12 hours following his arrival at the Medical and Diagnostic Center. No inmate shall be held in "medical hold" for over a 36-hour period without being seen by a medical technical assistant, a registered nurse, or a physician.

9. That doctors at the referring institutions shall approve all delays in the transfer from those institutions to the Medical and Diagnostic Center.

10. That the medical director shall develop a program of continual evaluation for all facilities, including personnel, and periodic inspections of all medical

facilities to ensure that the standards required by this decree are being met and that medically adequate care is being provided to all inmates. A system of reporting shall be initiated by the said medical director so that he is aware at all times of the status of the prison medical facilities in the Alabama system.

It is further ordered that the defendants shall make any and all of their facilities and medical records available to the representatives of the United States and the attorney for the plaintiffs for inspection.

The defendants shall prepare and file with this Court a report within six months of the date of this decree detailing the implementation of each item herein ordered. This report shall also include a statement of the financing of the Alabama Board of Corrections at the present time and of defendants' plans for securing whatever additional financing might be required.

It is further ordered that the defendants pay to the Clerk of this Court within not more than 30 days from the date of this decree the sum of $12,000 and the additional sum of $2,483.42, said sums to be, upon order of this Court, disbursed by the Clerk to the Honorable Joseph D. Phelps as a reasonable attorney's fee and the expenses necessarily and reasonably incurred in the representation of the plaintiffs and the members of their class.

It is further ordered that the costs incurred in this proceeding be and they are hereby taxed against the defendants.

[APPENDIX 31]

Cite as 501 F. 2d 1291 (1974)

Nazareth Gates et al., Plaintiffs-Apellees,
and
United States of America, Plaintiff-Intervenor-Appellee,

v.

John Collier, Superintendent, Mississippi State Penitentiary, et al., Defendants-Appellants.
No. 73–1023.

United States Court of Appeals,
Fifth Circuit.
Sept. 20, 1974.

Action was commenced by prison inmates alleging unconstitutional conditions and practices in maintenance, operation, and administration of prison. The United States District Court for the Northern District of Mississippi at Greenville, William C. Keady, Chief Judge, 349 F.Supp. 881, granted injunctive relief and state officials appealed. The Court of Appeals, Tuttle, Circuit Judge, held that it was not necessary to empanel a three-judge court to rule on constitutionality of statewide prison regulations where governor conceded the unconstitutionality of the practices and conditions at prison; that judgment enjoining defendants from engaging in racial discriminatory practices was within the remedial jurisdiction of the district court; that conditions which deprived inmates of basic elements of hygiene and adequate medical treatment and conditions of solitary confinement, and failure to provide adequate protection against physical assaults and abuses by other inmates, constituted cruel and unusual punishment; that practice of censoring all incoming and outgoing mail was unconstitutional; and that shortage of funds did not render the relief granted impermissible.

Affirmed.

See also 5 Cir., 489 F.2d 298.

1. Courts ⚷101.5(1)

A substantial constitutional question in controversy is a prerequisite to empanelling a three-judge court. 28 U.S.C.A. § 2281.

2. Courts ⚷101.5(1)

To justify convening a three-judge court it must appear that the constitutional question is a reasonably debatable one. 28 U.S.C.A. § 2281.

3. Courts ⚷101.5(1)

If point raised in support of allegation of unconstitutionality of statute is one already determined by the Supreme Court, the constitutional question cannot be regarded as substantial so as to require convening a three-judge court. 28 U.S.C.A. § 2281.

4. Courts ⚷101.5(4)

Defendants' failure to urge empanelling of three-judge court to determine constitutionality of statewide prison regulations could not confer jurisdiction. 28 U.S.C.A. § 2281.

5. Courts ⚷101.5(4)

Empanelling of three-judge court was not required in action challenging constitutionality of statewide prison regulations where governor of state conceded the unconstitutionality of the practices and conditions at state prison. 28 U.S.C.A. § 2281.

6. Constitutional Law ⚷223

Policy of state prison officials of segregating inmates in housing facilities, unrelated to prison security and discipline, violated the equal protection clause. U.S.C.A.Const. Amend. 14.

7. Constitutional Law ⚷215

State may not constitutionally require segregation of public facilities. U.S.C.A. Const.Amend. 14.

8. Courts ⚷262.4(2)

Injunction restraining state officials from engaging in racial discriminatory practices of any nature in the operation or administration of state prison was within the jurisdiction of the district court. U.S.C.A.Const. Amend. 14.

9. Criminal Law ⚷1213

Constitutional prohibition against cruel and unusual punishment is not limited to specific acts directed at selected individuals, but is equally pertinent to general conditions of confinement that may prevail at a prison. U.S.C.A.Const. Amend. 8, 14.

10. Prisons ⚷4

Prison officials possess broad discretion in area of conditions of confinement.

11. Criminal Law ⚷1213

Adequacy of conditions of confinement of prisons, such as medical treatment, hygienic materials, and physical facilities, is subject to Eighth Amendment scrutiny. U.S.C.A.Const. Amends. 8, 14.

12. Prisons ⚷4

Constitutional questions do not arise merely because a state prison inmate has been treated at variance with state low. U.S.C.A.Const. Amends. 8, 14.

13. Courts ⚷263(2)

Federal court's pendent jurisdiction in suit challenging constitutionality of conditions and practices in state prison was not limited to federal questions, but extended to questions of state law arising out of the same operative facts. 28 U.S.C.A. §§ 1331(a), 1343(3, 4).

14. Criminal Law ⚷1213

Confinement of inmates at state prison in barracks unfit for human habitation and in conditions that threatened their physical health and safety and deprived them of basic hygiene and medical treatment by reason of gross deficiencies in plant, equipment and medical staff constituted "cruel and unusual punishment." Code Miss.1942, §§ 7930, 7942, 7959; U.S.C.A.Const. Amends. 8, 14.

See publication Words and Phrases for other judicial constructions and definitions.

15. Criminal Law ⚷1213

Order requiring prison authorities to employ additional medical personnel to comply with standards of correctional association relating to medical services for prisoners, to have prison hospital brought into compliance with state licensing requirements, to refrain from use of inmates to fill civilian medical staff positions, requiring renovation of living quarters and elimination of unconstitutional con-

ditions in inmate housing was not beyond what was minimally required to comport with prohibition against cruel and unusual punishment. U.S.C.A.Const. Amends. 8, 14.

16. Criminal Law ⚷1213

Although solitary confinement, as a mode of punishment, is not per se cruel and unusual, there are constitutional boundaries to its use. U.S.C.A.Const. Amends. 8, 14.

17. Criminal Law ⚷1213

Solitary confinement of naked prison inmates in state prison's dark hole, without any hygienic materials, any beddings, adequate food or heat, without opportunity for cleaning either themselves or the cell, and for longer than 24 hours continuously, constituted cruel and unusual punishment. U.S.C.A.Const. Amends. 8, 14.

18. Prisons ⚷17

Order permitting state prison officials to used dark hole for solitary confinement only on condition that inmates be fed the daily prison ration, be permitted to wear regular institutional clothing, be supplied with soap, towels, toothbrush and shaving utensils, that cells be adequately heated and ventilated and that no inmate be confined in any isolation cell for period in excess of 24 hours did not exceed court's remedial jurisdiction. Code Miss.1942. § 7968; U.S.C.A.Const. Amends. 8, 14.

19. Criminal Law ⚷1213

Punishment of prison inmates by administering milk of magnesia, stripping inmates of their clothes, depriving inmates of mattresses, hygienic materials, and adequate food, handcuffing inmates to fence and to cells for long periods of time, shooting at and around inmates to keep them standing or moving and forcing inmates to maintain awkward positions for prolonged periods constituted cruel and usual punishment. Code Miss.1942, § 7968; U.S.C.A.Const. Amends. 8, 14.

20. Criminal Law ⚷1213

State prison trusty system, which utilized unscreened inmates and allowed inmates to exercise unchecked authority over other inmates, constituted cruel and unusual punishment. Code Miss.1942, § 7965; U.S.C.A.Const. Amends. 8, 14.

21. Criminal Law ⚷1213

Failure to provide adequate protection to prison inmates against physical assaults and abuses by other inmates and placement of excessive number of inmates in barracks without adequate classification or supervision, and assignment of custodial responsibility to incompetent and untrained inmates, constituted cruel and unusual punishment. Code Miss. 1942, §7965; U.S.C.A. Const. Amends. 8, 14.

22. Prisons ⚷17

Order directing prison authorities to implement system of assigning inmates to barracks according to severeity of their offense, a system of reporting inmate assaults, procedure for controlling possession of weapons by inmates, rule prohibiting gambling and fighting, plan requiring custodian guards to be assigned to each barracks during night hours and temporary measure of placing dividers in appropriate places to ameliorate risk of personal injury by overcrowding of inmates in a single room was not beyond the remedial jurisdiction of the district court, Code Miss. 1942, § 7965; U.S.C.A. Const. Amends. 8, 14.

23. Prisons ⚷4

Prison authorities' practice of censoring all incoming and outgoing mail of inmates was unconstitutional. U.S.C.A. Const. Amend. 1.

24. Prisons ⚷13, 15(1)

Inasmuch as disciplinary sanctions against inmates for violation of prison regulations potentially involved some degree of loss of good-time and/or solitary confinement, the minimum procedural requisites set forth by United States Supreme Court decisions were required. U.S.C.A. Const. Amend. 14.

25. Federal Civil Procedures ⚷219

Relief granted against superintendent of state penitentiary, state penitentiary board and governor with respect to unconstituional conditions and practices in state prison was not impermissible on theory that state legislature was a neces-

sary party in that none of the named defendants could carry out the nature of the relief exacted which required expending of substantial funds which only the legislature could appropriate. Code Miss. 1942, § 7994; U.S.C.A. Const. Amends. 8, 14.

26. Constitutional Law ⚷82

Shortage of funds is not a justification for continuing to deny citizens their constitutional rights. U.S.C.A. Const. Amend. 14.

27. Federal Civil Procedure ⚷361

Fact that governor, superintendent and members of state penitentiary board were not the same individuals holding those positions when suit was commenced for relief from unconstitutional conditions and practices in maintenance and operation of state prison was immaterial inasmuch as defendants were sued in their official, not to their individual capacities, and it was only in their official court order to act.

28. Injunction ⚷22

Changes made by defendants after suit is filed do not remove the necessity for injunctive Relief.

29. Injunction ⚷210

Fact that prison officials had taken steps to improve prison facilities since filing of suit by inmates for relief from unconstitutional conditions and practices was not ground on which to seek modification of order directing reforms at prison.

30. Prisons ⚷4

That it might be inconvenient or more expensive for state to run its prison in a constitutional fashion was neither a defense to inmates' action for relief from unconstitutional conditions and practices nor a ground for modification of judgment requiring prison reforms.

A. F. Summer, Atty. Gen., William A. Allain, P. Roger Googe, Jr., Asst. Attys. Gen., Jackson, Miss., for defendants-appellants.

H. M. Ray, U.S. Atty., Oxford, Miss., Michael Davidson, Jesse H. Queen, Thomas R. Sheran, Dept. of Justice, Civil Rights Div., Washington, D. C., for intervenor.

Roy S. Haber, Native American Rights Fund, Boulder, Colo., George Peach Taylor, Frank Parker, Jackson, Miss., Edward J. Reilly, New York City, for plaintiffs-appellees.

Before TUTTLE, BELL and GOLDBERG, Circuit Judges.

TUTTLE, Circuit Judge:

This appeal by the Superintendent of the Mississippi State Penitentiary, members of the Mississippi Penitentiary Board, and the Governor of the State of Mississippi, challenges the nature and extent of the equitable relief granted by the district court which required major physical facility renovations and Missisippi (hereinafter Parchman). The district court made extensive findings of fact and conclusions of law, reported in Gates v. Collier, 349 F. Supp. 881 (N.D. Miss. 1972). The decision held that the conditions and practices in the maintenance, operation and administration of Parchman deprived inmates of rights secured by the First, Eighth, Thirteenth and Fourteenth Amendments and by 42 U.S.C.A. §§ 1981, 1983, 1985 and 1994, and granted injunctive and declaratory relief for the plaintiffs.

The decision of this Court has been withheld pending a decision by the Supreme Court in the case of *Wolff* v. *McDonnell*, 418 U.S. 539, 94 S. Ct. 2963, 41 L. Ed. 2d 935, 1974, a case which dealt with some of the issues here on appeal.

The inadequateness of the Parchman prison facilities and its "trusty" personnel system as practiced are well established by the fact that the Governor of Mississippi forthrightly conceded the existence of constitutional violations in the Parchman operations: "We are, in effect, Your Honor, admitting that the consitutional provisions have been violated." The Governor asked the court: "Isn't there enough of the incriminating facts in these depositions and interrogatories to give the Court adequate grounds to find a conclusion of fact that the First Amendment and all other constitutional provisions have been violated . . . ?" A

consultant committee engaged by the Mississippi State Planning Agency, the Law Enforcement Assistance Administration (LEAA) and the American Correctional Association concluded that prevent conditions at Parchman are "philosophically, psychologically, physically, racially and morally intolerable." The district court's abstract of the findings of fact about the conditions and practices at Parchman paints a shocking picture.

We proceed to summarize the structure of the decision, to examine whether any issues in this case must be initially considered by a statutory three-judge court, to review the court's determination of the merits, and to discuss why we reject the appellants' contention that the relief was too "sweeping."

I. SYNOPSIS OF DISTRICT COURT'S ORDER

This action was commenced on February 8, 1971, by two overlapping classes of plaintiffs. The first class consisted of *all* inmates confined at Parchman, while the second class was comprised of *black* inmates whose grievances included racial discrimination and segregation, as well as deprivation of the broad range of rights claimed by the first class. A motion by the United States to intervene in this suit pursuant to 42 U.S.C.A. § 2000h–2 was granted on August 23, 1971. Thereafter, the parties conducted protracted pre-trial discovery proceedings. On May 11, 1972, four days before trial, counsel for all parties agreed to waive presentation of evidence in open court and to submit the case on the record including pleadings, stipulations, depositions, interrogatories and answers, offers of proof, factual summaries, proposed trial plans, evidentiary synopses, photographs, exhibits, reports and other documentary evidence assembled by the parties. All of these items were admitted into evidence, defendants stipulating that they would not contest the facts set forth therein. Findings of fact and conclusions of law were issued by the district court on September 12, 1972, but judgment was reserved pending a hearing on the proper form and measure of relief to be granted.

Beginning on October 16, 1972, the district court held a two day hearing to solicit testimony from all interested parties and technical experts in order to assist its fashioning an appropriate judgment. Representatives of the LEAA advised the court that federal funds were available to aid the improvement of the conditions at Parchman. In the decision rendered on October 20, 1972, the district court divided its injunctive relief into two parts: (A) immediate and intermediate and (B) long-range.

The (A) immediate and intermediate relief was directed towards (1) the elimination of unconstitutional censorship of prisoner mail; (2) the establishment of definite and constitutionally permissive rules and regulations regarding inmate discipline; (3) the prohibition of any form of corporal punishment of such severity as to offend present day concepts of human dignity; (4) the ban against use of disciplinary segregation or isolation at the Maximum Security Unit except under conditions which would satisfy the requirements of the cruel and unusual punishment clause; (5) the improvement of medical facilities and staff; (6) the institution of reasonable procedures to protect inmates from assault by fellow inmates; (7) the abolition of the trusty system insofar as it utilizes trusties in custodial positions; (8) and certain renovations in the physical facilities involving health hazards at Parchman.

Regarding the (B) long-range relief, the court ordered the defendants to submit "a comprehensive plan for the elimination of all unconstitutional conditions in inmate housing, inadequate inmate housing, inadequate water, sewer and utilities, inadequate fire fighting equipment, inadequate hospital and other structures condemned by this court."

II. NECESSITY OF A THREE-JUDGE COURT

At the outset, we must determine whether any questions in this case should have been presented initially to a statutory three-judge court. This task is imperative in light of the recent decision of this Court sitting en banc in Sands v. Wainwright et al., 491 F.2d 417 (5th Cir. 1974), which consolidated for opinion purposes four cases concerning inmates' rights in state prisons. *Sands et al.* held that 28 U.S.C. § 2281 requires the empaneling of a three-judge court if the action to be enjoined is authorized by statewide prison regulations.

[1] However, having examined the issues in the en banc litigation we conclude that this law suit although similarly involving statewide prison regulations is presented in a significantly different posture, so as to preclude the necessity of a three-judge court. As we have already noted, the Governor of the State of Mississippi conceded the unconstitutionality of the practices and conditions at Parchman. For the following reasons this factor in the case at bar substantially distinguishes its framework from *Sands et al.* and precludes a finding that a substantial constitutional question is in controversy in this case, a prerequisite to empanelling a three-judge court.

In *Sands et al.* this Court thoroughly reviewed the decisions having either an expansive or limiting impact on the application of the three-judge court statute, 28 U.S.C. § 2281.[1] As outlined in the en banc opinion, one limiting doctrine is "the rule that a three-judge court need not be convened when either the constitutional attack on the State statute or regulation is insubstantial, Ex parte Poresky, 1933, 290 U.S. 30, 54 S.Ct. 3, 78 L.Ed 152, or the constitutional defense is frivolous, Bailey v. Patterson, 1962, 369 U.S. 31, 82 S.Ct. 549, 7 L.Ed.2d 512." *Sands et al., supra*, 491 F.2d at 422.

Ex parte Poresky also teaches us that. "the question may be plainly insubstantial, either because it is 'obviously without merit' or because 'its unsoundness so clearly results from the previous decisions of this Court as to foreclose the subject and leave no room for the inference that the question sought to be raised can be the subject of controversy.' " 290 U.S. at 32, 54 S.Ct. at 4.[2]

The only problem is that the test for determining the substantiality of the constitutional question elucidated in Ex Parte Poresky, *supra*, does not afford a formula which can be applied to a particular case with mathematical precision. *See* Green v. Board of Elections of City of New York, 380 F.2d 445, 448 (3d Cir. 1967). Fortunately, another Supreme Court decision, Bailey v. Patterson, 369 U.S. 31, 82 S.Ct. 549, 7 L.Ed.2d 512 (1962), further clarified this test. In *Bailey* plaintiffs sought to enforce their rights to non-segregated transportation, allegedly refused them under color of state statutes. On appeal from an abstention order of a three-judge court, the Supreme Court held that the case was one for a single judge. Stressing that prior decisions had settled beyond argument that statutes requiring segregation of transportation were unconstitutional, the Court held:

"Section 2281 does not require a three-judge court when the claim that a statute is unconstitutional is wholly insubstantial, legally speaking non-existent. Ex parte Poresky, 290 U.S. 30, 54 S.Ct. 3, 78 L.Ed. 152; Bell v. Waterfront Comm'n, 2 Cir., 279 F.2d 853, 857–858. *We hold that three judges are similarly not required when, as here, prior decisions make frivolous any claim that a state statute on its face is not unconstitutional.* Willis v. Walker, D.C., 136 F.Supp. 181; Bush v. Orleans Parish School Board, D.C., 138 F.Supp. 336; Kelley v. Board of Education, D.C., 139 F.Supp. 578. We denied leave to file petitions for mandamus in *Bush*, 351 U.S. 948, 76 S.Ct. 854, 100 L.Ed. 1472, and from a similar ruling in Booker v. Tennessee Board of Education, 351 U.S. 948, 76 S.Ct. 856, 100 L.Ed. 1472. The reasons for convening an extraordinary court are inapplicable in such cases, for the policy behind the three-judge requirement—that a single judge ought not to be empowered to invalidate a state statute under a federal claim—does not apply. The three-judge requirement is a technical one to be narrowly construed, Phillips v. United States, 312 U.S. 246, 251, 61 S.Ct. 480, 483, 85 L.Ed. 800." *Id.* at 33, 82 S.Ct. at 551. (Emphasis supplied).

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[1] 28 U.S.C. § 2281 states: "An interlocutory or permanent injunction restraining the enforcement, operation or execution of any State statute by restraining the action of any officer of such State in the enforcement or execution of such statute or of an order made by administrative board or commission acting under State statutes, shall not be granted by any district court of judge thereof upon the ground of the unconstitutionality of such statute unless the application therefor is heard and determined by a district court of three judges under section 2284 of this title."

[2] For other decisions adopting this precise test for determining the existence of substantial constitutional questions see Goosby v. Osser, 409 U.S. 512, 518, 93 S.Ct. 854, 35 L.Ed.2d 36 (1972); Swift Co., Inc. v. Wickham, 382 U.S. 111, 115, 86 S.Ct. 258, 15 L.Ed.2d 194 (1965); Bailey v. Patterson, 369 U.S. 31, 82 S.Ct. 549, 7 L.Ed.2d 512 (1962); California Water Service Co. v. City of Redding, 304 U.S. 252, 255, 58 S.Ct. 865, 82 L.Ed. 1323 (1938); Kline v. Rankin, 489 F.2d 387 (5th Cir. 1974); Local No. 300, Amal. Meat Cutters & B. Work. v. McCulloch, 428 F.2d 396 (5th Cir. 1970); Mayhue's Super Liquor Store, Inc. v. Meiklejohn, 426 F.2d 142, 144 n. 4. (5th Cir. 1970).

The import of the *Bailey* decision was to make it clear that a substantial constitutional question was not in controversy, not only when the claim was simply a frivolous attack on the consttiutionality of a statute, but also when the unconstitutionality of a statute was obvious.

It is further significant that Professor Currie in his often cited article "The Three Judge District Court in Constitutional Litigation," 32 Chi.L.Rev. 1, 64–65 (1964), surmised that:

"[T]his somewhat startling decision [Bailey v. Patterson, *supra*] had been foreshadowed by several opinions from the Fifth Circuit where confronted with great numbers of segregation cases all presenting the same, already decided question, the courts were understandably eager to avoid the burden of so many extraordinary benches. *E.g.*, Board of Supervisors v. Tureaud, 225 F.2d 434, 446 (5th Cir. 1966) (Rives, J., concurring)."

Continuing his exposition on the impact of *Bailey*, Pofessor Currie also stated:

"Perhaps as when the invalidity of the statute is conceded there is no plausible claim of authorization by a 'statute.'" *Id.* at 65.

At another juncture in the article, footnote 222, the principle is reiterated in this manner:

"Again, three judges are not required if the defendants concede the unconstitutionality of the statutes, for in substance this too is to disclaim reliance on a statute. Gibson v. Board of Pub. Instruction, 170 F.Supp. 454, 457 (D.Fla. 1958); McKissick v. Durham Bd. of Educ., 176 F.Supp. 3, 12 (M.D.N.C.1959)."

In addition in Gibson v. Board of Pub. Instruction, 170 F.Supp. 454 (S.D.Fla. 1958), the court held that the Florida statute in question obviously violated the constitution under the *Brown* decision, pointing out that all parties *conceded* this fact. No discussion was necessary; the court simply stated. "All parties concede this fact. A three-judge court, in this case, is not required," citing Bush v. Orleans Parish School Board, 138 F.Supp. 337 (E.D.La.1956); Carson v. Warlick 238 F.2d 724 (4th Cir. 1956); Kelley v. Board of Education of Nashville, 139 F.Supp. 578 (M.D.Tenn.1956), aff'd., 270 F.2d 209 (6th Cir. 1959).

Two other decisions referred to in *Bailey* are noteworthy: Willis v. Walker, 136 F.Supp. 181 (W.D.Ky.1955) and Kelley v. Board of Educ., 139 F.Supp. 587 (M.D.Tenn.1956). The plaintiffs in Willis v. Walker, *supra*, challenged the constitutionality of a state statute and constitutional provision authorizing segregation; the defendants "freely conceded" that such constitutional and statutory provisions were invalid by reasons of the Supreme Court's decision in Brown v. Board of Educ., 347 U.S. 483, 74 S.Ct. 686, 98 L.Ed. 873 (1954). Similarly, in Kelley v. Board of Educ., *supra*, a desegregation case controlled by *Brown*, the court held that there was no necessity for a three-judge court, since the unenforcibility of the constitution and statutes has been "conceded" by the defendants.

[2, 3] Therefore, it has become settled that to justify convening a three-judge court it must appear that the constitutional question is a reasonable debatable one, and if the point raised in support of the allegation of unconstitutionality is one already determined by the Supreme Court, this precludes constitutional questions from being regarded as substantial. Another corollary of this principle is that if the parties concede the unconstitutionality of a statute or regulation or practice, there is no room for inference that the constitutional question raised is to be the subject of the controversy. Therefore, the question of the constitutionality of a given act may be insubstantial because previous decisions have either upheld or outlawed the act, or, as we hold here, because the parties have conceded the unconstitutionality of all of the alleged acts whether authorized by statute or regulation, or merely practiced.

[4] Just as the law became well-defined in the school desegregation suits, so progress the prisoner rights cases based on the conditions of inmate habitation and practices of prison administration. Apparently, the Governor of Mississippi, in recognition that Parchman was operated in such an unacceptable manner, chose to concede the unconstitutionality of the conditions and practices. The defendants on appeal to this Court only challenged the extent of the relief granted, and *disputed neither the questions of fact nor conclusions of law* made by the district court. Of course, such a failure could not confer jurisdiction; but here there was simply no substantial constitutional issue in controversy. All agreed on the unconstitutionality.

[5] In conclusion, based on these decisions interpreting section 2281, we hold that, since the Governor of the State of Mississippi conceded the unconstitutionality of the practices and conditions at Parchman, no substantial constitutional question is in controversy in this case.

III. MERITS OF THE PRISONERS' COMPLAINTS

Having resolved that none of the issues in this case must initially be heard by a three-judge court, we proceed to review the district court's adjudication on the merits. The sole argument on appeal is that the state lacks the financial ability to implement the district court's order within the time schedule designated its jurisdiction in ordering the total elimination of the armed trusty system, the improvement of the physical facilities, the classification of inmates, the implementation of inmate protection procedures, and emendation of medical facilities. More specifically, the appellants' argument is that after the entry of the judgment they immediately promulgated conforming rules and regulations concerning punishment, the discipline of inmates, and disciplinary confinement, but lacked the funds to effectuate the other portions of the judgment in accordance with the time guidelines specified. It is important to note that the appellants do not challenge, for example, the court's holding that equal protection requires reclassification of the inmates on a basis other than race or that the English Amendment requires improvements in the physical and medical facilities at Parchman and the elimination of the trusty system. The appellants did not deny the unconstitutionality of their previous operation and administration of Parchman and do not now controvert the constitutional mandate for the reforms ordered. Rather their sole argument is that they do not have the financial capacity to effectuate these reforms. To reiterate, appellants do not challenge a single finding of fact or conclusion of law by the trial court.

However, in order to evaluate the issues here it is necessary to consider the threshold question of whether the district court, given the concession of the unconstitutionality of the current practices at Parchman, correctly determined to what extent changes in Parchman's facilities and administrative practices must be effectuated in order to meet constitutional standards, and, then, secondly, to determine whether fund shortage may require a modification of the district court's judgment regarding these matters. Each component of the district court's judgment regarding these matters will be individually examined. It should be repeated that none of the district court's findings of fact is disputed by the appellants. We simply adopt those findings throughout our discussion. The severest criticisms that follow are in the words of the trial court.

A. Elimination of racial segregation and discrimination

[6, 7] The practice at Parchman has been and is to maintain a system of prison facilities segregated by race through which black inmates are subjected to disparate and unequal treatment. Blacks are housed in more crowded quarters than whites are assigned to different work details, are denied the same vocational training opportunities and are punished and disciplined more severely than whites for the same offense. Undoubtedly the appellants' policy of segregating inmates in housing facilities, unrelated to prison security and discipline, is in violation of the equal protection clause of the Fourteenth Amendment. We need not labor the point that a State may not constitutionally require segregation of public facilities, Johnson v. Virginia, 373 U.S. 61, 83 S.Ct. 1053, 10 L.Ed.2d 195 (1963), and the principle is as applicable to jails as to other public facilities. Lee v. Washington, 263 F.Supp. 327 (M.D. Ala. 1966), aff'd, 390 U.S. 333, 334, 88 S.Ct. 994, 19 L.Ed.2d 1212 (1966); United States v. Wyandotte County, Kansas, 480, F.2d 969 (10th Cir. 1973). As reiterated by the Supreme Court in Cruz v. Beto, 405 U.S. 319, 321, 92 S.Ct. 1079, 1081, 31 L.Ed.2d 263 (1971); ". . . racial segregation, which is unconstitutional outside prisons, is unconstitutional within prisons, save for 'the necessities of prison security and discipline.' Lee v. Washington, 390 U.S. 333, 334, 88 S.Ct, 994, 19 L.Ed.2d 1212." For other cases in which this principle has been applied to the administration of correctional institutions, *see, e. g.*, Owens v. Brierley, 452 F.2d 640 (3rd Cir. 1971); McClelland v. Sigler, 327 F. Supp. 829 (D.Neb. 1971), aff'd., 456 F.2d 1266 (8th Cir. 1972); Holt v. Sarver, 309 F.Supp. 362 (E.D.Ark. 1970), aff'd., 442 F.2d 304 (8th Cir. 1971); Wilson v. Kelley, 294 F.Supp. 1005 (N.D.Ga. 1968), aff'd., 393 U.S. 266, 89 S.Ct. 477, 21 L.Ed.2d 425 (1968); Tilden v. Pate, 390 F.2d 614 (7th Cir. 1968); Rivers v. Royster, 360 F.2d 592 (2d Cir. 1966); Rentfrow v. Carter, 296 F.Supp. 301 (N.D.Ga. 1968).

[8] Therefore, as part of the intermediate relief the district court's judgment enjoined the defendants from engaging in racial discriminatory practices of any nature in the operation or administration of the penitentiary. Recognizing that immediate desegregation in housing facilities could not feasibly be accomplished, the district court allowed the prison authorities until April 20, 1973, six months from the date of the judgment on October 20, 1972, to devise and implement a plan desegregating the housing facilities. Such relief was well considered, was within the jurisdiction of the district court and necessary for the prison operation to comport with the equal protection clause.

B. Physical facilities and medical treatment

The district court findings of fact, unchallenged here by appellants, described the living conditions at Parchman as follows.

The housing units are unfit for human habitation under any modern concepts of decency. Facilities for the disposal of human waste at all camps present an immediate health hazard; contamination of the prison water supply caused by inadequate sewage has led to the spread of infectious diseases. The entire waste disposal system has been condemned by state health and pollution agencies. The electrict wiring is frayed and exposed, representing a safety hazard. At most camps there is a lack of adequate fire fighting equipment making it, as stated by the Penitentiary Superintendent, "almost impossible to put out a fire at Parchman with he present water system and the present fire-fighting equipment." The bathroom, kitchen, heating, and housing facilities are inadequate. Broken windows are stuffed with rags to keep out the cold and rain. The bathroom facilities lack the number and quality of operable commodes, showers and other hygienic necessities. For example, at Camp B., for 80 men, there are three wash basins which consist of oil drums cut in half. The building facilities at most camps, "are in a deplorable state of maintenance and repair," as reported by the Mississippi Joint Legislative Committee, January 4, 1971, and result in subhuman conditions.

The medical staff and available facilities fail to provide adequate medical care for the inmate population. As a result many inmates have not received prompt or efficient medical examination, treatment, or medication. Unsanitary conditions are rampant. Some inmates with serious contagious diseases are allowed to mingle with the general prison population; other inmates have developed complications from lack of medical treatment. Inmates are often discouraged from seeking medical attention by the prison practice of punishing those who on examination appear to be healthy.

[9, 10] The prohibition against cruel and unusual punishment contained in the Eighth Amendment, applicable to the State of Mississippi through the Due Process Clause of the Fourteenth Amendment, Robinson v. California, 370 U.S. 660, 82 SCt. 1417, 8 L.Ed.2d 758 (1962), is not limited to specific acts directed at selected individuals, but is equally pertient to general conditions of confinement that may prevail at a prison. Our decisions have recognized the right of prisoners to seek judicial review of their conditions of confinement and have provided relief from unconscionable methods of incarceration. *See, e. g.*, Huchens v. State of Alabama, 466 F.2d 507 (5th Cir. 1972); Campbell v. Beto, 460 F.2d 765, 768 (5th Cir. 1972); Novak v. Beto, 453 F.2d 661 (5th Cir. 1971); Rocha v. Sowers, 454 F.2d 1155 (5th Cir. 1972); Woolsey v. Beto, 450 F.2d 321 (5th Cir. 1971); Sinclair v. Henderson, 435 F.2d 125 (5th Cir. 1970). Although the prison officials possess broad discretion in the area of conditions of confinement, this Court has repeatedly stated that there may be cases in which the deprivation of medical care or hygienic facilities will warrant judicial action. *See, e. g.*, Haskew v. Wainwright, 429 F.2d 525 (5th Cir. 1972); Roy v. Wainwright, 418 F.2d 231 5th Cir. 1969); Granville v. Hunt, 411 F.2d 9 (5th Cir. 1969). Thompson v. Blackwell, 374 F.2d 945 (5th Cir. 1967); Schack v. Florida, 391 F.2d 593 (5th Cir. 1968); Bowman v. Hale, 464 F.2d 1032 (5th Cir. 1972). Burroughs v. Wainwright, 464 F.2d 1027 (5th Cir. 1972).

It is pertinent to review this Court's discussion in Novak v. Beto, 453 F.2d 661 (5th Cir. 1971), rehearing denied en banc, 456 F.2d 1303 (5th Cir. 1972), of the common thread in cruel and unusual punishment cases. In *Novak*, this Court held, one judge dissenting, that the lightless cell, the limited bedding and the minimal food provided prisoners in solitary confinement in Texas did *not* constitute cruel and unusual punishment. A noteworthy portion of the decision is the court's lengthy discussion emphasizing that the factual situation there did not involve a deprivation of basic elements of hygiene; nor any threat to the prisoners' health:

"On the question of particular conditions, there are several cases that have concluded that certain prison conditions were so 'base, inhuman and barbaric' that they violate the Eighth Amendment. We have studied these cases and the condition depicted herein rather carefully, and find in none of them support for condemnation of solitary confinement in this case. In the first place, *there is a common thread that runs through all these cases and that is not present in our case. That thread is the deprivation of basic elements of hygiene. See, e. g.,* Wright v. McMann, 2d Cir. 1967, 387 F.2d 519 [complaint alleged cell encrusted with excrement, plaintiff entirely naked, forced to sleep on concrete floor, windows open throughout sub-freezing weather, no soap, towel or toilet paper]; Hancock v. Avery, M.D.Tenn. 1969, 301 F.Supp. 786 [hole for waste, flushed irregularly by guard, no soap, towel or toilet paper, prisoner slept naked on floor]: Holt v. Sarver, supra [isolation cells dirty and unsanitary, prevaded with bad odors, plain cotton mattress uncovered and dirty; conductive to spreading, and did spread, infections diseases); Jordan v. Fitzharris, N.D.Cal.1966, 257 F. Supp. 674 [cells not cleaned regularly, prisoner had no means to clean himself, a hole for receiving bodily wastes, no flushing mechanism]. By contrast with these cases, the prisoners in the TDC solitary confinement cells are deprived of none of the basic elements of hygiene." (Emphasis added) 453 F.2d at 665.

In addition, one segment of the *Novak* decision, labeled "*Exercise Caution So That Health Is Not Jeopardized,*" states: "We must also take into account the fact that the prison authorities as a matter of policy are careful to limit use of the diet to avoid damage to the prisoner's health." 453 F.2d at 670.

[11] Moreover, this Court in Campbell v. Beto, 460 F.2d 765, 768 (5th Cir. 1972) has recently reaffirmed this idscussion in *Novak* as follows:

". . . it is apparent that the courts cannot close their judicial eyes to prison conditions which present a grave and immediate threat to health or physical well being. Haines v. Kerner, *supra,* [1972, 404 U.S. 519, 92 S. Ct. 594, 30 L.Ed.2d 652]; Woolsey v. Beto, 5 Cir. 1971, 450 F.2d 321; Rocha v. Sowers, 5 Cir. 1972, 454 F.2d 1155; Jackson v. Bishop, 8 Cir., 1968, 404 F.2d 571; Novak v. Beto, 5 Cir., 1971, 453 F.2d 661, 665, rehearing en banc denied, 1972, 456 F.2d 1303. If the 'deprivation of basic elements of hygiene' has consistently been held violative of constitutional guarantees (see *Novak, supra,* 453 F.2d at 665), then *certainly* practices which result in the deprivation of basic elements of adequate medical treatment, particularly such deprivation as immediately threatens life and limb, would be equally vulnerable." (Emphasis added).

Thus the adequacy of conditions of confinement of prisons—such as medical treatment, hygienic materials, and physical facilities—is clearly subject to Eighth Amendment scrutiny.

In contrast to the factual situation in *Novak,* this case involves conditions and practices that clearly threaten the health and well being of the prison community and substantially deprive inmates of basic elements of hygiene and adequate medical treatment. The district court found that the plaintiffs in this case had shown by substantial evidence that the prison authorities had clearly abused their discretion in providing physical facilities and medical treatment to inmates.

[12, 13] In addition, these conditions deny inmates proper care, treatment, and feeding as required by State law, Miss.Code Ann. § 7930, wholesome food prepared under sanitary cnditions as required in Miss.Code Ann. § 7942, and efficient hospital and medical services as provided in Miss.Code Ann. § 7959.[3] Although

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[3] Section 7930 states: "The superintendent, . . . shall be vested with the exclusive management and control of the prison system, and all properties belonging thereto, subject only to the limitations of this act and shall be responsible for the management of affairs of the prison system and for the proper care, treatment, feeding, clothing and management of the prisoners confined therein . . ."

Section 7942 states: "The superintendent shall see that all state prisoners are fed good and wholesome food, properly prepared under wholesome, sanitary conditions, and in sufficient quantity, and reasonably varied, and he shall hold employees performing this work strictly to account for any failure to carry out this provision. . . ."

Section 7959: "The prison hospital at Sunflower farm shall be under the immediate control and management of the prison physician, but under the general control of the superintendent. . . . There shall be separate wards for male and female prisoners and other classifications as the superintendent may provide and it shall be equipped for the treatment of sick and wounded prisoners . . . He shall cause all prisoners to be vaccinated for all communicable diseases known to constitute a health hazard under such living conditions. . . . The Board of Trustees of State Eleemosynary Institutions shall make periodic inspections of the hospital facilities at the Mississippi State Penitentiary to see that hospital procedures, health standards, and sanitary conditions are maintained in a satisfactory manner, and make recommendations and suggestions pertaining to same to the Superintendent of the Mississippi State Penitentiary, and the Governor of Mississippi."

constitutional questions do not arise merely because a state prisoner has been treated at variance with state law, it is still significant that the current conditions at Parchman even fail to comply with the state standards, much less constitutional norms.[4]

[14] Therefore, we agree with the district court's conclusion that the prison authorities have abused their discretion and that the confinement of inmates at Parchman, in barracks unfit for human habitation and in conditions that threaten their physical health and safety and deprive them of basic hygiene and medical treatment by reason of gross deficiencies in plant, equipment and medical staff, not only departs from state law, but constitutes cruel and unusual punishment.

[15] To reiterate, the defendants admitted the unconstitutionality of these conditions, the district court so found, and our review of the law compels us to agrees. The challenged issue is whether the district court's judgment here ordered relief beyond what was minimally required to comport with the Constitution's prohibition against cruel and unusual punishment.

As *immediate* relief regarding medical care, the district court required the defendant prison authorities (1) to employ such additional medical personnel as necessary so that the prison's medical staff shall consist of at least three full-time physicians, two full-time dentists, two full-time trained physician assistants, six full-time nurses certified as RN or LPN, one medical records librarian, and two medical clerical personnel, and to obtain the consultant services of a radiologist and a pharmacist; (2) to comply with the general standards of the American Correctional Association relating to medical services for prisoners; (3) to have the prison hospital and equipment brought into compliance with state licensing requirements for a hospital and infirmary, including adequate treatment for the chronically ill; (4) to refrain from punishment unless the superintendent makes an express finding that the inmate seeks medical care unnecessarily and for malingering purposes; and (5) to refrain from the use of inmates to fill any of the above described civilian medical staff, but to encourage utilization of trained and competent inmate personnel to supplement the above minimal civilian medical staff.

As *immediate* relief concerning the physical facilities, the court ordered the defendant prison officials to make all improvements and expenditures which were specified in the Interim Committee's Report on Mississippi State Penitentiary (subject to recommendations of State pollution authority.) These improvements, which include the installation of facilities, renovation of living quarters, employment of additional personnel, and purchase of other equipment and supplies, were ordered to be completed by December 20, 1972. In addition, the court instructed the defendants to file by December 20, 1971 a report with the court which details all facilities and equipment purchased, installed, and/or improved, the location of such installation or improvement, and the date of the installation or improvement.

As *long range* relief, the district court instructed the prison officials to submit by December 29, 1972, a comprehensive plan for the elimination of all unconstitutional conditions in inmate housing, inadequate inmate housing, inadequate water, sewer and utilities, inadequate fire fighting equipment, inadequate hospital and other structures. The court then suggested areas of study that should be included in this plan, "without undertaking to dictate or limit the nature or content of long-range plans."

The court's order regarding immediate relief reflects a tenor of restraint and use of independent sources' studies, in determining to what extent the conditions at Parchman must be changed in order to meet minimal constitutional standards. The appellants' brief does not challenge specific elements in the order, but generally complains of insufficient funds to implement these ingredients.

The district court found that the record showed that the medical facilities were grossly understaffed and the physical facilities totally inadequate. The more difficult task is discerning the exact remedy to elevate these conditions to minimal constitutional standards. At this juncture, approximately two years after the entry of the district court's initial judgment, we are concerned over unnecessarily and uninformedly adjudicating this complex question. In view of the recognition by the prison officials themselves of the unconstitutionality of the practices and the extensive studies, complied by the Mississippi Legislature

[4] At different points we will discuss the deviation of the Parchman practices from Mississippi law. Because of the federal claims, this Court has jurisdiction of this case. 28 U.S.C. §§ 1331(a) and 1343(3) and (4). Our pendent jurisdiction is not limited to federal questions, but extends to questions of state law that arise out of the same operative facts.

and other professional consultants, recommending renovations in these two areas, we must assume at least initial improvements have been accomplished. Furthermore, the district court ordered the defendants to submit a long range plan for improving medical and physical facilities. This court does not know the content of this plan, and to what extent, if any, the prison officials have already remedied the conditions at Parchman.

In short, we clearly have affirmed that part of the district court order recognizing the unconstitutionality of the conditions generated by the inadequate medical care and insufficient physical facilities. In addition, we recognize the district court's power to prescribe a remedy. However, any decision dissecting what precise degree of improvements in these two areas is necessary to meet constitutionally minimal standards is premature at this stage. We uphold the present injunctive relief for the time being, but recognize that the district court has retained jurisdiction to update the present conditions at Parchman. Given the avowed interest of various entities, including the Mississippi Legislature, the LEAA and other consultant professionals in this project, it is anticipated that cooperation will prevail and will result in implementing the necessary constitutional innovations.

C. Solitary confinement

[16] The penitentiary superintendent's statutory authority to prescribe rules regarding solitary confinement of prisoners is limited to Miss. Code Ann. § 7968 in the following manner:

"The superintendent may set up rules regarding the discipline of prisoners. No prisoner may be placed in solitary confinement except under orders of the superintendent. Any prisoner held in solitary confinement shall be fed at least once every day and shall be examined by a physician at least once every two (2) days. No prisoner shall be placed in the 'dark hole' of the maximum security unit for a longer period than twenty-four (24) hours. . . ."

Although solitary confinement, as a mode of punishment, is not per se cruel and unusual, there are constitutional boundaries to its use. There is a line where solitary confinement conditions become so severe that its use is converted from a viable prisoner disciplinary tool to cruel and unusual punishment.

Once again, a prerequisite in resolving whether the solitary confinement *as practiced at Parchman*, constitutes cruel and unusual punishment, is to examine the solitary confinement conditions in *Novak, supra*, which this Court held *not* violative of the English Amendment. Solitary confinement in *Novak*, was described as follows:

"It is uncontradicted that solitary cells are scrubbed by the guards each time the prisoner leaves to bathe, which occurs at least three times a week. The cells are identical to the regular cells of the TDC in size and facilities; they contain flush toilets, a drinking fountain, and a bunk. The prisoner is supplied with toilet paper, a toothbrush and toothpaste. Although the bunk is stripped in the sense that it has no mattress or pillow, the prisoner is given two blankets and is clothed in a gown or other garb, so that there is nothing to compare with the reports of prisoners sleeping naked on concrete floors in the above-cited cases. In addition, solitary cells in the TDC have the same temperature controls that regular cells in the prison have." 453 F.2d at 665.

These conditions of solitary confinement in *Novak* are completely dissimilar to those in the case at bar. At Parchman, each wing of the Maximum Security Unit (MSU) contains thirteen cells, each of which is approximately 8′ x 10′ in size. The individual cells are equipped for use by two men, with double metal bunks, lavatory and commode. In addition, each side has one 6′ x 6′ cell, known as the dark hole, with no lights, commode sink or other furnishings. A hole in the concrete floor is located in the middle of the cell and is approximately 6″ in diameter that will flush to dispose of body wastes. A heavy metal door without a window closes the cell. For solitary confinement at Parchman the inmates are placed in the dark hole naked, without any hygienic material, without any bedding, and often without adequate food. It is customary to cut the hair of an inmate confined in the dark hole by means of heavy-duty clippers. Inmates have frequently remained in the dark hole for forty-eight hours and may be confined there for up to seventy-two hours. While an inmate occupies the dark hole, the cell is not cleaned, nor is the inmate permitted to wash himself.

[17] Even under the restrictive standards for determining cruel and unusual punishment enunciated in *Novak*, this solitary confinement in the dark hole at Parchman undoubtedly meets the test as found by the district court. It is unassailable that the solitary confinement of naked persons in MSU's dark hole

without any hygienic materials, *any* bedding, adequate food or heat, without opportunity for cleaning either themselves or the cell, and for longer than twenty-four hours continuously, is constitutionally forbidden under the Eighth Amendment.

[18] The district court refused to enjoin use of the dark hole under all circumstances, but permitted its use only under the following conditions: (1) inmates be fed the daily prison ration, or at least 2000 calories per day; (2) inmates be permitted to wear regular institutional clothing; (3) inmates be supplied with soap, towels, toothbrush and shaving utensils; (4) all cells be adequately heated, ventilated and maintained in a sanitary condition; (5) no inmate shall be confined in any isolation cell, referred to as the dark hole, for a period in excess of twenty-four hours. The time limitation and food provision were already required by the state law, Miss. Code Ann. § 7968. The clothing, heating, sanitation stipulations merely conform to the conditions of solitary confinement existing in *Novak*. It is clear that these changes ordered by the district court only alleviate the conditions of solitary confinement to minimal constitutional standards and do not exceed the court's remedial jurisdiction.

D. Corporal punishment

In addition to prescribing the length of solitary confinement, Miss. Code Ann. § 7968 also expressly discourages corporal punishment of any kind, and forbids it except upon express written order of the superintendent.[5]

[19] Section 7968 makes it illegal for any prison official other than the superintendent to order corporal punishment; and where corporal punishment is expressly authorized by the superintendent, it is limited to the whip or lash, which is not to be used for more than seven licks. While the evidence indicated that the lash had not been used at Parchman since 1965, the record was replete with innumerable instances of physical brutality and abuse in disciplining inmates who are sent to MSU. These include administering milk of magnesia as a form of punishment, stripping inmates of their clothes, turning the fan on inmates while naked and wet, depriving inmates of mattresses, hygienic materials, and adequate food, handcuffing inmates to the fence and to cells for long periods of time, shooting at and around inmates to keep them standing or moving, and forcing inmates to stand, sit or lie on crates, stumps, or otherwise maintain awkward positions for prolonged periods. Indeed, the district court found the superintendent and other prison officials acquiesced in these practices. Unquestionably, the district court correctly enjoined prison authorities from punishing inmates by these methods of corporal punishment. We have no difficulty in reaching the conclusion that these forms of corporal punishment run afoul of the Eighth Amendment, offend contemporary concepts of decency, human dignity, and precepts of civilization which we profess to possess. *See, e.g.*, Jackson v. Bishop, 404 F. 2d 571 (8th Cir. 1968) (J. Blackmun) (use of strap for whipping).

E. Trusty system

A system of inmate trusties is authorized by Miss. Code Ann. § 7965 until July 1, 1974:

"From and after July 1, 1974, no inmate at the penitentiary shall serve as a trusty and perform any duties of guarding other inmates to prevent their escape. Prior to the date aforesaid, the superintendent may select *a reasonable number of deserving and trustworthy inmates* to be used to guard inmates and to supervise their prison work details. The superintendent shall, within the monies appropriated by the Legislature, employ a reasonable number of civilian guards to prevent inmates from escaping and in supervising inmates' work details. The

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[5] Section 7968 states: "The superintendent may set up rules regarding the discipline of prisoners . . . Corporal punishment of any kind is hereby discouraged and shall not be administered to any prisoner except on the written authority of the superintendent and if corporal punishment is administered, to any prisoner, it shall be administered in the presence of any two (2) of the following persons; the superintendent, the chaplain or a member of the board. Whenever a sergeant or other employee of the penitentiary considers it necessary that a prisoner be punished, he must make a written report to the superintendent regarding punishment, stating in such report the offense committed by the prisoner and in the event the superintendent, after investigation, considers it necessary that such prisoner be given corporal punishment, he shall give written authority therefor directed to the sergeant specifying the number of licks or lashes, not to exceed seven (7) which may be administered. The written request of the sergeant and the written authorization of the superintendent, signed by them, as well as a statement by the witnesses attesting that they witnessed the lashing, shall be placed in the file of the prisoner involved and a copy of same shall be placed in permanent register available to the Governor, the board and legislative investigating committees. . . ."

Board is authorized to eliminate the trusty system at a faster and earlier date if deemed feasible and consistent with consolidation procedures and operations as outlined in Section 11 [§ 7926.5] of this act." (Emphasis supplied).

The inefficacy of the Parchman trusty system stemmed from the prison authorities' failure to select as trusties "deserving and trustworthy inmates" as required by state law.[6]

The district court found that the trusties at Parchman were selected by the sergeants without the use of objective criteria or uniform standards and in a process infected with payoffs, favoritism and extortion. The responsibility of guarding other inmates was primarily performed by these trusties. Some of the trusties were armed, referred to as "trusty shooters" and numbering approximately 150. Armed trusties guarded each of the prison camps, oversaw inmates while working in the fields, and on occasions were left in sole charge of the fields. Penitentiary records indicated that some of the armed trusties had been convicted of violent crimes, and, that of the armed trusties serving as of April 1, 1971, thirty-five percent had not been psychologically tested, forty percent of those tested were found to be retarded, and seventy-one percent of those tested were found to have personality disorders. There was no formal program for training trusties. Trusties were instructed to maintain discipline by shooting at inmates who got out of gun line; in many cases trusties had received little training in the handling of firearms. In addition to abusing their authority and engaging in loansharking, extortion and other illegal conduct, the trusties shot, maimed or otherwise physically maltreated scores of inmates subject to their control. For example, during Superintendent Cook's administration, thirty inmates received gunshot wounds, an additional twenty-nine inmates were shot at, and fifty-two inmates were physically beaten.

On October 20, 1972, the district court ordered the prison officials (1) to eliminate all trusties at MSU and replace them with civilian guards; and (2) to replace all armed shooters in the fields with civilian guards by December 20, 1972. On that date the prison authorities were to submit a plan for the total elimination of the use of trusties for armed guard duty and for other custodial responsibility no later than June 20, 1973. In the interim period, i.e., from October 20, 1972 to June 20, 1973, custodial trusties could be used if selected after a careful review of inmate personnel records and psychological tests assuring that the inmates were mentally and emotionally fit to perform their assigned tasks.

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[6] The Mississippi State Penitentiary Rules and Regulations Handbook, issued February, 1973; also stressed that the trusties should be deserving and trustworthy inmates:

"*Trustee system*"

"At the Mississippi State Penitentiary there are two categoires of trustys. They are Full-Trusty and Half Trusty.

"Full Trusty.—This category is provided for inmates who are considered to be trustworthy in every respect, and who have by virtue of their work habits, conduct, and attitudes of cooperation proven their trustworthiness. Full Trustys are in the Minimum 'B' Custody classication, and can work without constant supervision by employees or security officers.

"Half Trusty.—This category is provided for inmates who are considered to be trustworthy, but need limited supervision by employees or security officers. Such inmates have proven their reliability through their work habits, conduct and attitudes. Half Trustys are in the Minimum 'A' Custody classification and require only limited supervision by employees or security personnel.

"In order to become a Full Trusty or a Half Trusty, the inmate must be recommended to the Classification Committee for a change in custody classification by his Camp Sergeant or a member of that administrative staff of the institution.

"The Classification Committee has established the following policy to regulate applications for change of custody classification considered for a change of custody classification.

"1. Inmates having detainers against them will not be considered for a change of custody classification.

"2. Inmates who have been convicted of a charge of arson or for any sexual offense will not be considered for a change of custody classification until they have been examined and approved by the Psychiatric Staff of the State Hospital at Whitfield or the Staff Psychiatrist of the State Penitentiary.

"3. Inmates who have escaped from a penal institution within four years of the date of application will not be considered for a change of custody classification.

"4. Inmates who have escaped from jails or mental institutions or similar institutions of confinement within two years of application will not be considered for a change of custody classification.

"5. Inmates having served less than ninety days in the institution will not be considered for a change of custody classification.

"6. Inmates who are in the Half-Trusty classification must remain in that classification at least ninety days before they can be considered for the Full-Trusty classification.

"7. Inmates who have lost their Trusty classification due to disciplinary action will not be considered for reinstatement prior to ninety days from the completion of the punishment for the offense."

In section 7965 the Mississippi Legislature has called for the complete elimination of this trusty system by July 1, 1974. That statute encourages this eradication at a "faster and earlier date if deemed feasible." Furthermore, the Parchman trusty system has been the subject of investigation and critical comment in past years by committees of the Mississippi Legislature, by public officials and by a study team from the University of Georgia. Comprehensive reports of such findings were last submitted to the Mississippi Legislature in 1971. As a result, section 7965 calling for the removal of the trusty system was approved April 29, 1971. More recently, a consultant committee engaged by the Mississippi State Planning Agency, the LEAA, and the American Correctional Association reviewed conditions at Parchman and found that the prison was operated in accordance with the following three principles which must be eliminated to correct gross deficiencies in the prison administration, to wit: (1) The prison system must operate at a profit at any cost; (2) Armed inmate guards are acceptable and capable of insuring safety and security within the system; and (3) Security and control of inmates are insured through maintaining a high degree of fear within the inmate population.

[20] One basis for the district court's order was that the trusty system, as presently constituted and practiced, was a method of cruel and unusual punishment. After placing in the hands of some inmates weapons or other forms of control over the other inmate population, the prison officials either could not or had failed to prevent the arbitrary infliction by the trusties of physical and economic injury upon their fellow inmates. A second underpinning of the district court order was deviation from state law: "Indeed, the Mississippi statutes do not contemplate for guard duty the use of trusties who are corrupt, venal, incompetent, or dangerous." Moreover, the Mississippi Legislature had even called for its elimination. We have no difficulty in reaching the conclusion that this trusty system, which utilizes unscreened inmates violates state law, and which allows inmates to exercise unchecked authority over other inmates, constitutes cruel and unusual punishment in violation of the Eighth Amendment, warranting the district court's prohibition of certain portions of the trusty system prior to the legislative cut off date of July 1, 1974. We do not discuss at length the intricacies of the procedure for eliminating the trusty system as proposed by the district court's order, for due to the lateness of the hour even the cut off date proscribed by Mississippi's Legislature has passed. The district court's abolition of the trusty system can easily be justified at *this* juncture as simply in conformance with the state law.[7]

F. Inadequate protection of inmates

Inmates, except those who are in MSU, are housed in buildings which have two separate wings and contain barracks known as "cages"; one for regular inmates called "gunmen" and the other for trusties. On the gunmen side the inmates are placed in one large room where they are assigned to bunks. The district court found that the risk of personal injury inherent in this cage confinement was increased by the following practices. The inmates are not classified according to the severity of their offense, resulting in the intermingling of inmates convicted of aggravated violent crimes with those who are first offenders or convicted of nonviolent crimes. In addition, the custodial responsibility of inmates has been assigned to other inmates who serve as hallboys, floorwalkers and cage bosses. Hallboys perform administrative duties; floorwalkers are nontrusties who perform custodial duties and on whose recommendation inmates may be punished. Cage bosses are charged with enforcing discipline in the barracks. The evidence is replete with instances of inhumanities, illegal conduct and other indignities visited by these inmates who exercise authority over their fellow prisoners.

Although many inmates possess weapons, there is no established procedure for discovering and confiscating weapons, nor is possession of weapons reported or punished. The record revealed at least eighty-five instances where inmates had physically assaulted other inmates; twenty-seven of these assaults involved armed attacks in which an inmate was either stabbed, cut or shot.

[7] *See* note 4, *supra.*

Only *one* civilian guard is assigned to each camp. The one civilian guard is prohibited from entering the cages. As stated by Superintendent Cook, penitentiary employees have no control over inmates after the lights are turned out and "there is no way that anyone can guard the safety of an inmate in the Parchman situation," because of the dormitory style system and the lack of civilian guards. The district court found that in some cases, supervisory personnel have allowed inmates to fight, gamble and acquire liquor and drugs in violation of prison rules and state law. The operation of the trusty system, as previously outlined, further compounds the dilemma of the protection of inmates.

The district court determined that the Parchman administration had subjected its inmate population to cruel and unusual punishment by failing to provide adequate protection against physical assaults and abuses by other inmates, by placing excessive numbers of inmates in barracks without adequate classification or supervision, and by assigning custodial responsibility to incompetent and untrained inmates. While prison officials may take all reasonable steps to insure proper prison discipline, security and order without threatened intervention by a federal court, the actions and practices here go far beyond any concept of reasonableness. It is the obligation of penitentiary officials to insure that inmates are not subjected to any punishment beyond that which is necessary for the orderly administration of Parchman. Although the limits of the Eighth Amendment's proscription are not easily or exactly defined, certainly one facet of cruel and unusual punishment would be caging inmates in one barrack room and giving incompetent inmates weapons, the authorization to use them and the power to recommend disciplinary action, unsupervised by any prison authorities, which results in assaults on other inmates. The infliction of these physical injuries is no less tolerable because accomplished by the inmates with the assistance and acquiescence of the prison authorities, then if perpetrated by the prison superintendent alone. Each factor separately, i.e., overcrowding dormitory barracks, lack of classification, according to severity of offense, untrained inmates with weapons, lack of supervision by civilian guards, absence of a procedure for confiscation of weapons, may not rise to constitutional dimensions; however, the effect of the totality of these circumstances is the infliction of punishment on inmates violative of the Eighth Amendment, as determined by the trial court.

Therefore, the district court ordered the prison authorities to implement (1) a system of assigning inmates to barracks according to the severity of their offense, (2) a system of reporting inmate assaults to the County Prosecuting Officer, maintaining a record of assaults on other inmates, and making reasonable efforts to isolate inmates who have a history of violence on other inmates, (3) a procedure for controlling the possession of weapons by inmates, (4) a rule prohibiting gambling and fighting, (5) a plan requiring three civilian guards to be assigned to each barracks during night hours and the inmate cage bosses, hallboys, and floorwalkers to be relieved of all custodial responsibilities, and (6) the temporary measure of placing wire or other dividers in appropriate places to ameliorate the risk of personal injury by overcrowding of inmates in a single room. These were regarded as interim measures to be carried out by December 20, 1972, within two months of the judgment. The modification of the physical facilities generally and the eradication of the entire trusty system, two elements of relief in other areas, were conceived to provide the necessary greater long term improvements in inmate protection.

[21, 22] Not only do we agree that the totality of the present practices fosters cruel and unusual punishment, but we also conclude that none of the above measures ordered require burdensome implementation or is beyond the remedial jurisdiction of the district court. Rather they merely construct the minimal foundation for assuring that the confinement in the present dormitory style facilities at Parchman does not run afoul of the Eighth Amendment. Constantly mindful that the federal courts should not undertake to run the prison and completely aware as we are that this part of the judgment does set forth tasks involved in the administration of a penal institution, we nonetheless determine that the remedy ordered simply sets forth the parameters for administration and leaves for the prison officials wide latitude in which to devise the manner in which these concepts may be implemented.

G. Mail censorship

Prior to trial, the practice at Parchman was to censor *all incoming and outgoing* mail of inmates. On May 5, 1972, Superintendent Collier issued a memorandum on correspondence advising that there would be *no censorship of incoming or outgoing mail*, that there would be no limit to letters an inmate may write except where limitation may be imposed as a matter of discipline, and that only *incoming mail* would be *opened in the presence of the inmate* to determine whether money is contained therein. The October 20, 1972 judgment of the district court ordered the following regarding correspondence:

"(1) Said defendants, and all persons in privity with them, *shall not open* or otherwise interfere with any *outgoing* mail of inmates addressed to:

"(*a*) Officials of the federal, state and local courts;

"(*b*) All federal officials including the President of the United States, any senator or congressman, and officials of any United States agency or department; all state officials including the Governor, members of the state Senate and House of Representatives and officials of any state agency or department;

"(*c*) All members and employees of the State Probation and Parole Board;

"(*d*) The attorney of record of an inmate in any pending action, civil or criminal, in any duly constituted local, sate or federal court.

"(2) Said defendants, and all persons in privity with them, are phohibited from interfering with *outgoing* mail of inmates to any other addressee *except to open and inspect, in the presence of the inmate, any letter where prison officials have reasoable ground to suspect such communication is an attempt to formulate, devise or otherwise effectuate a plan to escape from the penitentiary, or to violate the laws of the State of Mississippi or of the United States.*

"(3) The defendants, and all persons in privity with them, are prohibited from interfering with *incoming* mail from any source *except to open and inspect such mail, in the presence of the inmate addressee, whenever the prison officials have reasonable grounds to suspect escape attempts or to discover drugs, weapons or other material expressly prohibited by state or federal law or by prison rules.*

"(4) There shall be no restriction placed on the number of letters that an inmate may write to the addressees listed in (1) about. Reasonable limitations may be imposed upon all other classes of mail as an appropriate disciplinary measure pursuant to published prison rules." (Emphasis supplied).

In the February, 1973 handbook, the Mississippi Penitentiary Board promulgated new regulations regarding correspondence which fully incorporated each requirement of the district court's prescription.[8] Athough the appellants challenge the district court's order in its entirety on appeal, the mail issue was not focused upon as beyond the remedial jurisdiction of the district court.

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[8] The regulations in the 1973 handbook entitled "Mississippi State Penitentiary: Rules and Regulations," state:

"*Policy regarding mail.*—It is considered essential to the eventual resocialization of the inmates that they maintain contact with their families and desirable friends through use of the mail. Therefore, inmates are encouraged to make use of the mail and every means compatible with security is provided for them to do so.

S401. *Outgoing mail.*—Outgoing mail of inmates addressed to the following will not be opened or otherwise interfered with:

1. Officials of the federal, state and local courts.
2. All federal officials, including the President of the United States, any senator or congressman, and officials of any United States agency or department; all state officials, including the Governor, members of the state Senate and House of Representatives; and officials of any state agency or department.
3. All members and employees of the State Probation and Parole Board.
4. The attorney of record of an inmate in any pending action, civil or criminal, in any duly constituted local, state or federal court. Other outgoing mail of inmates to any other addressee will not be interfered with except to open and inspect, in the presence of the inmate where prison officials have reasonable grounds to suspect such communication is an attempt to formulate, devise, or otherwise effectuate a plan to escape from the penitentiary, or to violate the laws of the State of Mississippi or of the United States.

S402. *Incoming mail.*—Incoming mail from any source will not be interfered with except to open and inspect such mail, in the presence of the inmate addressee, whenever the prison officials have reasonable grounds to suspect escape attempts or to discover drugs, weapons or other material expressly prohibited by state or federal laws or by prison rules. Inmates shall be given written notice which describes any material confiscated or returned and the reason for such action. Any material confiscated because of alleged obscene content shall be recorded and forwarded to federal postal authorities for appropriate action.

S403. *Mail limitations.*—There shall be no restriction placed on the number of letters or addresses to whom an inmate may write."

Moreover, two recent Supreme Court cases have made it clear that revision in Parchman's mail rules was constitutionally compelled. In Procunier v. Martinez, 416 U.S. 396, 94 S.Ct. 1800, 40 L. Ed.2d 224 (1974), the Supreme Court held that First Amendment liberties of the correspondents with inmates were implicated in censorship of inmate mail. Noting that the federal courts have traditionally adopted a broad hands-off attitude toward problems of prison administration, the Supreme Court, nonetheless, determined that prison officials did not have unbridled discretion in establishing inmate mail regulations. The majority opinion emphasized that it was not adjudicating to what extent an inmate's right to free speech survives incarceration, but grounded its holding on the narrower basis that the inmate correspondent's rights were being violated by the censorship. The Court stressed that whatever the status of an inmate's claim to uncensored mail, the censorship of prisoner mail concomitantly imposes a restriction on the First and Fourteenth Amendment rights of those who are not prisoners, and therefore may be curbed. The Court then formulated the proper standard for deciding whether a particular regulation or practice relating to inmate correspondence constitutes an impermissible restraint of the First Amendment liberties of the inmate's correspondent. The Court held that the censorship of inmate mail was justified (1) if the regulation or practice in question furthered an important or substantial governmental interest unrelated to the suppression of expression and (2) if the limitation of First Amendment freedoms was no greater than is necessary or essential to the protection of the particular governmental interest involved. Utilizing that standard, the Supreme Court upheld the district court's invalidation of regulations that authorized, *inter alia*, censorship of statements that "unduly complain" or "magnify grievances," expressions of "inflammatory political, racial, or religious or other views," and matter deemed "defamatory' 'or "otherwise inappropriate."[9]

In addition, the *Procunier* Court agreed with the district court that the decision to censor or withhold delivery of a particular letter must be accompanied by minimum procedural safeguards. The Court approved the district court's requirement that an inmate be notified of the rejection of a letter written by or addressed to him, that the author of that letter be given a reasonable opporunity to protest that decision, and that complaints be referred to a prison official other than the person who originally disapproved the correspondence.

Soon thereafter, the Supreme Court again considered inmate correspondence in Wolff v. McDonnell, 418 U.S. 539, 94 S.Ct. 2963, 41 L.Ed.2d 935 (1974), where the narrow issue presented was whether *incoming* letters from attorneys could be *opened* by prison authorities in the presence of the inmate or whether such mail must be delivered unopened if normal detection techniques failed to indicate contraband. The prison regulation under challenge in that case provided that "all incoming and outgoing mail will be read and inspected." The state conceded that it could not open and *read* incoming mail from attorneys, but contended, that it could *open* all *incoming* letters from attorneys *in the presence of the inmates.*[10] Ultimately, the *Wolff* Court did not adjudicate the constitutional require-

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[9] The Court stated:

"These regulations fairly invited prison officials and employees to apply their own personal prejudices and opinions as standards for prisoner mail censorship. Not surprisingly, some prison officials used the extraordinary latitude for discretion authorized by the regulations to suppress unwelcome criticism. For example, at one institution under the Department's jurisdiction, the checklist used by the mailroom staff authorized rejection of letters 'criticizing policy, rules or officials,' and the mailroom sergeant stated in a deposition that he would reject as 'defamatory' letters 'belittling staff or our judicial system or anything connected with the Department of Corrections.' Correspondence was also censored for 'disrespectful comments,' 'derogatory remarks,' and the like:

"Appellants have failed to show that these broad restrictions on prisoner mail were in any way necessary to the furtherance of a governmental interest unrelated to the suppression of expression. Indeed, the heart of appellants' position is not that the regulations are justified by a legitimate governmental interest but that they do not need to be. . . . The regulation, however, is not narrowly drawn to reach only material that might be thought to encourage violence nor is its application limited to incoming letters. In short, the Department's regulations authorized censorship of prisoner mail far broader than any legitimate interest of penal administration demands and were properly found invalid by the District Court." 416 U.S. at 415, 94 S.Ct. at 1812 (1974).

[10] The Supreme Court reemphasized that Procunier v. Martinez, *supra*, was not based on the inmates' rights but on the correspondent's rights: "While First Amendment rights of correspondence with prisoners may protect against the censoring of inmate mail, when not necessary to protect legitimate governmental interests, see Procunier v. Martinez, 416 U.S. 396, 94 S.Ct. 1800, 40 L. Ed.2d 224 (1974), this Court has not yet recognized First Amendment rights of prisoners in this context, *see* Cruz v. Beto, *supra*, Cooper v. Pate, *supra* (378 U.S. 546, 84 S.Ct. 1733, 12 L.Ed.2d 1030 (1964)]. Furthermore, freedom from censorship is not equivalent to freedom from inspection or perusal." 418 U.S. 539, 575, 94 S.Ct. 2963, 2984, 41 L.Ed.2d 935 (1974).

ments pertinent to the opening of inmate-attorney mail, for the Court concluded that "the State [in that case], by acceding to a rule whereby the inmate is present when mail from attorneys is inspected, has done all, and perhaps even more, than the Constitution requires." 418 U.S. 539, 577, 94 S.Ct. 2963, 2985, 41 L.Ed.2d 935.

Therefore, the issue whether the inspection of incoming mail from attorney must be accompanied by the presence of the inmate in order to satisfy constitutional standards was not actually resolved.

[23] Turning to the instant case, first, we readily conclude under the standard of review announced in *Procunier*, that the previous Parchman practices of censoring *all incoming and outgoing* mail are unconstitutional. Although the Supreme Court in *Procunier* settled one facet of inmate-mail litigation by determining that the prison officials in the name of internal administration could not at will *censor* inmates' mail due to the infringement *on the rights of the correspondent* with the inmate, significant collateral problems regarding the extent to which mail could be *opened although unread*, were left unanswered. For example, two principal questions remaining would be (1) whether disallowing *any* opening of *outgoing* mail to a designated class of public officials is constitutionally compelled, and (2) whether *opening* all *incoming* mail and *opening* all *outgoing* mail except to the designated class of public officials, could only be accomplished in the presence of the inmate, in order to meet constitutional standards. Moreover, given *Procunier's* broad indictment of inmate mail censorship except in narrow circumstances, it would be feasible to raise the issue in subsequent mail cases, to what extent would disallowing reading, but allowing opening without the present of the inmate when normal detection devises have failed to discover contraband, permit a subterfuge of the censorship prohibition.[11] Another question might be whether the governmental interest in maintaining security is legitimately furthered under the *Procunier* standards by opening *outgoing* mail to persons in the public trust, such as those in the designated class of public officials in the district court's order.

H. Disciplinary procedures

Prior to November, 1970, inmates were punished summarily without adherence to any defined procedure. Thereafter, the superintendent established a "trial council," composed of three civilian penitentiary employees, to handle disciplinary actions against inmates. The camp sergeant was charged with preparing a written report of the violation and with delivering it to the security officer for distribution to the trial council. The council was required to interview an inmate and adjudicate his guilt. The record revealed that an inmate was not notified of the charge orally or in writing prior to appearance before the council, the inmate was not permitted assistance, was not allowed to present witnesses, or cross-examine and was not entitled to a transcript of the proceedings. The sergeant's written report to the council need not identify anyone with personal knowledge of the information or investigation by the sergeant. Only in one percent of the cases, did the trial council make any independent investigation, and the word of the reporting sergeant was generally accepted if it contradicted the inmate's report. The punishment recommendation of the reporting sergeant was generally approved by both the trial council and the superintendent. Punishments imposed were not uniform. Finally, although the rules required all offenses to be heard by the trial council, the district court found that inmates had been punished without a hearing, not only for conduct which was not listed in the charges, but for conduct which was not a violation of prison rules.

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[11] The rationale for allowing the presence of the inmate was well stated by the First Circuit Court of Appeals in Smith v. Robbins, 454 F.2d 696, 697 (1st Cir. 1972), where the court required the presence of an inmate for the inspection of inmate-attorney mail:

"However strongly the warden may feel about a possible indignity to the prison administration in a suggestion by the court that it is not to be trusted not to read the letter, this misses the point. The court does not suggest that the warden is untrustworthy. Rather, it is that a prisoner, and possibly some attorneys, may feel, if only to a small degree, that someone in the chain of command may not be trusted, and that the resulting fear may chill communications between the prisoner and his cousel. Once it is granted, as the warden now concedes, that the prisoner has a right to have the confidence between himself and his counsel totally respected, the burden must be on the warden to show a need for any act which could produce even a suspicion of intrusion. If a prisoner can see no good reason for opening a letter in his absence, it would not be unnatural for him to suspect a bad one. Inasmuch as the warden has failed to suggest any reason that seems adequate even to us, we see no reason to leave such possible apprehensions on such an important matter as right to counsel in the minds of the prisoner or his attorney."

To rectify these practices, the district court's October 20, 1972 order required the immediate implementation of the following practices:

"(a) An inmate may not be punished except for conduct which violates an existing penitentiary rule or regulation.

"(b) Any inmate accused of infraction of an existing penitentiary rule or regulation shall be given written notice of the charge against him, which notice shall identify the prison rule alleged to have been violated and be served upon the accused at least 24 hours prior to the hearing.

"(c) The accused must be afforded an opportunity to appear before a tribunal to respond to the charge. In no event shall the person bringing the charge serve on the disciplinary tribunal which conducts the hearing."

The district court further ordered that the prison officials, not later than November 20, 1972, compile comprehensive regulations governing misconduct which apprise inmates of:

"(a) Conduct which constitutes a breach of discipline;

"(b) The penalties and sanctions which may be imposed for such conduct;

"(c) A complete statement of the procedure by which such determination shall be made."

It should be noted that the district court's order here incorporated with foresight the dilemma in *Wolff*, by allowing officials to open and inspect all *incoming* mail in the presence of the inmate. Furthermore, prior to the Supreme Court's recent mail decisions, this Court had surmised that the censorship of inmate-attorney mail may constitute a denial of federal constitutional rights. Barlow v. Amiss, 477 F.2d 896, 898 (5th Cir. 1973); Frye v. Henderson, 474 F. 2d 1263 (5th Cir. 1973); *cf.* Cruz v. Hauck 45 F.2d 45 (5th Cir. 1973). Also, this Court had previously held that *opening* of an inmate's *incoming* mail from his attorney, the courts and public officials by an electric letter opener to determine whether contraband was being sent into the prison did not deny any federally protected right. Frye v. Henderson, 474 F.2d 1263 (5th Cir. 1973). The district court here incorporated that holding with the caveat discussed in *Wolff*, that the inspection occur in the presence of the inmate.[12]

In any event, inasmuch as the state in the case at bar has promulgated regulations which incorporate all elements of the district court's order and since the parties have not specifically challenged in their brief the components of that order, it would be inappropriate in this case to delimit the boundaries of the First Amendment mail protection of the inmates' *correspondents* and to define to what extent an *inmate's* First Amendment rights survive incarceration. Therefore, we do not adjudicate whether the requirements that the inspection be in the presence of the inmates, as well as the other components of the district court's order are constitutionally compelled, since the state at this juncture has acceded to adopting these reguations, and has not specifically challenged the extent of the district court's order on this facet of the appeal.[13]

The February 1973 handbook promulgated by the Mississippi Penitentiary Board contained extensive rules regarding inmate disciplinary procedures. The rules first set forth (1) prohibited acts constituting major violations, (2) pro-

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[12] We point out that certain issues previously adjudicated by this Court concerning correspondence are not presented here and thus do not require in this case reconsideration in light of the recent *Procunier* and *Wolff* decisions. *See* Schack v. Wainwright, 391 F.2d 608 (5th Cir. 1968) (inmate's right to have his mail relating to legal proceedings sent "postage prepaid by certified mail—return receipt requested,"); Heft v. Carlson, 489 F.2d 268 (5th Cir. 1973) (inter-institutional correspondence); O'Brien v. Blackwell, 421 F.2d 844 (5th Cir. 1970) (exhaustion of administrative remedies in mail suits).

[13] The thrust of the defendants' appeal was directed towards those ingredients in the district court's judgment which would require substantial expenditures to implement. The Appellants Brief, at p. 5 states:

"The defendants-appellants have already promulgated rules and regulations concerning the censorship of mail. use of corporal punishment, and the discipline of inmates and disciplinary confinement. However, the monumental task that remains concerns the elimination of the armed trusty system, improving physical facilities, classification of inmates, and improvement of medical facilities. All of these will necessarily require funds: funds that will necessarily have to be supplied by the Legislature of the State of Mississippi."

hibited acts considered minor violations, and (3) the respective disciplinary action for each type of violation.[14]

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[14] The following acts were prohibited and would be dealt with as *major* violations:
"1. Killing.
2. Assaulting any person.
3. Fighting with another person, except in self-defense.
4. Extortion, blackmail, demanding or receiving money or anything of value in return for protection against others, to avoid bodily harm, or undue threat of informing.
5. Engaging in sexual acts with others.
6. Escape.
7. Attempting or planning escape.
8. Setting a fire.
9. Willfully or maliciously destroying, altering, or damaging state property or the property of another person.
10. Stealing (theft).
11. Unauthorized possession or distribution of any explosive or any ammunition.
12. Unauthorized possession or distribution of a gun, firearm, weapon, sharpened instrument, knife, or tool.
13. Unauthorized possession, introduction, or use of any narcotic, narcotic paraphernalia, drugs, or intoxicants not prescribed for the individual by the medical staff.
14. Rioting.
15. Encouraging others to riot.
16. Engaging in or encouraging any group demonstration or conduct which disrupts or interferes with the security or orderly running of the instituion.
17. Counterfeiting, forging, or unauthorized reproduction of any article or identification, money, security, or official paper.
18. Making intoxicants.
19. Gambling.
20. Preparing or conducting a gambling pool.
21. Giving or offering any staff member a bribe, or anything of value.
22. Conspiring with or aiding another person to commit any of the above offenses shall be considered the same as a commission of the offense itself."
The following acts were prohibited and would be dealt with as minor violations:
"23. Threatening another with bodily harm or with any offense against his person or his property.
24. Making sexual threats to another.
25. Indecent exposure.
26. Wearing a disguise or mask with the intent to violate prison rules and regulations.
27. Willfully or maliciously destroying or otherwise interfering with any locking device.
28. Misuse of authorized medication.
29. Unauthorized possession of money or currency.
30. Loaning of property or anything of value for profit or increased return.
31. Possessing any officer's or staff clothing, unless specifically authorized.
32. Refusing to work.
33. Encouraging others to refuse to work, or participation of work stoppage.
34. Refusing to obey an order of any staff member.
35. Unexcused absence from work or any other assignment.
36. Malingering, feigning an illness.
37. Using abusive or obscene language that disrupts or interferes with the security or orderly running of the institution.
38. Lying, or providing a false statement to a staff member.
39. Being in an unauthorized area without official permission.
40. Willfully using any equipment, machinery, or vehicle which is not specifically authorized.
41. Willfully using any equipment or machinery contrary to instruction or posted facility standards.
42. Failing to stand count, unless officially excused.
43. Interfering with the taking of count.
44. Being intoxicated (alcohol).
45. Smoking where prohibited.
46. Tattooing or self-mutilation.
47. Unauthorized use of telephone or violation of mail regulations.
48. Violation of visiting regulations.
49. Giving money or anything of value to, or accepting money or anything of value from, another inmate, a member of his family or his friends without prisons written approval (see Article 7).
50. Removing or having in your possession any eating or cooking utensil from the dining room or kitchen without authorization.
51. Conspiring with or aiding another person to commit any of the above minor offenses shall be considered the same as a commission of the offense itself."
The following disciplinary action was prescribed for minor violations:
"Whenever an inmate is found guilty of a minor violation, he may be subjected to one or more of the following disciplinary actions with the approval of the Superintendent. The disciplinary action taken will be individualized in keeping with such factors as the offender's past history, institutional adjustment, motivation, and attitude. For any offense within a twelve-month period, the maximum punishment is set forth; however, the council may recommend less than the maximum depending on the individual facts and circumstances surrounding the violation.
(a) For a first offense within a twelve-month period:
1. Reprimand.
2. *Loss of six days good time.*
3. Loss of plasma privileges for one thirty days.
4. Loss of visiting privileges for one Sunday.

The February 1973 regulations also contained the following procedures for administratively handling infractions of these disciplinary rules:

"S302. *Administration of discipline of inmates.*—Inmate discipline shall be administered by a Disciplinary Council consisting of three employees. These three employees shall be members of a nine man group designated by the Superintendent to serve on the Disciplinary Council. The Disciplinary Council shall consider and dispose of minor matters of discipline where no danger to safety, property, or life exists, as well as the more serious and persistent violations of institution rules. In addition, any inmate who is involuntarily removed from the general prison population shall, upon request, be afforded the disciplinary hearing procedure as set forth below.

"S303. *Disciplinary council procedure.*—Inmates appearing before the Disciplinary Council are entitled to the assistance of a counselor if they so desire. Counselors shall be employees of the institution designated by the Superintendent to serve in that capacity when so requested. Any inmate may not be punished except for conduct which violates an existing penitentiary rule or regulation. Any inmate accused of infraction of an existing penitentiary rule or regulation shall be given written notice of the charge against him, which notice shall identify the prison rule alleged to have been violated and be served upon the accused at least 24 hours prior to the hearing. The accused will be afforded an opportunity to appear before a tribunal to respond to the charge and be present with a counselor if he so desires during the entire hearing. The *counselor shall call necessary witnesses* for the accused inmate *if the counselor deems* the witnesses' testimonies as necessary for the disposition of this matter. In no event shall *the person bringing the charge* serve on the disciplinary tribunal which conducts the hearing" (Emphasis supplied).

Similar to the mail portion of the district court's order, the appellant prison officials here, although technically appealing from the trial decision in its entirety, do not set forth specific challenges to disciplinary procedures ordered. Moreover, the recent decision in Wolff v. McDonnell, 418 U.S. 539, 94 S.Ct. 2963, 41

(b) For a second offense within a twelve-month period:
1. *Loss of twelve days good time.*
2. Loss of plasma privileges for two months.
3. Loss of visiting privileges for one month.
(c) For a third offense within a twelve-month period:
1. *Seventy-two hours in isolation.*
2. *Loss of twenty four days good time.*
3. Assignment for thirty days of time to a camp where the following privileges are not available:
a. Television; b. Radio; c. Movies; d. Commissary privileges; e. Handicraft work; f. Use of the regular library; g. Visiting privileges; h. Athletic program; i. Plasma privileges; and j. Free tobacco.
(d) For any offenses after a third offense within a twelve-month period, the punishment will be the same as can be given for a third offense." (Emphasis supplied).

The following disciplinary action was prescribed for *major* violations:

"Whenever an inmate is found guilty of a major violation, he may be subjected to one or more of the following disciplinary actions with the approval of the Superintendent. The disciplinary action taken will be individualized in keeping with such factors as the offender's past history, institutional adjustment, motivation, and attitude. For any offense within a twelve-month period, the maximum punishment is set forth; however, the council may recommend less than the maximum depending on the individual facts and circumstances surrounding the violation.
(a) For a first offense within a twelve-month period:
1. *Seventy-two hours in isolation.*
2. *Loss of six days good time.*
3. Loss of plasma privileges for thirty days.
4. Loss of visiting privileges for one Sunday.
(b) For a second offense within a twelve-month period:
1. *Seventy-two hours in isolation.*
2. *Loss of six days good time.*
3. Loss of plasma privileges for two months.
4. Loss of visiting privileges for one month.
5. *Confinement for a period not to exceed twenty-four hours in the dark hole*, said period of time will be a part of the seventy-two hours that the inmate may be in isolation.

(c) For a third offense within a twelve-month period:
1. *Seventy-two hours in isolation.*
2. *Loss of twenty-four days good time.*
3. Assignment for thirty days of time to a camp where the following privileges are not available:
a. Television; b. Radio; c. Movies; d. Commissary privileges; e. Handicraft work; f. Use of the regular library; g. Visiting privileges; h. Athletic program; i. Plasma privileges; and j. Free tobacco.
4. *Confinement for a period not to exceed twenty-four hours in the dark hole*, said period of time will be a part of the seventy-two hours that the inmate may be in isolation.
(d) For any offense after a third offense within a twelve-month period, the punishment will be the same as can be given for a third offense."

L.Ed.2d 935 (1974), not only puts to rest any doubt regarding the necessity of the revisions in Parchman's disciplinary procedures ordered by the district court here, but also raises the likelihood that even further procedural requisites in Parchman's disciplinary rules could be required by the district court.

The Supreme Court in *Wolff* held that the forfeiture of the state's statutorily created good time credits for serious misbehavior by the inmate must be accompanied by certain minimal due process requirements (though not the full range of procedures mandated in *Morrissey* v. *Brewer*, 408 U.S. 471, 92 S. Ct. 2593, 33 L.Ed.2d 484 (1972) and *Gagnon* v. *Scarpelli*, 411 U.S. 778, 93 S. Ct. 1756, 36 L.Ed.2d 656 (1973) : (1) twenty hours advance written notice of the claimed violation; (2) a written statement of the fact findings as to the evidence relied upon and the reasons for the disciplinary action taken; (3) permitting a restricted right to call witnesses and present documentary evidence in his defense when permitting him to do so will not be unduly hazardous to institutional safety or correctional goals; and (4) allowing illiterate inmates, when the complexity of the issue makes it unlikely that the inmate will be able to collect and present the evidence necessary for an adequate comprehension of the case, to seek the aid of a fellow inmate or another person on the prison staff. The Court sounded the final caveat that its decision at this point was "not graven in stone," but that "as the nature of he prison disciplinary process changes in fuure years, cricumstances may then exist which will require further consideration and reflection of this Court." 418 U.S. 572, 94 S. Ct. 2982.

[24] In addition, for our purposes here, one further segment of the Supreme Court's Wolff decision is noteworthy and applicable. In footnote 19, the Court stated:

"Although the complaint put at issue the procedures employed with respect to the deprivation of good time, under the Nebraska system, the same procedures are employed where disciplinary confinement is imposed. The deprivation of good-time and 'solitary' confinement are reserved for instances where serious misbehavior has occurred. This appears a realistic approach, for it would be difficult for the purposes of procedural due process to distinguish between the procedures that are required where good time is forfeited and those that must be extended when solitary confinement is at issue. The latter represents a major change in the conditions of confinement and is normally imposed only when it is claimed and proved that there has been a major act of misconduct. Here, as in the case of good-time, there should be minimum procedural safeguards as a hedge against arbitrary determination of the factual predicate for imposition of the sanction. We do not suggest, however, that the procedures required by today's decision for the deprivation of good-time would also be required for the imposition of lesser penalties such as the loss of privileges."

This footnote is particularly significant in the instant case for under the new Parchman regulations, prisoners can lose their statutory good-time credits and be subject to solitary confinement for all misconduct violations. *See, infra* n. 14 (p. 1315) where the potential disciplinary action is set out in full. Therefore, we easily conclude that in the instant case since the disciplinary sanction always potentially involves some degree of loss of good-time and/or solitary confinement, the minimum procedural requisites discussed in *Wolff* are required.[15]

The issues thus become (1) whether the district court's order here incorporated all of the procedural requisites mandated in *Wolff* as attendant to disciplinary proceedings involving loss of good time and solitary confinement and (2) whether the procedures actually included in the district court's order were constitutionally required. The district court required the appropriate twenty-four hours written notice of charges and permitted he accused inmate to respond to the charges, but did not allow cross-examinations—all compatible with *Wolff*.

The district court did not, however, demand a written statement of fact finding as to the evidence relied upon and the reasons for the disciplinary action taken, and the 1973 Parchman regulations did not fill the gap regarding the written

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[15] Mississippi in Miss. Code Ann. § 7944 (1971) also has provided statutorily that commutation of time for good conduct shall be granted by the superintendent, i.e., good time credit, and that the following deduction shall be made from the term or terms of sentences:

"Three (3) days per month off of the first year's sentence; four (4) days per month off of the second year sentence; five (5) days per month off of the third year of sentence; six (6) days per month off of the fourth year of sentence; seven (7) days per month off of the fifth year of sentence; eight (8) days per month off of the fourth year of sentence; nine (9) days per month off of the seventh year of sentence; ten (10 days per month off of the eighth year of sentence; eleven (11) days per month off of the ninth year of sentence; fifteen (15) days per month off of the tenth year, and all succeeding years of sentence. A prisoner under two (2) or more cumulative sentences shall be allowed commutation as if they were all one (1) sentence. . . ."

statement. In addition, the 1973 rules, although providing inmates the assistance of a counselor, permitted the counselor to call necessary witnesses for the accused inmate, if *the counselor* deemed their testimony necessary. This appears to run afoul of the *Wolff* requirement that the inmate be allowed to present documentary evidence and call witnesses, if the security of the prison is not jeopardized thereby. Finally, the 1973 Parchman rules only provide for the inmate to have the assistance of an institutional employee counselor, whereas, *Wolff* seems to permit illiterate inmates the choice of seeking the assistance of a few inmate or an institutional staffer in preparation of his defense to disciplinary charges. This is simply exemplary, not exhaustive, analysis of the potential issues to be resolved. For, in any event, at this juncture we simply point out these discrepancies. Since the plaintiff-inmates have not cross-appealed and since the 1973 regulations are not before us for review, we do not reach the issue of what additional requirements could be included in the district court's order under *Wolff's* holding. Also, similar to the mail issue, since the defendant prison officials, although technically appealing the decision in its entirety, have not specifically set forth challenges in their brief to the procedures included in the order, but have implemented regulations incorporating the requirements outlined in the district court's judgment, we do not reach the issue of whether all of the requirements in the judgment were constitutionally compelled. We merely affirm the action taken by the trial court and leave to the parties the initiative in suggesting any further requirements under *Wolff.*

I. Defense of fund shortage: Failure to state a claim upon which relief can be granted

The final catchall plea on appeal is the financial inability to implement the district court's order. Appellants' contention is that the complaint fails to state a claim upon which relief can be granted on the grounds (1) that the state legislature is a necessary party, because none of the named parties defendant can adequately carry out the nature of the relief exacted which requires expending of substantial funds which only the legislature can appropriate, or (2) that the character of the relief granted by the district court has a bearing on whether plaintiffs ever had a cause of action; that is, when relief granted is so severe that it is inappropriate, the relief should influence a decision whether the cause of action ever existed. More specifically, the particular relief to which the appellants object includes the elimination of the armed trusty system, the improvement of physical facilities, the classification of inmates, the implementation of inmate protection procedures and emendation of medical facilities. The appellants claim they do not have the authority nor the funds to recruit, employ, train and equip 150 new employees at an estimated cost of 1.4 million dollars prior to June 20, 1973, nor to construct or renovate the physical facilities. The United States, as appellee-intervenor, views the question similarly; whether the relief granted was within the discretion of the trial court.

Where state institutions have been operating under unconstitutional conditions and practices, the defenses of fund shortage and the inability of the district court to order appropriations by the state legislature, have been rejected by the federal courts. In *Holt* v. *Sarver*, 309 F.Supp. 362 (E.D. Ark.1970), aff'd, 442 F. 2d 304 (8th Cir. 1971), an installment of the Arkansas prison litigation, the district court stated:

"Let there be no mistake in the matter; the obligation of the Respondents to eliminate existing unconstitutionalities does not depend upon what the Legislature may do, or upon what the Governor may do, or, indeed, upon what Respondents may actually be able to accomplish. *If Arkansas is going to operate a Penitentiary System, it is going to have to be a system that is countenanced by the Constitution of the United States.*" 309 F. Supp. at 385. (Emphasis supplied).

See Watson v. *City of Memphis*, 373 U.S. 526, 537, 83 S. Ct. 1314, 1321, 10 L.Ed. 2d 529 (1963) (". . . vindication of conceded constitutional rights cannot be made dependent upon any theory that it is less expensive to deny [them] than to afford them."—desegregation of public parks); *Rozecki* v. *Gaughan*, 459 F. 2d 6, 8 (1st Cir. 1972) ("Humane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations."—prison heating system); *Jackson* v. *Bishop*, 404 F. 2d 571, 580 (8th Cir. 1968) ("Humane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations . . ."—rehabilitative devices); *Hamilton* v. *Love*, 328 F. Supp. 1182, 1194 (E.D.Ark.1971) ("Inadequate resources can never be an adequate justification for the state's depriving any person of his constitutional

rights,"—pre-trial detention unit). On the contrary, appellants cite no cases in support of their contention that the relief fashioned by the trial court cannot be granted.

It seems that the most onerous aspect of the district court's judgment, as far as the State of Mississippi is concerned, is that compliance will cost the State a considerable amount of money. *But the district court did not require that the legislature appropriate monies for prison reform; it simply held, in keeping with a plethora of precedent on the fund shortage problem, that if the State chooses to run a prison it must do so without depriving inmates of the rights guaranteed to them by the federal constitution.* Mississippi wants this Court to hold that the conditions described in the district court opinion should be allowed to continue until funds needed to correct them are available and the Legislature acts on appropriations. This position is unsupported by the law and even more untenable in light of the fact that one million dollars has already been made available by LEAA, to meet some of the most pressing needs including installation of facilities to alleviate immediate health and safety hazards, the employment of additional guards, and installation of necessary sanitary facilities. In addition, we have recognized the power of the district court to prescribe remedial relief in the area of medical and physical facilities, but have refrained at this stage from delineating precisely what innovations would be constitutionally compelled. However, that determination, if eventually necessary to be made, will focus on what are the minimal constitutional health standards to be supplied and not on what funds are available to operate the prison. Furthermore, even the Mississippi legislature has called for the elimination of the trusty system by July 1, 1974, and we also have held that the trusty system, as constituted and practiced at Parchman, effected cruel and unusual punishment in contravention of the Eighth Amendment.

[25, 26] Therefore, we cannot agree that the relief here granted was impermissible. Having found these numerous constitutional violations, which were even conceded by the appellants, the court had the duty and obligation to fashion effective relief. In such circumstances, the trial court is allowed wide discretion. "Once a right and a violation have been shown, the scope of a district court's equitable powers to remedy past wrongs is broad, for breadth and flexibility are inherent in equitable remedies." Swam v. Board of Educ., 402 U.S. 1, 15, 91 S.Ct. 1267, 1276, 28 L.Ed. 2d 554 (1971). The relief ordered by the trial court was tailored to alleviate the deplorable practices and conditions at Parchman. Shortage of funds is not a justification for continuing to deny citizens their constitutional rights.

J. Change of officials

[27] The appellants contend that because individuals who are presently Governor, Superintendent and members of the Penitentiary Board are not the same individuals holding these positions when this suit was commenced, they are not now subject to the trial court's order. That the individuals now holding those offices may not be the same as those in office when this suit was commenced is immaterial for purposes of this appeal since the defendants were sued in their official, not their individual capacities, and it is only in their official capacities that they are constrained by the district court's order to act. In addition, the complaint was not only filed against the named individuals, but also against "their successors."

K. Good faith actions warrant setting aside judgment?

Lastly, the appellants urge that their good faith actions in initiating the ordered reforms at Parchman, following entry of the district court's order, make the harsh and extensive order of the district court now inappropriate. It is pointed out that steps are underway to improve the prison facilities and that the Governor and other state officials have pledged to create a model prison. The appeal to this Court is that since improvements are being implemented in the condition and operation of Parchman, the order of the district court should be set aside and "the defendants should be left to operate their own state prison."

[28, 29] Changes made by defendants after suit is filed do not remove the necessity for injunctive relief, for practices may be reinstated as swiftly as they were suspended. In United States v. Oregon State Medical Society, 343 U.S. 326, 333, 72 S.Ct. 690, 695, 96 L.Ed. 978 (1952), the Supreme Court stated:

"When defendants are shown to have settled into a continuing practice . . . courts will not assume that it has been abandoned without clear proof. . . . It is the duty of the courts to beware of efforts to defeat injunctive relief by protesta-

tions of repentance and reform, especially when abandonment seems timed to anticipate suit, and there is probability of resumption."

The past notoriety of the protracted inhumane conditions and practices at Parchman reveals the necessity for the continuance of the injunctive order of the district court. It is significant that the improvements made at Parchman were not undertaken until after the filing of this suit. Although good faith may be relevant in determining whether defendants have complied with the order of the court, it certainly is not a ground upon which to seek moification of that order.

While recognizing that steps have been taken, since the filing of this suit, to improve conditions at Parchman, it is evident that much is left to be done before Parchman is operated in accord with the constitutional requirements set out in the district court's judgment. In fact, it is noteworthy that on August 22, 1973, the court found it necessary to establish the office of federal court monitor to check all the phases of prison administration, management and operation of Parchman and to determine the degree of compliance with provisions of its order dated October 20, 1972. The appointment of a federal monitor, based upon inmates' motion alleging civil contempt by the state in failing to comply with the order, certainly casts doubt upon the good faith compliance asserted by the defendants.

[30] As a final resort the appellants, listing a number of quotations, assert that federal courts should not meddle in the internal affairs of state prisons and that matters of prison administration are to be left to the states, not dictated by federal courts. But this is not a situation where minutiae of prison administration are at issue. This case was submitted on an agreed record with gross constitutional violations admitted. The prompt and peremptory response of the district court to these issues was totally justified and was within its broad discretion and power to fashion equitable remedies. That it may be inconvenient or more expensive for the State of Mississippi to run its prison in a constitutional fashion is neither a defense to this action or a ground for modification of the judgment rendered in this case.

IV. CONCLUSION

Based upon the court's exhaustive investigation of the operation of Parchman, it properly conducted a special hearing on the proper forms and measure of relief to be granted, and then realistically composed part of the remedy as (A) immediate and intermediate relief, and fashioned another segment of the remedy as (B) long range relief. In view of the lengthy analysis by the district court, we adopt the court's findings of fact and conclusions of law as our own and affirm the judgment.

Judgment affirmed.

[APPENDIX 32]

Cite as 376 F. Supp. 402 (E.D. Okla. 1974)

Bobby Battle, Plaintiff, United States of America, Plaintiff-Intervenor,

v.

Park J. Anderson, Warden et al., Defendants.

Civ. No. 72-95.

United States District Court,
E. D. Oklahoma.
May 30, 1974.

Prisoner at state penitentiary brought action to remedy alleged misconduct of prison officials and for monetary damages. The United States intervened. The District Court, Bohanon, J., held that automatic detention of inmates in punishment areas for alleged disciplinary infractions prior to disciplinary hearings denied due process; that use of chemical agents as a punitive measure rather than as a control device was violative of prohibition against cruel and unusual punishment; that confinement of inmates in dark, unventilated and unsanitary isolation cells without means of metal or emotional diversion would constitute cruel and unusual punishment if imposed for prolonged periods; that

level of medical care available to inmates was inadequate to meet health care needs and was violative of proscription against cruel and unusual punishment and denied due process; that restrictions on free flow of information to inmates in the form of general circulation newspapers and magazine was violative of First Amendment; and that policy of denying inmates, including Muslims, the opportunity to gather together for corporate religious services was not justified.

Order accordingly.

1. Constitutional Law ⚷223

State policy or practice of racial segregation in the operation of detention facilities denies equal protection. U.S.C.A..Const. Amend. 14.

2. Prisons ⚷13

Racial segregation of correctional facilities cannot be justified on the basis that integration may result in inmate violence. U.S.C.A.Const. Amend. 14.

3. Constitutional Law ⚷223

Racial discrimination in any aspect of prison administration is prohibited by equal protection clause. U.S.C.A.Const. Amend. 14.

4. Prisons ⚷4

Privileges must be afforded equally to prisoners of all races and prison officials may not discriminate on the basis of race when making job assignments or administering discipline. U.S.C.A.Const. Amend. 14.

5. Civil Rights ⚷13.2(1)

Cessation of segregation in housing of inmates of state penitentiary, subsequent to filing of inmate's suite for alleged misconduct of prison officials, because of emergency conditions resulting from prison riot did not preclude injunctive relief against such segregation in light of prolonged practice of segregation prior to riot in contravention of stated policy, uncertainty of postriot conditions and importance of rights at stake. U.S.C.A.Const. Amend. 14.

6. Constitutional Law ⚷272

Due process clause proscribes any serious disciplinary sanctions against state prison inmate unless he is found to have violated written rules which are adequately promulgated prior to the commission of the infraction charged and which describe punishable conduct with reasonable precision. U.S.C.A. Const. Amend. 14.

7. Constitutional Law ⚷272

Summary punishment of state prison inmates for alleged disciplinary infractions denies due process; serious disciplinary sanctions may not be imposed on inmates without hearing and official written notice of specific charges a reasonable time prior to hearing. U.S.C.A.Const. Amend. 14.

8. Prisons ⚷4

Detemination of prison officials to impose serious disciplinary sanctions on prisoners must be made by an impartial decision maker. U.S.C.A.Const. Amend. 14.

9. Prisons ⚷4

Impartial disciplinary tribunal which must determine whether to impose serious disciplinary sanctions on prisoners may not abdicate sentencing responsibility by permitting line officers to determine length of confinement for disciplinnary infractions.

10. Constitutional Law ⚷272

Indefinite "lockup" sentences imposed for infraction of prison disciplinary rules deny due process unless there is regular, meaningful and independent review reasonably designed to enable disciplinary tribunal or some other responsible and disinterested administrative official or body to make its own determination regarding duration of confinement. U.S.C.A.Const. Amend. 14.

11. Prisons ⚷13

Imposition of significant additional restrictions or sanctions on prison inmates who have already been placed on disciplinary "lockup" requires same procedural safeguards as apply at time of original punishment. U.S.C.A.Const. Amend. 14.

12. Constitutional Law ⚷272

Automatic detention of inmates in punishment area for alleged violations of prison disciplinary rules prior to disciplinary hearings denies due process. U.S.C.A.Const. Amend. 14.

13. Prisons ⚷13

Inmates who are charged with disciplinary infractions should be segregated from general prison population only if reasonable basis exists therefor, e.g., their continued presence in general population status poses actual threat to security of the institution, and then only for reasonable time until disciplinary committee can convene to hear case.

14. Prisons ⚷4

Practice of having disciplinary committee meet weekly to determine whether inmates charged with disciplinary infractions should be punished was not adequate; such hearings should be held as soon as is practicable under the circumstances.

15. Prisons ⚷13

Detention in punishment area prior to disciplinary hearing of prison inmate who has allegedly committed infraction of prison disciplinary rules in excess of 48 hours, or 72 hours on weekends, is presumptively unreasonably sufficient extenuating circumstances.

16. Constitutional Law ⚷272

Even where confinement of prison inmate under punitive conditions is denominated and processed as an administrative rather than a disciplinary matter, indefinite confinement under such conditions without standards or criteria and without standards or criteria and without minimal procedural safeguards denies due process. U.S.C.A. Const. Amend 14.

17. Constitutional Law ⚷270, 272

Prohibition against cruel and unusual punishment was applicable to state through due process clause. U.S.C.A. Const. Amends. 8, 14.

18. Criminal Law ⚷1213

Parameters of prohibition against cruel and unusual punishment are not rigidly defined but are discernible only in the context of specific factual situations. U.S.C.A.Const. Amend. 8.

19. Criminal Law ⚷1213

Prohibtion against cruel and unusual punishment is applicable to general conditions of confinement in prisons as well as to specific acts directed at selected individuals. U.S.C.A.Const. Amend. 8.

20. Prisons ⚷4

Use of chemical agents to punish inmates constituted "corporal punishment" within statute proscribing the use of such punishment, 57 Okl.St.Ann. § 31.

See publication Words and Phrases for other judicial constructions and definitions.

21. Criminal Law ⚷1213

Use of corporal punishment on state prison inmates constitutes cruel and unusual punishment, at least in a state where state law clearly proscribes its use. 57 Okl.St.Ann. § 31.

22. Criminal Law ⚷1213

Use of chemical agents against state prison inmates as a punitive measure rather than as a control device was violative of prohibition against cruel and unusual punishment. U.S.C.A.Const. Amend. 8; 57 Okl.St.Ann. § 31.

23. Civil Rights ⚷13.13(1)

Evidence that chemical agents had been employed unnecessarily in state prison, or with justification but in excessive amounts, permitted inference that such agents had been used as a punitive measure in violation of prohibition against cruel and unusual punishment rather than as a control device. U.S.C.A.Const. Amend. 8; 57 Okl.St.Ann. § 31.

24. Criminal Law ⚷1213

Solitary confinement of prison inmate does not constitute "cruel and unusual punishment" per se but such confinement may constitute cruel and unusual punishment if it is maintained in a manner fairly characterized as foul, inhuman, and violative of basic concepts of human decency. U.S.C.A. Const. Amend. 8.

See publication Words and Phrases for other judicial constructions and definitions.

25. Criminal Law ⚷1213

Confinement of state prison inmates in subterranean isolation area in which personal hygiene was impossible due to lack of materials necessary for personal sanitation and the inability to properly dispose of bodily waste constituted cruel and unusual punishment. U.S.C.A. Const. Amend. 8.

26. Criminal Law ⚷1213

Confinement of prison inmates in dark, unventilated and unsanitary isolation cells without any means of mental or emotional diversion constitutes cruel and unusual punishment if imposed for prolonged periods. U.S.C.A. Const. Amend. 8.

27. Prisons ⚷13

Inmates held in segregation from general prison population for security or other nondisciplinary reasons must be provided as many of the privileges enjoyed by the general prison population as the nature of their confinement allows.

28. Criminal Law ⚷1213

Confinement of state prison inmates to their cells for period of up to one year following riot at prison and subjection of inmates to continual and enforced idleness without affording any opportunities for physical exercise, voluntary work or educational programs was violative of prohibition against cruel and unusual punishment. U.S.C.A. Const. Amend. 8.

29. Prisons ⚷17

Inmates have basic right to receive needed medical care while they are confined in prison.

30. Prisons ⚷17

Prison officials have affirmative duty to make available to inmates a level of medical care which is reasonably designed to meet the routine and emergency health care needs of inmates.

31. Constitutional Law ⚷272
Criminal Law ⚷1213

Failure to provide prison inmates with level of medical care necessary to meet predictable health care needs was violative of prohibition against cruel and unusual punishment and subjected inmates to disabilities beyond those contemplated by incarceration in violation of due process clause. U.S.C.A. Const. Amends. 8, 14.

32. Constitutional Law ⚷91

Inmates of state prison had preferred constitutional right to correspond with attorneys, courts and government officials for the purpose of petitioning government and the courts for the redress of grievances and the confidentiality of such correspondence could not be arbitrarily denied by prison officials.

33. Prisons ⚷4

Practice of limiting confidential treatment of prison inmates' correspondence to correspondence with one attorney for each inmate, state courts and state government officials and not extending such treatment to correspondence with federal counterparts constituted an arbitrary and unreasonable intrusion upon inmates' right to freely petition their government and the courts.

34. Prisons ⚷4

To be valid, prison mail censorship must further an important governmental interest unrelated to the suppression of speech and mode of censorship must result in limitations which are no greater than are necessary or essential to the protection of the particular governmental interest involved.

35. Constitutional Law ⟹90.1(1)

Prison mail regulations which automatically limit inmates to personal correspondence with a fixed number of immediate family members work an arbitrary and unconstitutional prior restraint on protected speech of both inmates and their "freeworld" correspondents.

36. Constitutional Law ⟹90.1(1)

Policy of state prison officials of intercepting, censoring and rejecting incoming and outgoing inmate correspondence based oon unwritten and/or ill-defined prohibitions against "improper language" or "gossip," including "false statements to any correspondents," was overboard on its face and, as applied, infringed upon protected speech of inmates and their "freeworld" correspondents.

37. Constitutional Law ⟹90.1(1)

Restriction and censorship of prison mail deprived both inmates and their "freeworld" correspondents of the "liberty" of free speech whether based upon identity or characteristics of the correspondents.

38. Constitutional Law ⟹272

Due process requires that determination to censor correspondence of inmates be based on facts rationally determined pursuant to such procedures as are necessary to insure fairness, including notice to interested correspondents and reasonable opportunity to protest censorship decision to a prison official other than person who originally has disapproved correspondence. U.S.C.A. Const. Amend. 14.

39. Constitutional Law ⟹90.1(1)

Restrictions on the free flow of information to prison inmates in the form of general circulation newspapers and magazines denied First Amendment rights of such inmates, absent showing that such restrictions are reasonably necessary to the preservation of security, good order or discipline within the penitentiary or to the rehabilitation of inmates. U.S.C.A. Const. Amend. 1.

40. Prisons ⟹4

When prison officials conclude that effective security, good order or rehabilitation require censorship of general circulation newspapers and magazines, basis for determination with respect to each objectionable publication must be provided to each inmate who seeks to obtain it, including written notice setting forth relevant facts with respect to particular publication, and inmates must be provided a reasonable opportunity to submit additional facts and views to decision maker before such determination becomes final.

41. Prisons ⟹4

Actual, final decision to exclude specific issue of any general circulation publication from prison must be made by warden or deputy warden who must prepare and retain on file a detailed statement of specific basis for each such exclusion for any jurisdictional court review.

42. Constitutional Law ⟹328

Prisoners, no less than other persons, have constitutional right of access to the courts.

43. Constitutional Law ⟹328

To be meaningful, prisoner's right of access to courts must include means to frame and present legal issues and relevant facts effectively for judicial consideration.

44. Prisons ⟹4

Prison officials have affirmative duty to provide inmates with necessary means for obtaining access to courts.

45. Constitutional Law ⟹328

State prison law library, which was so lacking in legal reference books and publications as to constitute no library at all, and legal assistance program whereby only law librarian who was frequently not available could provide legal assistance to inmates failed to provide state prison inmates with constitutionally adequate access to courts.

46. Constitutional Law ⚷328

Requirement that prison officials provide state prison inmates with necessary means for obtaining access to courts extended to insuring adequate access with respect to at least habeas corpus actions, civil rights actions and out-of-time appeals. 42 U.S.C.A. § 1983.

47. Prisons ⚷4

State may not prohibit inmate self-help or mutual inmate assistance in legal matters unless it provides inmates with some reasonable alternative means of protecting their right of access to the courts.

48. Prisons ⚷4

Where precepts of a religious sect call for its adherents to engage in a religious practice which does not present a threat to the security, discipline and good order of prison, state has burden of justifying policies or practices which prevent inmate adherents from engaging in such religious practices. U.S.C.A. Const. Amend. 1.

49. Prisons ⚷4

State prison officials' policy of denying inmates, including Muslims, the opportunity to gather together for corporate religious services was unjustified. U.S.C.A. Const. Amend. 1.

50. Constitutional Law ⚷84

Prison officials' refusal to provide food free of pork and pork by-products to Muslim inmates whose religion required that they abstain from such food was violative of inmates' right to religious freedom. U.S.C.A. Const. Amend. 1.

51. Constitutional Law ⚷84

Prison officials who sought to proscribe religious publications, including Muslim literature, from being distributed within prison had burden of showing that such publications presented threat to the security, discipline and good order of prison that could not be overcome other than by excusion. U.S.C.A. Const. Amend. 1.

52. Prisons ⚷4

Prison officials' proscription against distribution of Muslim publications within prison was unjustified absent showing that such publications presented threat to the security, discipline and good order of the institution that could not be overcome other than by exclusion. U.S.C.A. Const. Amend. 1.

53. Civil Rights ⚷13.16

District court in which inmate brought action challenging alleged misconduct of prison officials had authority and responsibility to order cessation of all violations of federal constitutional and civil rights and the rights and privileges secured by the laws regulations and policies of the state. 28 U.S.C.A. § 1343(3, 4).

54. Civil Rights ⚷13.16

Notwithstanding grossly offensive conditions in treatment of inmates at state penitentiary, district court in which prisoner brought action challenging prison officials' alleged misconduct had discretion to refrain from entering any order that would require, or have effect of requiring, the closing of the penitentiary.

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Jesse H. Queen, Quinlan J. Shea, Jr., Thomas R. Sheran, Charles N. Ory and Margie A. Utley, Dept. of Justice, Washington, D.C., for plaintiff-intervenor, United States.

Paul Crowe, Kay Karen Kennedy and Kenneth Deleshaw, Jr., Assistant Attorneys General, Oklahoma City, Okla., for defendants, Leo McCracken, Roy Sprinkle, Sam C. Johnston, Captain Black, Danny Nace and Otis P. Campbell.

Willard Gotcher, McAlester, Okla., for defendant, Park J. Anderson.

MEMORANDUM OPINION

JUDGMENT, DECREE, INJUNCTION AND ORDER FOR REMEDIAL ACTION

BOHANON, District Judge.

Preliminary statement

This case was initiated on April 24, 1972, with the filing of a *pro se* complaint by Bobby Battle, a prisoner at the Oklahoma State Penitentiary.

On July 27, 1972, plaintiff Battle filed an amended complaint on behalf of himself and other inmates of the Oklahoma State Penitentiary alleging deprivations of rights secured by the Federal Constitution and Civil Rights laws including the rights to due process and equal protection of the laws, to free speech, to petition for the redress of grievances, to have access to the courts and to be free from cruel and unusual punishment. The complaint seeks injunctive relief, on behalf of all members of the plaintiff class, to remedy the alleged misconduct of the defendants as well as monetary damages for plaintiff Battle.

Named as defendants were Leo McCracken, Director of Corrections, Park J. Anderson, Warden, and Sam C. Johnston, Deputy Warden of the State Penitentiary at McAlester. Since the commencement of this action, Leo McCracken has been replaced by John Grider, who now serves as Acting Director of Corrections, and Park J. Anderson has been replaced by Sam C. Johnston, who now serves as Acting Warden of the State Penitentiary at McAlester, and Mr. Pete Douglas has replaced Sam C. Johnston as Acting Deputy Warden. Mr. Roy Sprinkle, Deputy Director of Corrections in charge of Institutions, Captain Black, Danny Nace and Otis Campbell, Correctional Officers at the State Penitentiary, have been added as defendants.

On March 15, 1973, the late Judge Edwin Langley granted the United States' Motion to Intervene pursuant to Title IX of the Civil Rights Act of 1964, 42 U.S.C. § 2000h–2. The complaint in intervention alleged segregation by race in housing assignments and certain other aspects of penitentiary operations.

On March 5, 1974, the Court granted the United States' motion to amend its compaint in intervention which now alleges, in addition to the allegations of the original complaint in intervention, that the defendants have discriminated against black inmates in making job assignments and the operation of the penitentiary disciplinary system; and that they have, with regard to all inmates of the Oklahoma State Penitentiary, without regard to race, subjected them to disciplinary procedures and taken disciplinary action against them without providing due process of law; subjected those inmates in disciplinary segregation to cruel and unusual punishment by depriving them of food, clothing, bedding, light and necessary personal hygiene items; placed inmates in non-disciplinary administrative segregation without providing them with due process of law and subjected them to unreasonable conditions of confinement; inflicted upon inmates summary punishment without due process of law and cruel and unusual punishment by the use of chemical agents, including mace and tear gas; inflicted upon inmates cruel and unusual punishment by maintaining and operating a medical care delivery system that is incapable of providing and has failed to provide adequate medical care; imposed upon inmates arbitrary and unreasonable restrictions on mailing privileges, including censorship and rejection of mail to and from attorneys, courts, government officials, family members and religious ministers; refused inmates the right to subscribe to or receive personal legal reference materials, as well as certain other periodicals; and denied inmates adequate access to the courts by failing to provide an adequate law library or any reasonable and adequate alternative thereto and by specifically refusing to permit inmates to have in their possession any personal legal reference materials or to assist each other on legal problems.

The parties have conducted extensive pretrial discovery consisting of depositions, inspections and investigations conducted by attorneys, FBI agents and experts in penology.

At the final pretrial conference held on March 4, 1974, counsel orally stipulated and agreed and the court ordered that all depositions taken prior to trial be admitted into evidence and made a part of the record.

Trial on the merits was heard at McAlester, Oklahoma, on March 14 and 15, 1974. At the outset, counsel for all parties stipulated and agreed to the authen-

ticity of copies of documents marked exhibits 1 through 161 and contained in 18 bound volumes previously tendered to counsel and the court by the United States. It was further stipulated and agreed and the court ordered that the said exhibits be admitted into evidence and made a part of the record in this case.

Upon the basis of the depositions and exhibits and the oral testimony heard at the trial of this case and the case of Holland et al. v. Anderson (No. 73–324) heard on March 12, 1974, and the consolidated cases of Barnett et al. v. Hall (No. 73–237), Johnson v. Anderson (No. 74–8), Barnett et al. v. Pontesso (No. 70–97) and Johnson et al. v. Anderson (No. 72–90) heard on March 13, 1974, the court makes its findings of fact and conclusions of law as follows:

Findings of fact

1. The Oklahoma State Penitentiary system consists of a main maximum security facility at McAlester and several subsidiary institutions located at McAlester and other locations throughout the southeastern and western portion of Oklahoma. These subsidiaries include a dual unit women's ward and a male trusty unit which are also located at McAlester; a medium security vocational training school located at Stringtown, Oklahoma, about 40 miles south of McOlester; a smaller minimum security facility for vocational training located near Hodgens, Oklahoma; and an Honor farm near Farris, Oklahoma.

2. The Oklahoma State Penitentiary System was established by law for the purpose of housing persons committed to the custody of the Department of Corrections under the administrative direction and control of the Division of Institutions, Title 57 O.S.A. § 509.

3. The Board of Corrections, composed of seven members appointed by the Governor, appoints the Director of the Department of Corrections. The Board has statutory authority to establish policies for the operation of the Department. Title 57 O.S.A. §§ 503. 504. The Director of the Department of Corrections is vested by statute with the authority and responsibility for the operation of all facilities within the department, for prescribing rules pertaining to the management of said institutions and for the control, care and treatment of inmates remanded to the custody of the Department of Corrections. Title 57 O.S.A. §§ 507 and 510. Such rules, when reduced to writing, are customarily promulgated in the form of departmental policy statements, but may also be issued in the form of operations memoranda.

The Deputy Director of Corrections in charge of Institutions is appointed by the Director and is charged with the administrative responsibiilty for the operation of all facilities within the Department of Corrections. Title 57 O.S.A. §§ 508, 509.

The Warden of the Oklahoma State Penitentiary at McAlester is vested by statute with the responsibility for performing all duties pertaining to the penitentiary as are fixed by the Director of Corrections. Title 57 O.S.A. § 510. The established duties of the Warden include supervisory responsibility for the government and operation of the Oklahoma State Penitentiary at McAlester, Oklahoma, and its subsidiary units. Written rules issued pursuant to the authority of the Warden are promulgated in the form of memoranda, directives, etc.

4. All persons convicted of felonies and sentenced by duly constituted courts of the State of Oklahoma to a term of imprisonment which is not to be served in a county jail are committed to the custody of the Oklahoma Department of Corrections to be confined in one of the facilities subject to the jurisdiction of the Department. Title 57 O.S.A. § 521.

5. Between January, 1970 and July 27, 1973, the total population in the penitentiary system averaged about 2,990 male and 120 female inmates. The largest concentration of inmates in the system was "behind the walls" at the main facility at McAlester.

6. On July 27, 1973, a riot occurred at the McAlester facility which resulted in the destruction of some physical facilities and damage to others. Following the riot, many programs, procedures, practices and operations that had been in effect at the penitentiary were either eliminated or curtailed. The general inmate population was placed on a twenty-four-hour lockdown which continued with only minor modifications at the time of the trial in this case. Numerous examples could be cited from the record of practices and conditions which were justified as emergency measures in the immediate aftermath of the riot and even for some time thereafter, but which were still in substantial effect at the time of the trial of this case, long after their justification had ended.

7. During the 7 months of 1973 prior to the riot, the inmate population at the main facility averaged about 1,778 or 57 percent of the total penitentiary population. The racial composition of the population at the main facility averaged 29.5 percent Black and 70.5 percent non-Black inmates. Many of these inmates were transferred to subsidiary institutions and to municipal and county holding facilities and commitments to McAlester were suspended following the riot. The population at McAlester dropped to 1,338 in August 1973, and after several additional reductions has leveled off at approximately 900 inmates since the first of this year.

8. Prior to the riot, the facilities at the main penitentiary consisted of an administration building, four general population cellhouses and a mess hall radiating from a central rotunda, a maximum security unit and combination hospital-gymnasium and a series of industrial and maintenance buildings, some of which were located in the "industrial area" north of the main walls. Two of the general population cellhouses were constructed in 1907. The third and fourth units were added in 1932 and 1935. The design capacity of the penitentiary was approximately 1,200.

9. The civilian staff level of about 350 at the main McAlester facility has remained fairly constant. Out of this total civilian staff, about 242 have been employed as security personnel holding the rank of Correctional Officer I (about 160 men); Correctional Officer II (about 65 men); Correctional Officer III or Lieutenant (about 11 men); and Correctional Officer IV or Captain (about 6 men). Under the normal conditions as they existed before the riot, the security staff provided 24 hours, 7 day a week supervision and surveillance over the cellhouses, lockup areas, guard towers and hospital complex. The staff also provided daytime supervision and surveillance over the work areas (industrial, maintenance and administrative), the yard and special inmate work gangs. They also supplied the supervision required for the transfer of inmates to other Oklahoma penal facilities, to outside medical facilities and to the courts. Their post-riot activities have generally consisted of carrying out such security functions as were deemed necessary, from time to time, by penitentiary authorities.

10. The security force at the Oklahoma State Penitentiary at McAlester is understaffed and spread far too thin. The continuing deficiencies in needed personnel have been at least 30 to 35 percent less than the level required to maintain adequate supervision and control. This limited staff is inadequately trained and poorly supervised. There is a high turnover among correctional officers; the monthly rate reaching 8 to 9 percent, particularly among lower echelon security personnel. Proper training may well be impossible with this shortage of personnel accompanied by such a continuing turnover rate.

The available security force is simply inadequate to maintain proper order and carry on even minimally effective corrections operations. Staffing deficiencies have been a causative factor in the conditions which existed and still exist at the penitentiary. The level of violence inside the penitentiary has been alarming. From January 1970 until July 27, 1973, defendants' own records reflect a total of 19 violent deaths. In addition, there were 40 stabbings and 44 serious beatings of inmates. Some of the violence occurred in the cellhouses where frequently only one guard was available for an entire cellhouse. Some violence occurred on the prison yard where frequently only one or two guards were available to supervise and control the entire general population.

11. Since the riot, lack of adequate security has been used continuously as an excuse for the confinement of the majority of inmates in their cells 24 hours a day, in complete idleness and without any form of exercise or other recreation. As previously indicated, this massive and almost total lockdown has continued for over 8 months, with the limited exception that inmates not confined in disciplinary maximum security have recently been granted the meager privilege of eating one or two meals in the mess hall every other day provided adequate security is available. Only a limited number of inmates are regularly permitted out of their cells to perform penitentiary maintenance and housekeeping chores such as preparing food and repairing or maintaining the physical complex.

Racial discrimination and segregation

12. Prior to the July riot, the policy and practice at the Oklahoma State Penitentiary was to maintain a prison system segregated by race and by means of which black inmates were subjected to discriminatory and unequal treatment. Except for the maximum security unit, where inmates under disciplinary punishment were confined in single cells, all inmates were routinely assigned to housing

units on the basis of race. The reception center, the mess hall, the recreation yard and barber facilities were racially segregated. Black inmates were discriminated against in job assignments and were subjected to more frequent and disparate punishment than white inmates. The guard force was and remains predominantly while. A policy statement issued by the Department of Corrections on October 20, 1972, declared the official departmental policy to be that all of its correctional facilities would be integrated in order to insure equal rights and equal opportunity to all persons confined therein. This policy statement also directed correctional administrators to formulate, implement and follow up procedures to insure that discrimination did not occur in practice. The need to increase minority personnel at every level was made clear and it was suggested that each correctional facility appoint an official to be directly responsible for supervising the recruitment and fair treatment of minority employees. A departmental operations memorandum issued on the same date set forth specific requirements for the implementation of the departmental policy statement. Wardens at each state penal facility were directed to prepare plans for complete integration, to take immediate action to inform and instruct all employees regarding the official policy on racial segregation and of their obligations thereunder, to implement an objective and fair classification system for inmates with respect to all aspects of institutional life, to inform the inmates of the racial segregation policy, and to make telephonic progress reports each Monday morning to the Deputy Director of Institutions or the Director of the Department of Corrections detailing the percentages of integration at each location and any major problems encountered. Both the policy statement and accompanying operations memorandum were completely ignored by the Warden at the Oklahoma State Penitentiary at McAlester. Racial segregation, as had been practiced prior to the issuance of these directives, continued unabated. Not until the July riot did any noticeable changes occur. Only at that time, operating under emergency conditions, were inmates randomly lined up and ordered into cells. At the present time the housing units are not racially segregated. Due to perceived emergency conditions the prison population is temporarily confined to single cells under 24 hour lockdown. The defendants have instituted a security classification system under which inmates are assigned either a medium, maximum, or close custody grade and separated into various housing units according to their respective classifications. The new grading system does not, however, provide for specific cell assignments and transfers on a non-racial basis. Accordingly, there is no present assurance that housing units will not become resegregated when normal operations are restored.

Disciplinary rules, punishment and procedure

13. Prior to the July 27, 1973, riot, defendants administered a disciplinary program which could result in punitive sanctions including punitive segregation as well as loss of incentive time and other privileges. These sanctions were imposed pursuant to a disciplinary process which is described in departmental policy statements and in the most recent inmate manual. Viewing the disciplinary process as a whole, to include both policies and practices, defendants have failed to afford inmates the procedural safeguards which are minimally necessary to insure fundamental fairness. The record discloses the following:

(a) Inmates are not fairly adequately apprised of the conduct which can lead to disciplinary action. Some, but not all, punishable conduct is contained in various rule books and manuals. There is, however, no policy limiting punishment to listed infractions; some infractions are specified in employee manuals, but excluded from inmate rule books; some of the most common, minor infractions are nowhere listed or defined although punishment routinely results in the event of violations. In some instances, inmates have been punished for violating unwritten rules against constitutionally protected activity (*e.g.*, assisting or being assisted by one another in legal matters in the absence of reasonable alternatives).

(b) In the event that disciplinary charges are filed, the applicable Department of Corrections policy statement provides for pre-hearing detention in "serious cases" only. It was formerly the official O.S.P. practice to segregate only those charged with "major" offenses, as described in the employee manual. This practice was later changed by O.S.P. officials, and, thereafter, all inmates charged with any rule infraction(s) were automatically confined in segregation, prior to a hearing, in the punishment work gang lockup area located in New Cellhouse or the new jail in the West Cellhouse. Because the Disciplinary Committee usually

met only once a week, inmates could routinely be held in segregation for up to six days without a hearing, regardless of the seriousness of the offense charged. Inmates have in fact been so held for up to six weeks before receiving their hearings.

(c) The Department of Corrections has published rules governing the procedures to be followed at disciplinary hearings. They do not require, however, that the disciplinary committee be comprised of disinterested persons. In practice, hearings have been and are held on occasion before committees with a member or members who have either brought the charges against the inmate or otherwise participated in the preparation or processing thereof.

(d) The official policy is to afford inmates a prehearing interview and an opportunity to appear and be heard at the hearing itself. Inmates are, however, denied the right to call witnesses on their own behalf or to confront and cross-examine adverse witnesses. No representation is provided by the institution and outside assistance from counsel or any other source is prohibited.

(e) There are no departmental rules, criteria or standards governing the type or duration of punishment which the disciplinary committee may impose for any given infraction. It has been the policy and practice at the penitentiary to impose indefinite sentences to the various lockup facilities. As a result of this practice, inmates have in fact often been held on punitive segregation for prolonged terms (which frequently reached six months to a year) under extremely harsh restraints and conditions.

(f) It is the written policy of the Department of Corrections to afford a weekly review of all persons on lockup by the Deputy Warden or his designee. The Standard to be applied and the procedures to be followed during these review sessions are not, however, set forth. In practice, there is no meaningful independent review by the Deputy Warden or other high-ranking, responsible administrative officer or panel. Instead, the responsibility for determining length of confinement has been abdicated to the correctional officers in charge of the individual lockups.

(g) The officer in charge of the Maximum Security Unit has been permitted to punish inmates summarily, without a hearing or any other procedural safeguards for conduct which takes place in the unit. Accordingly, inmates have had the minimal privileges afforded on M.S.U. further reduced for conduct deemed objectionable by the officers in charge. Similarly, inmates may be transferred to one of several isolation cells on M.S.U. at the sole discretion of the officer in charge, without any procedural safeguards other than the informal requirement that the Deputy Warden or chief of Security be notified.

14. Inmates confined in disciplinary lockup, particularly in the Maximum Security Unit, have been held for prolonged periods in close confinement. Exercise was limited to 15 minutes twice a week prior to the riot. Since that time all exercise was being denied as recently as the date of this trial. Sleeping accommodations consist of mattresses placed directly on the floor or on a concrete slab. There were and are no beds. The cells are vermin infested. Lighting throughout the lockup areas was and is inadequate.

The isolation cells have the same dimensions and fixtures as other M.S.U. cells. They are, however, sealed off from the rest of the unit by a dividing wall. These isolation cells have only a small window or "bean hole" which can be closed to isolate the occupant completely and to seal out all light and ventilation. Such inmates receive no exercise, reading material or any other form of recreation.

Inmates who were sentenced to that form of disciplinary status officially referred to as "72 hour detention," were deprived of food, clothing, bedding and necessary hygienic materials and confined in cells generally known and commonly referred to as "hole" cells. These are totally dark and stripped of all fixtures other than latrines and faucets. Penitentiary officials published rules for such "72 hour detention," but there were no published departmental policies governing the use of these "hole" cells. Confinement in these "hole" cells was discontinued in the fall of 1972, pursuant to an unwritten administrative directive. The actual cells have been maintained and remain available in substantially the same condition as before for future use at any time this or any subsequent administration so decides.

Administrative lockup

15. Prior to the riot, a large number of inmates were confined in administrative segregation on the top floor of the west cell house and on the top floor of the new cell house. Although some inmates were held in the administrative segregation areas for disciplinary punishment due to a lack of space in the maximum security

unit, the majority were so held for a variety of reasons such as protection from other inmates, observation, investigation, awaiting court action and pre-hearing detention. These inmates had been convicted of no infractions or offenses and had been provided no hearings or other procedural safeguards. In spite of this, they were subjected to conditions of confinement which were punitive in nature. They were held in closed confinement for prolonged periods with minimal lighting and ventilation. They received no exercise. Their privileges were restricted and they were denied the opportunity to participate in the prison work programs, to earn work time or to engage in any self-improvement programs. They were not considered for trusty status or parole eligibility. Following the riot, administrative segregation as previously practiced was dispensed with. Instead, through the process of custody grading and the 24 hour lockdown, essentially the entire prison population is now confined in administrative segregation under conditions which can still only be described as punitive. Inmates classified as "maximum custody," are not confined in the maximum security unit, and the first floor of East Cellhouse although they have been provided no disciplinary hearings. Inmates classified as "close custody" are now confined on the second and third floors of East Cellhouse. Inmates classified "medium custody" are confined on the fourth floor of East Cellhouse and throughout the West Cellhouse. A limited number of medium security inmates who have work assignments are also housed on the first floor of New Cellhouse. Inmates with different custody grades received different treatment. Those maximum custody inmates assigned to the maximum security unit receive the fewest privileges. At the other extreme are the medium custody inmates who have been afforded work privileges.

Use of chemical agents

16. The use of chemical mace and tear gas normally causes physical pain and discomfort and, on several occasions appearing in this record, the use of such chemical agents has caused serious physical injury and even death of inmates. Pursuant to his statutory authority, the Director of the Department of Corrections issued Policy Statement No. 7302.1 dated January 4, 1973, regarding the use of force including chemical agents at all Oklahoma Corrections Facilities. Under this policy, only such force was to be employed as was reasonably necessary under all attendant circumstances. Definite guidelines for implementing the policy included the following:

(a) No person was to lay hands on a prisoner, except in self defense, to prevent an escape, to prevent injury to persons or damage to property, or to quell a disturbance. In controlling or moving an unruly prisoner, sufficient personnel were to be used to preclude the necessity for striking or inflicting bodily injury. Gas was not to be used on an individual prisoner except to prevent serious injury or loss of life. Accordingly, physical force was not to be used to force compliance with rules or regulations other than under the foregoing circumstances.

(b) When the use of force was necessary, it was to be exercised according to the priorities of force and limited to the minimum degree necessary under the particular circumstances. When firepower was utilized, the aim would be to disable rather than to kill. The application of any or all of the priorities of force listed below, or the application of a higher numbered priority without first employing a lowered numbered one, was dependent upon and required to be consistent with the situation encountered during any particular disorder. Priorities of force were: (1) Physical restraint; (2) Show of force; (3) Use of physical force other than weapons fire (Riot Squads); (4) Use of high pressure water; (5) Use of chemical agents; (6) Fire by selected marksmen; and (7) Use of full fire power.

The policy statement required that whenever a chemical agent was used on an inmate and/or inmates, the Warden would immediately telephone the Director of the Department of Corrections or, in his absence, the Deputy Director of Institutions. The telephonic report was to be followed by a written report containing all facts and circumstances concerning the incident.

Notwithstanding these directives, the wardens and other high-level officials at the Oklahoma State Penitentiary at McAlester have approved or acquiesced in the use of chemical agents as a purely punitive measure against inmates, including even inmates locked in their cells, in violation of the limitations imposed by the Department of Corrections. Mace and tear gas have been used on inmates for such conduct as loud singing in cells, refusing to get haircuts or to shave, possession of contraband (such as instant coffee) in cells, destruction of state property (such as breaking plastic spoons), curing an officer, talking in a

loud voice or yelling, screaming for a doctor and shaking or rattling cell doors. None of the incidents discussed above were shown to have presented any real or immediate threat to the security of the institution and certainly did not rise to the level of threatening serious injury or loss of life. The Court finds as a fact that most, if not all, of these incidents were precisely the type of rules infractions concerning which the use of *any* type of physical force was intended to be prohibited by the departmental policy statement. They were, rather, incidents that should have been dealt with officially, if at all, by means of the use of the disciplinary system. Accordingly, it is clear that a pattern and practice exists of using chemical agents against inmates when inadequate (if any) consideration was given by the officials involved to the threshold question of whether a given situation warranted the use of any physical force at all, whether chemical agents or otherwise.

Chemical agents, such as mace and tear gas, have as an inherent characteristic the affecting of individuals other than those against whom they are specifically directed. This is a fact that has not been given adequate consideration by the defendants and their agents in determining whether such agents should be used in given situations. The record reveals incidents in which these various chemical agents were used against disorderely inmates under appropriate circumstances, but in excessive amounts. The Court finds that while the use of chemical agents was not wholly unjustified, the manner and extent of their use was improper.

The record also reveals incidents in which chemical agents were used against specific individual inmates under circumstances justifying the use of physical force as a behavior control measure, but where other reasonable means of controlling the behavior of the specific inmates existed and where the chemical agents could not be used without visiting their effects on other, innocent inmates. The Court finds that the choice of chemical agents as the behavior control device in such instances was not justified.

The wardens and other high level officials at the penitentiary have routinely received reports of the improper use of chemical agents by correctional officers, but have failed and refused to take any corrective action. The Dircetor of the Department of Corrections is either unaware of or condones the continued violations the Department's policy, since the evidence of record reflects no action having been taken to seek to compel adherence to the limitation imposed by the Department's own regulations.

17. Defendants have maintained and operated a medical care delivery system at the Oklahoma State Penitentiary which was and is incapable of providing, has failed to provide, and continues to fail to provide adequate medical care for the inmates.

The medical staff and facilities which are located at the main penitentiary at McAlester are relied upon to diagnose and treat the medical, dental and psychiatric problems of inmates throughout the penitentiary system. Prior to the riot of July 27, 1973, the on-site medical staff, facilities, equipment and procedures at the Penitentiary are systemically incapable of meeting the routine or emergency health care needs of the inmate population. This facility and the equipment and records it contains were destroyed during the riot. A temporary hospital ward has been established in a former cellhouse and the security Captain's office is now used as an examination room. Portions of the medical research facility adjacent to the penitentiary have also been converted to use as an examination area for trustees. It is obvious, however, that those inadequacies in plant and equipment which existed prior to the riot were aggravated by the riot and that no effective solution has been formulated.

Professional dental care was supplied to the entire population by a series of part time dentists until July of 1973. Though a full time dentist was hired at that time, no trained civilian support personnel have been hired to assist him. This level of dental staffing is unable to meet the routine dental care needs of the population intended to be served. Indeed, even if there were two dentists and they were provided minimal paradental support, they could still only be expected to treat 50 percent of the dental pathology involved.

Though approximately one half of the average in-patient population at the penitentiary is hospitalized for psychiatric reasons, there is no professional psychiatric staff available for treatment on a regular basis. A visiting psychiatrist makes weekly visits pursuant to an informal agreement, but he has not assumed responsibility for the care of these patients. The only "treatment" available at the penitentiary consists of temporary relief from "distress" through sedation.

The professional medical staff available to the inmate male population at the time of trial consisted of one fully licensed, part-time M.D., serving as chief medical officer, and two additional doctors who have institutional licenses which permit them to practice in state institutions, but only under the supervision of a fully licensed physician. The services of the institutional licensed physicians have been equaly divided between health care of inmates and operation of the plasmaphersis program at the penitentiary so that the services of only one of them are normally available at any given time. The actual services supplied by the chief medical officers have varied. The chief medical officer at the time of the riot was supplying full time services. Since his resignation, only part-time services are provided by his successor, Dr. Karl Sauer, who also, maintains an active, private orthopedics practice in McAlester. Part of Dr. Sauer's time at the penitentiary is required to be spent on administrative matters.

For many years, the penitentiary system has, for all practical purposes, been without any professionally trained medical support personnel whatsoever. Due to shortages in staff, defendants have continuously relied on unlicensed, untrained and unqualified correctional officers and other penitentiary employees, as well as inmate personnel, to perform clinical and related medical services which should be performed solely by licensed and qualified professionals. Such services performed by unqualified inmate and civilian personnel includes, for example, screening medical complaints to determine which inmates on sick call will actually get to see a doctor, as well as providing actual treatment and nursing care. Subsequent to the riot, defendants have placed even greater reliance on such unqualified personnel at the main facility where almost the entire inmate population was being held on 24 hour lockdown as recently as the time of this trial. The lockdown has in fact seriously exacerbated previously existing problems in the medical area.

Defendants have endeavored, both before and since the riot, to supply some medical services by referrals to various outside facilities. This system of referrals, however, has failed to compensate for on-site deficiencies in staff and facilities and does not and cannot adequately meet the medical needs of the inmates.

The past and present systemic medical deficiencies at O.S.P. have resulted in instances of actual impairment of inmate health and continue to pose an actual and potential threat to the physical health and well-being of the O.S.P. inmate population.

Correspondence rights

18. Defendants have engaged in a pattern and practice of arbitrary and unreasonable restriction, interruption and delay of mail to and from inmates at the Oklahoma State Penitentiary.

Defendants have unduly restricted the inmates' opportunity to conduct sealed or privileged correspondence with counsel, the courts and other governmental agencies. Incoming sealed correspondence has never been permitted from any source and, until quite recently, all such incoming mail was opened and read. Outgoing sealed correspondence with attorneys, other than the correspondent's single "attorney of record," and to federal courts and government officials has also been denied privileged treatment, even after defendants purported to recognize limited "privileged" correspondence on or about February 2, 1973. Accordingly, at least some letters to and from courts, attorneys and government agencies continued to be opened, copied, recorded, and/or rejected. Furthermore, defendants' policy on privileged correspondence was never fully implemented. In apparent contravention of that policy, the established practice of officers in charge of the various lockup facilities at the penitentiary was to deny any sealed correspondence privilege to their charges.

An additional barrier to the confidentiality of such correspondence has been the failure to provide notary services within the secured areas of the penitentiary. Accordingly, legal documents which required notarization could not be sealed by the inmates, inasmuch as they were required to turn these matters in for notarizing, which was effected outside their presence.

At the supplemental pretrial conference held on December 6, 1973, counsel for the defendants tendered to the Court and opposing counsel a new Department of Corrtions policy statement governing inmate correspondence. Implementation of the policy statement was not undertaken until very recently and the record is unclear as to the exact manner in which the new policy has been applied in practice. On its face the document permits sealed out-going correspondence without restrictions. All incoming mail is still to be opened. Only inspection for impermissible enclosures is expressly authorized, but reading is not actually

prohibited. Any inspection is required to be conducted in the presence of the inmate addressee, if the mail is from an attorney. This procedure is expressly extended to inmates on lockup or "segregated" status.

Under the new policy no privilege is recognized with respect to mail from courts and government officials. There is no provision for solving the problem on confidentiality of outgoing mail requiring notarization. Moreover, any inmate whom unidentified officials determine has violated "certain imposed guidelines" will apparently be reduced to the limited opportunity to conduct sealed correspondence, as recognized under the old policy.

The new mail policy also eliminates a number of restrications formerly applied to unprivileged mail. Prior to and during most of the time this case has been pending, defendants severely restricted personnal corespondence to five immediate family members, as approved by the penitentiary classification office. No other "personal" correspondence was allowed. Mail of a non-personal nature was permitted, but only if the inmate's classification officer made a determination that the particular communication was of a "business" nature. No written rules or guidelines defining "business" mail were ever established or made available either to the inmates or to the employees who were required to make such evaluations. In practice, classification officers exercised this undefined authority in a manner that rejected letters to and from ministers, attorneys, government officials and other similar correspondents.

Under the new mail policy, inmates may not correspond with outside businesses or institutions for the purpose of soliciting catalogues, fee samples or educational material, or for the purpose of conducting their own business. Regardless of purpose, they may not conduct any correspondence with persons known to them only through newspaper or magazine ads, or with persons in prison who are not immediate family members. There is a separate departmental policy statement governing the practice of religion which prohibits inmates from communicating with ministers who are ex-convicts.

In addition to the foregoing expressed limitations, evidence in the record shows that certain inmates have not been permitted to correspond with a San Francisco, California, prisoner aid group, believed by the inmates to be a possible source of legal services. There is no indication of change in defendant's continuous, but unwritten, policy of prohibiting correspondence of any kind in a foreign language.

As indicated above the new policy authorizes inspection, but neither authorizes nor prohibits the reading of incoming mail. On the other hand, there was never any express authority to read inmate mail under the prior policy. Nevertheless, the actual practice at the penitentiary routinely involved the reading of inmate mail for the purpose of discovering and rejecting mail containing "gossip" and "improper language." There was no expressed policy, purpose, direction or standards for such censorship, so the employees authorized to censor such mail did so on an entirely subjective basis.

Publications

19. Defendants have in the past prohibited and continue to prohibit inmate subscriptions to, receipt and/or possession of certain magazines and newspapers.

In the past, the official written rule was that subscriptions could be obtained to any periodicals on the approved periodical list. In fact, such a list did not exist. Decisions on individual requests to subscribe to various periodicals were made on a case-by-case basis, by penitentiary personnel, guided by essentially no promulgated standards or procedures.

After the riot, a practice was instituted that prevented inmates from subscribing to any newspapers or periodicals. Quite recently, there has actually been promulgated an approved periodicals list. As will be set forth in greater detail, this list still operates to exclude legal and religious periodicals. No procedure has been promulgated whereby inmates may seek to obtain approval for subscriptions to periodicals not on the approved list. In fact, they have been advised that all periodicals not on the list are contraband. The Court takes judicial notice that innumerable publications containing protected speech have not been included on the current approved list.

Access to the courts

20. The defendants have failed to provide an adequate law library or any reasonably and adequate alternative thereto. The library, such as it is, is located in a wood frame shelter attached to the wall of the main rotunda. Because of

its size, approximately ten feet by six feet, only two or, at most, three inmates can use the facility at any one time. The facility is so lacking in legal reference books and publications as to constitute no library at all. For example there are no reports of decisions by the United States Supreme Court or lower Federal Courts.

Inmates are prohibited from assisting one another on legal matters and in preparing their legal papers since such assistance may permissibly be provided only by a law librarian. In practice, penitentiary officials have also followed a policy of preventing inmates from acquiring legal books. In addition, inmates have been and are now prohibited from subscribing to any legal periodicals and have been denied the right to have in their possession any personal legal materials or other assets belonging to them and acquired for the purpose of working on their legal problems, although the latter prohibition has recently been relaxed.

For extended periods of time, the law library has been closed to inmates because no librarian was available. It is noted that during the year 1973, except for approximately six weeks, no law librarian was employed by the penitentiary. During such periods an inmate could use the library only if a classification officer was available to accompany him and to and open the library for him. Approximately 15 percent of the inmate population is illiterate and the sixth or seventh grade average reading ability of the population is less than that which is required for effective use of the more common legal reference materials. As is noted above, only the institutional "law librarian" may permissibly assist these and other inmates on legal matters. The use of the term "law librarian" is misleading since no librarian employed by the penitentiary has had any legal training. When such a librarian has been available he has been able to assist only three or five inmates per day. Inmates frequently must wait up to five weeks to receive assistance, if it is available at all. Inmates on lockup, regardless of the length of confinement, are prohibited from using the law library. They are only provided with legal forms which may be used to file petitions with the courts. Male inmates from subsidiary facilities must request transfers to the main facility at McAlester in order to use the library facilities. Women inmates are afforded no library privileges and must depend upon visits from the law librarian, when one is employed and is available. Recently a new employee was hired to perform the functions of a law librarian. This employee is classified as a correctional officer I, but due to illness, has been unavailable for some time. It is heartening to note from the record that the defendants have made plans for upgrading the law library facilities, employing a full-time attorney and engaging the services of law students to provide legal assistance to inmates. However, such plans have not as yet been implemented and the conditions mentioned above still prevail.

Religious freedom

21. Inmates at the Oklahoma State Penitentiary who follow the Muslim faith do not, because of their religious beliefs, eat pork or any food mixed with pork or pork by-products. Said inmates have on numerous occasions petitioned penitentiary officials to provide them with pork free meals. Penitentiary officials have refused and still refuse to provide the pork free meals so requested. Defendants have failed to provide special diets, even when requested by the medical staff for medical patients, and nutritional analyses of penitentiary menus show that there are vitamin and protein deficiencies in the diet generally provided inmates.

It is common knowledge that many meals are prepared with pork or pork by-products. However, the Court cannot determine with specificity, from the menus placed in the record, the extent to which pork or pork by-products are used in the food now served to the inmates. Of course, pork served in its natural state is easily discernible, but meals seasoned with pork are often difficult of detection. The record is devoid of any evidence indicating that inmates are advised of foods actually prepared with pork or pork by-products. It naturally follows that those inmates whose religious beliefs prevent the eating of pork in any form, are often forced either to chance that the food they eat is free of pork or to refuse the food altogether. Because of the dietary deficiencies found to exist in the regular meals now being prepared and served to all inmates, the Court finds that inmates who follow the Muslim teachings cannot obtain an adequate diet by foregoing the eating of food prepared with pork and will, if they attempt to follow the tenets of their faith, receive a diet even more deficient than that received by other prisoners.

Muslim inmates have also been deprived of the opportunity to gather together for group religious services. It is unclear for what periods this condition prevailed prior to the riot, since there is evidence in the record that some arrangement for such meetings had been made through the auspices of the Catholic Chaplain. Subsequent to the riot, there has been a total ban on group religious services regardless of denomination. This prohibition appears to have had a greater impact on the Muslims, because such services provide their only opportunity for religious guidance. Protestants and Catholics at the penitentiary have at least the services of a civilian chaplain with whom individual consultations may be arranged however brief or unsatisfactory they may be.

Religious periodicals have not been included on the various official and unofficial approved periodical lists that have been in effect at the penitentiary at diverse times. Moreover, Muslim publications entitled "Elijah Muhammad Speaks" and "The Message to the Black Man in America" have been and are specifically prohibited by a departmental policy statement dated April 25, 1968. No factual justification for the exclusion of these two specific publications is shown. Likewise, no justification whatsoever is shown for the failure to include religious publications generally on the various approved periodicals lists.

Members of the Muslim sect at McAlester have earnestly urged this Court that their religious principles have been offended by their integration with non-Muslim inmates. For the reasons set forth in the Court's discussion of racial integration this aspect of the Muslim complaint will not be honored and must be rejected.

It is also claimed that none of the guards presently employed at the penitentiary are followers of Muslim faith. The Court has no reason to doubt this assertion, but finds no evidence that this condition has been the result of or has resulted in any direct or covert discrimination based upon religion or race.

Finally, the Muslim plaintiffs have complained that following the July 27 riot, they were locked up because of their religious beliefs. The Court notes that the entire population at McAlester was and continues to be locked up under punitive conditions which it finds deplorable. There is, however, no evidence that Muslims, because of their beliefs, have been subjected to conditions or restrictions more punitive than other inmates of the Penitentiary.

Prior findings of this court

The trial in this case was heard on March 14, and 15, 1973, following a series of individual *pro se* cases presented to the court during the week of March 11. At the close of this trial, the Court entered a series of preliminary findings which dealt in general terms with the numerous uncontitutional conditions and practices which have been described in greater detail herein. The Court further found from the totality of the record, that plaintiff as well as the other inmates at McAlester are entitled to such injunctive and mandatory relief, as is necessary to correct the deprivations of rights which have occurred in the past and will continue unless enjoined by order of this Court.

The requests for additional relief were, however, denied because of evidence of contributing fault on the part of inmates. Accordingly, it was and is the determination of this Court that the record does not support the award of money damages to any prisoner nor is there evidence which would warrant the release of any prisoner from confinement prior to serving his full sentence.

CONCLUSIONS OF LAW

Jurisdiction

1. This Court has jurisdiction of this case 28 U.S.C. § 1343(3) & (4).

2. The Attorney General of the United States was authorized to intervene in this action on behalf of the United States pursuant to Section 902 of the Civil Rights Act of 1964, 42 U.S.C. § 2000h-2.

3. "Federal courts sit not to supervise prisons but to enforce the constitutional rights of all 'persons,' which include prisoners. We are not unmindful that prison officials must be accorded latitude in the administration of prison affairs, and that prisoners necessarily are subject to appropriate rules and regulations. But persons in prison, like other individuals, have the right to petition that Government for redress of grievances. . . ." Cruz v. Beto, 405 U.S. 319, 321, 92 S.Ct. 1079, 1081, 31 L.Ed.2d 263 (1972). While federal courts are "reluctant to intervene in matters of prison administration," Hoggro v. Pontesso, 456 F.2d 917 (C.A. 10, 1972), the record in this case has led this Court to conclude that the defendants have been and are operating the Oklahoma State Penitentiary

in a manner which violates many rights secured to inmates by the Constitution and laws of the United States. "[A] policy of judicial restraint cannot encompass any failure to take cognizance of valid constitutional claims whether arising in a federal or state institution. When a prison regulation or practice offends a fundamental constitutional guarantee, federal courts will discharge their duty to protect constitutional rights. Johnson v. Avery, 393 U.S. 483, 486, 89 S.Ct. 747, 21 L.Ed.2d 718 (1969." Procunier v. Martinez,—U.S.—, 94 S.Ct. 1800, 1807, 40 L.Ed.2d 224 (1974).

Racial discrimination and segregation

[1, 2] 4. A state policy or practice of racial segregation in the operation of detention facilities violates the equal protection clause of the Fourteenth Amendment. Washington v. Lee, 263 F.Supp. 327 (N.A.Ala. 1966), aff'd; Lee v. Washington, 390 U.S. 333, 88 S.Ct. 994, 19 LEd.2d 1212 (1968); Wilson v. Kelley, 294 F.Sup. 1005 (N.D.Ga. 1968) aff'd 393 U.S. 266, 89 S.Ct. 477, 21 L.Ed.2d 425 (1968). Racial segregation of correctional facilities cannot be justified on the basis that integration may result in inmate violence. United States v. Wyandotte County, 480 F.2d 969 (C.A. 10, 1973) (per curiam); cert. denied 414 U.S. 1068, 94 S.Ct. 577, 38 L.Ed.2d 473 (1973); McClelland v. Sigler, 327 F.Supp. 828 (D.Neb. 1971) aff'd, 456 F.2d 1266 (C.A. 8, 1972) (per curiam).

[3, 4] 5. The equal protection clause of the Fourteen Amendment prohibits racial discrimination in any aspect of prison administration. Privileges must be afforded equally to prisoners of all races. Rivers v. Royster, 360 F.2d 592 (C.A. 4, 1966); Jackson v. Godwin, 400 F.2d 529 (C.A. 5, 1968); Owens v. Brierley, 452 F.2d 640 (C.A. 3, 1971). Specifically, prison officials may not discriminate on the basis of race when making job assignments or administering discipline. Gates and United States v. Collier, 349 F.Supp. 881, 901 (N.D.Miss., 1972) (appeal pending).

[5] 6. The present cessation of segregation in inmate housing coming subsequent to the filing of a lawsuit due to emergency conditions beyond defendants' control is insufficient grounds upon which to conclude there is "no reasonable expectation that the wrong will be repeated." N. L. R. B. v. Raytheon Co., 398 U.S. 25, 27, S.Ct. 1547, 1549, 26 L.Ed.2d 21 (1970); United States v. W. T. Grant Co., 345 U.S. 629, 633, 73 SCt. 894, 97 L.Ed.2d 1303 (1953).

In light of the prolonged practice of segregation prior to the riot in contravention of stated policy, and because of the uncertainty of post-riot conditions and the importance of the rights at stake, judicial relief continues to be both appropriate and necessary. Rowe v. General Motors Corp., 457 F. 2d 348 (C. A. 5, 1972); United States v. West Peachtree Henth Corp., 437 F. 2d 221, 228 (C. A. 5, 1971).

Procedural due process

[6] 7. The due process clause proscribes any serious disciplinary sanctions against an inmate unless he is found to have violated written rules which are adequately promulgated prior to the commission of the infraction charged and which describe punishable conduct with reasonable precision. Sinclair v. Henderson, 331 F. Supp. 1123 (E. D. La. 1971); Gates and United States v. Collier, 349 F. Supp. 881 (N. D. Miss. 1972) (appeal pending).

[7] 8. Summary punishment is unconstitutional; serious disciplinary sanctions may not be imposed on inmates without a hearing. Inmates who are charged with infractions must be given official written notice of the specific charges against them. This notice must be given a reasonable time prior to conducting the hearing. Sinclair v. Henderson, *supra;* Sostre v. McGinnis, 442 F. 2d 178 (C. A. 2, 1971); Nolan v. Scafati, 430 F. 2d 548 (C. A. 1, 1970); Landman v. Royster, 333 F. Supp. 621 (E. D. Va. 1971); see also, Black v. Warden, 467 F. 2d 202 (C. A. 10, 1972).

[8] 9. The determination to impose serious disciplinary sanctions on prisoners must be made by an impartial decision-maker Sostre v. McGinnis, 442 F. 2d 178 (C. A. 2, 1971), cert. denied sub nom. Sostre v. Oswald, 404 U.S. 1049, 92 S. Ct. 719, 30 L. Ed. 2d 740 (1972).

[9, 10] 10. The impartial disciplinary tribunal may not in effect abdicate sentencing responsibility by permitting line officers to determine the length of confinement. Accordingly, a denial of procedural due process results where indefinite lockup sentences are imposed without a regular, meaningful and independent review reasonably designed to enable the disciplinary tribunal or some other responsible disinterested administrative official or body to make its own determination regarding duration of confinement.

See, Adams v. Carlson, 488 F. 2d 619 (C. A. 7, 1973); Gray v. Creamer, 465 F. 2d 179 (C. A. 3, 1972); United States ex rel. Walker v. Mancusi, 467 F. 2d 51 (C. A. 2, 1972).

[11] 11. The imposition of significant additional restrictions or sanctions on inmates who have already been placed on disciplinary lockup requires the same procedural safeguards as apply at the time of the original punishment. Adams v. Carlson, *supra*; Palmigiano v. Baxter, 487 F. 2d 1280, 1284–1285 (C. A. 1, 1973).

[12–15] 12. Automatic detention of inmates prior to disciplinary hearings can result in a denial of procedural due process. Whether awaiting institutional or judicial proceedings or both, such inmates should be segregated only if a reasonable basis exists therefore (*e.g.*, their continued presence in general population status poses an actual threat to the security of the institution) and then only for a reasonable time until the disciplinary committee can convene to hear the case. The pre-riot practice at the Oklahoma State Penitentiary of having the disciplinary committee meet weekly is not an adequate one for this purpose. Such hearings must be held as soon as is practicable under the circumstances. Absent unusual and reasonably sufficient extenuating circumstances, prehearing detention in excess of 48 hours (72 hours if a weekend intervenes) is presumptively unreasonable. Landman v. Royster, 354 F. Supp. 1292, 1294 (E. D. Va. 1973).

[16] 13. Even where the confinement of an inmate under punitive conditions is denominated and processed as an administrative, rather than a disciplinary matter, the indefinite confinement of inmates under such conditions, without standards or criteria, and without minimal procedural safeguards, violates the due process clause of the Fourteenth Amendment. United States ex rel. Walker v. Mancusi, D.C., 338 F. Supp. 311, affirmed, 467 F. 2d 51 (C. A. 2, 1973); Adams v. Carlson, 488 F. 2d 619 (C. A. 7, 1973); Gray v. Creamer, 465 F. 2d 179 (C. A. 3, 1973); Howard v. Smyth, 365 F. 2d 428 (C. A. 4, 1966); Diamond v. Thompson, 364 F. Supp. 659 (M. D. Ala. 1973); Allen v. Nelson, 354 F. Supp. 505 (N. D. Cal. 1973); Bowers v. Smith, 353 F. Supp. 1339 (D. Vt. 1972).

Cruel and unusual punishment

a. *In general*

[17] 14. The prohibition against cruel and unusual punishment in the Eighth Amendment is applicable to the State of Oklahoma through the due process clause of the Fourteenth Amendment. Robinson v. California, 370 U.S. 660, 82 S. Ct. 1417, 8 L. Ed. 2d 758 (1962).

[18] 15. It is established that the Eighth Amendment does not have fixed, settled and definite limits. The "Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society." Trop v. Dulles, 356 U.S. 86, 100–101, 78 S. Ct. 590, 598, 2 L. Ed. 2d 630 (1958). This Court subscribes to the view of the Eighth Circuit:

"In summary, then so far as the Supreme Court decisions are concerned, we have a flat recognition that the limits of the Eighth Amendment's proscription are not easily or exactly defined, and we also have clear indications that the applicable standards are flexible, that disproportion, both among punishments and between punishment and crime, is a factor to be considered, and that broad and idealistic concepts of dignity, civilized standards, humanity, and decency are useful and usable." Jackson v. Bishop, 404 F. 2d 571, 579 (C. A. 8, 1968).

In short, the parameters of the constitutional prohibition are not rigidly defined and are, in effect, discernible only in the context of specific factual situations.

[19] 16. "Cruel and unusual punishment may be inflicted by the unconscionable penalty imposed by statute or by the inhumane execution of a permissible penalty imposed under a constitutionally permissible statute." Bethea v. Crouse, 417 F. 2d 504, 507–508 (C. A. 10, 1969). While the great majority of cases involving the Eighth Amendment have involved one or more specific acts directed at selected individuals (e.g., Trop v. Dulles, *supra*), the constitutional prohibition is equally applicable to general conditions of confinement. Holt v. Sarver, 309 F. Supp. 362, 372–373 (E. D. Ark. 1970), aff'd 442 F. 2d 304 (C. A. 8, 1971); Landman v. Royster, 333 F. Supp. 621 (E. D. Va. 1971); Gates and United States v. Collier, 349 F. Supp. 881 (N. D. Miss. 1972) (appeal pending).

b. *Use of chemical agents*

[20] 17. Chemical mace and tear gas inevitably inflict physical pain and discomfort upon, and can cause permanent physical injury and even death to the

individual(s) against whom they are used. Accordingly, the use of such chemical agents to punish inmates constitutes a form of corporal punishment.

[21] 18. At least in a State such as Oklahoma where State law clearly proscribes the use of corporal punishment, Title 57 O.S.A. § 31, the use of corporal punishment on inmates is also cruel and unusual within the meaning of the Eighth Amendment.

[22] 19. Whether or not proscribed by State law, the use of chemical agents such as mace or tear gas as a punitive measure rather than a control device results in the imposition of cruel and unusual punishment in violation of the Eighth Amendment. Landman v. Royster, 333 F. Supp. 621 (E. D. Va. 1971). See also Morales v. Turman, 364 F. Supp. 166, 173 (E. D. Tex. 1973) (involving Texas juvenile detention facilities).

[23] 20. That chemical agents have been used as a punitive measure may be inferred from evidence showing that such agents are employed unnecessarily (i.e., without proper justification based on a reasonable concern for the security of the institution) or with justification, but in excessive amounts. See Landman v. Royster, *supra*.

21. The established pattern of unreasonable and excessive use of chemical agents at the Oklahoma State Penitentiary has resulted in summary, as well as cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.

c. *Conditions of confinement*

[24–26] 22. Solitary confinement *per se* does not constitute cruel and unusual punishment. Novak v. Beto, 453 F. 2d 661 (C. A. 5, 1971); Graham v. Willingham, 384 F. 2d 367 (C. A. 10, 1967). Such confinement may constitute cruel and unusual punishment, however, if it is maintained in a manner fairly characterized as foul, inhuman and violative of basic concepts of human decency. Wright v. McMann, 387 F. 2d 519, 526 (C. A. 2, 1967). In most of the cases in which the conditions in solitary confinement have been condemned, the inmates were held in dark cells where personal hygiene was impossible due to the lack of materials necessary for personal sanitation and/or the inability to properly dispose of body waste. See e.g., LaReau v. MacDougall, 473 F. 2d 974 (C. A. 2, 1972) cert. denied, 414 U.S. 878, 94 S. Ct. 49, 38 L. Ed. 2d 123 (1973); Wright v. McMann, supra; Hancock v. Avery, 301 F. Supp. 786 (M. D. Tenn. 1969); Jordan v. Fitzharris, 257 F. Supp. 674 (N. D. Cal. 1966). Such conditions have prevailed in the subterranean isolation area referred to as "the hole." The conditions found to exist in the isolation cells in the maximum security unit approach, but do not, standing alone, reach the level of cruel and unusual punishment. Nevertheless, confinement in dark, unventilated and unsanitary isolation cells without any means of mental or emotional diversion if imposed for prolonged periods will result in conditions which equal cruel and unusual punishment. See, Morales v. Turman, 364 F. Supp. 166 (E. D. Tex. 1973). Cf. Novak v. Beto, 453 F. 2d 661, 671 (C. A. 5, 1971) (partial dissenting opinion); Sostre v. McGinnis, 442 F. 2d 178 (C. A. 2, 1971) cert. denied sub nom. Sostre v. Oswald, 404 U.S. 1049, 92 S. Ct. 719, 30 L. Ed. 2d 740 (1972).

[27] 23. Prisoners held in segregation for security or other non-disciplinary reasons must be provided as many of the privileges enjoyed by the general population as the nature of their confinement allows. Landman v. Royster, 354 F. Supp. 1292, 1294–1295 (E. D. Va. 1973); Allen v. Nelson, *supra*.

[28] 24. Where inmates are confined to their cells for periods up to one year and subjected to continual and enforced idleness without affording them any opportunities for physical exercise, voluntary work, or educational programs, it must be concluded that such conditions of confinement constitute cruel and unusual punishment in violation of the Eighth Amendment. Hamilton v. Love, 328 F. Supp. 1182 (E. D. Ark., 1971); Sinclair v. Henderson, 331 F. Supp. 1123 (E. D. La. 1971); *cf.* Osborn v. Mason, 359 F. Supp. 1107 (D. Conn. 1973).

d. *Denial of medical care*

[29] 25. Inmates have a basic right to receive needed medical care while they are confined in prison. Edwards v. Duncan, 355 F. 2d 993 (C. A. 4, 1966); Coppinger v. Townsend, 398 F. 2d 392 (C. A. 10, 1968); Schack v. Florida, 391 F. 2d 593 (C. A. 5, 1968), cert. denied, 392 U.S. 916, 88 S. Ct. 2080, 20 L. Ed. 2d 1376 (1968); Martinez v. Mancusi, 443 F. 2d 921 (C. A. 2, 1970); Sawyer v. Sigler, 320 F. Supp. 690 (D. Neb. 1970), aff'd 445 F. 2d 818 (C. A. 8, 1971).

[30] 26. As a necessary corollary of that right, prison officials have an affirmative duty to make available to inmates a level of medical care which is

reasonably designed to meet the routine and emergency health care needs of inmates. Fitzke v. Shappell, 468 F.2d 1072 (C.A. 6, 1972); Campbell v. Beto, 460 F.2d 765 (C.A. 5, 1972); Gates and United States v. Collier, 349 F.Supp. 881 (N.D.Miss.1972) (appeal pending); Newman v. Alabama, 349 F.Supp 278 (M.D. Ala.1972) (appeal pending); *cf.* Jones v. Wittenberg, 330 F.Supp. 707 (N.D.Ohio, 1971) affirmed sub nom. Jones v. Metzer, 456 F.2d 854 (C.A. 6, 1972); Chapman v. Gilligan, No. 8700 (S.D.Ohio, March 16, 1973). While a prisoner is not entitled to the medical care of his choice, Coppinger v. Townsend, supra, Judge Daugherty has held that "a failure to provide needed medical care by one having custody of a prisoner may under certain circumstances afford a prisoner a cause of action under Civil Rights Act." (Elsberry v. Haynes, 256 F.Supp. 738 (W.D.Okl.1966).

[31] 27. The actionable circumstances result where, as here, the level of medical care available to a confined and dependent population is inadequate to meet predictable health care needs because of obvious and sustained deficiencies in professional staff, facilities and equipment. When continued and systemic deficiencies of this nature exist and have resulted in the actual impairment of inmate health, and when such deficiencies continue to pose a current and potential threat to the physical health and wellbeing of an entire prison population, then inmates are deprived of the basic elements of adequate medical treatment in violation of the Eighth Amendment, Campbell v. Beto, *supra*, and are also subjected to disabilities beyond those contemplated by incarceration, in violation of the due process clause of the Fourteenth Amendment. Fritzke v. Shappell, *supra.*

Correspondence and publication

[32, 33] 28. Inmates have a preferred constitutional right to correspond with attorneys, courts and government officials for the purpose of petitioning government and the courts for the redress of grievances. LeVier v. Woodson, 443 F.2d 360 (C.A. 10, 1971); Sostre v. McGinnis, 442 F.2d 178 (C.A. 2, 1971) cert. denied sub nom. Sostre v. Oswald, 404 U.S. 1049, 92 S.Ct. 719, 30 L.Ed.2d 740 (1972); Palmigiano v. Travisono, 317 F.Supp. 776 (D.R.I.1970). The confidentiality of such correspondence may not be arbitrarily denied by prison officials, who are the likely subjects of an inmate's grievances. Defendants' practice of limiting confidential treatment to correspondence with one attorney, state courts and state government officials, but not with their federal counterparts, constitutes an arbitrary and unreasonable intrusion upon the inmates' right freely to petition their government and the courts. See, Palmigiano v. Travisono, *supra.*

[34, 35] 29. This Court does not conclude that prison officials may not regulate or restrict forms of prisoner mail. Because of its impact on the First Amendment rights of "freeworld" as well as inmate correspondents, however, the censorship of such mail must meet the constitutional standards which are generally applied to governmental regulation of protected speech. Accordingly, it must be shown that prison mail censorship furthers an important governmental interest unrelated to the suppression of speech and that the mode of censorship results in limitations which are no greater than are necessary or essential to the protection of the particular governmental interest involved. Procunier v. Martinez,— U.S.—, 94 S. Ct. 1800, 40 L.Ed.2d 224 (1974); United States v. O'Brien, 391 U.S. 367, 88 S.Ct. 1673, 20 L.Ed.2d 672 (1968). Prison mail regulations which automatically limit inmates to personal correspondence with a fixed number of immediate family members work an arbitrary and unconstitutional prior restraint on the protected speech of both inmates and their "freeworld" correspondents. Such overly broad restrictions have been imposed on inmates of the Oklahoma State Penitentiary solely to serve the administrative convenience of the defendants, without furthering any demonstrated interest in the orderly operation of the institution or the rehabilitation of is inmates. Procunier v. Martinez, *supra;* Morales v. Schmidt, 489 F.2d 1335 (C.A. 7, January 17, 1973) (rehearing en banc, May 29, 1973, 494 F.2d 85; LeMon v. Zelker, 358 F.Supp. 554 (S.D.N.Y. 1972).

[36] 30. Defendants' policy of intercepting, censoring and rejecting incoming and outgoing inmate correspondence based on unwritten and/or ill-defined prohibitions against "improper language" or "gossip" including "false statements to any correspondents" is overbroad on its face and has in fact been applied in such a manner as to infringe upon the protected speech of inmates and their "freeworld" correspondents. Procunier v. Martinez, *supra*; Adams v. Carlson, 352 F. Supp. 882 (E.D. Ill. 1973) reversed in part on other grounds, 488 F.2d 619 (C.A. 7, 1973); *cf.* LeMon v. Zelker, *supra* Palmigiano v. Travisono, supra.

[37, 38] 31. Whether based upon the identity or characteristics of the correspondents (as in the case of approved list restrictions), or upon the content

of their specific communications (such as "gossip" and "improper language"), the restriction and/or censorship of prison mail deprives both inmates and their "freeworld" correspondents of the "liberty" of free speech. Accordingly, due process requires that the determination to censor must be based on facts rationally determined pursuant to such procedures as are necessary to insure fairness. Such minimum procedural safeguards include notice to the interested correspondent(s) and a reasonable opportunity to protest the decision of a prison official other than the person who originally disapproved the correspondence. Martinez v. Procunier, D.C., 354 F.Supp. 1092, affirmed, Procunier v. Martinez, *supra.*

[39–41] 32. Restrictions on the free flow of information to prison inmates in the form of general circulation newspapers and magazines results in a denial of the First Amendment rights of such inmates, unless the State can show that such restrictions are reasonably necessary to the preservation of security, good order or discipline within the penitentiary or the rehabilitation of the inmates. Fortune Society v. McGinnis, 319 F. Supp. 901 (S.D.N.Y.1970); Laaman v. Hancock, 351 F. Supp. 1265 (D, N.H. 1972). The past and present restrictive practices of the defendants, pertaining to the acquisition and retention of general circulation newspapers and magazines have gone far beyond any possible legitimate needs based on the preservation of security, good order or discipline within the penitentiary or the rehabilitation of the inmates. Such rules that have existed and such practices as have been in effect have been arbitrary and capricious on their face and as applied. The legitimate interest of inmates in having access to the information, both social and educational, to be found in these various types of periodicals far outweighs any legitimate interest of penal administration or any proper regard to be afforded the expertise and discretionary authority of competent correctional officials. When prison officials conclude that effective security, good order or rehabilitation require the censorship of such material, then with respect to each objectionable publication, the basis for the determination, including a written notice setting forth the relevant facts with respect to the particular publication, shall be provided to each inmate who seeks to obtain it. Such inmates shall be provided a reasonable opportunity to submit additional facts and views to the decision maker before such determination becomes final. Laaman, *supra;* Sostre v. Otis 330 F. Supp. 941 (S.D.N.Y.1971); See Procunier v. Martinez, *supra.* If it is possible to do so without defeating the purpose of the proposed exclusion, the inmate should be allowed to examine the allegedly offensive material and set forth reasons in writing as to why he feels it should not be excluded. In any event, the actual, final decision to exclude a specific issue of any general circulation publication shall be made by the Warden or Deputy Warden, who shall prepare and retain on file a detailed statement of the specific basis for each such exclusion for any jurisdictional court review.

Access to the courts

[42] 33. Prisoners, no less than other persons, have a constitutional right of access to the courts. Johnson v. Avery, 393 U.S. 483, 89 S. Ct. 747, 21 L. Ed. 2d 718 (1969). " 'Regulations and practices that unjustifiably obstruct the availability of professional representation or other aspects of the right of access to the courts are invalid.' Ex parte Hull, 312 U.S. 546, 61 S. Ct. 640, L. Ed. 2d 1034 (1941)." Procunier v. Martinez, *supra.*

[43] 34. To be meaningful, the right of access to the courts must include the means to frame and present legal issues and relevant facts effectively for judicial consideration.

[44–46] 35. Because the state has substantial control over the activities of convicted prisoners and because many prisoners are indigent and poorly educated, prison officials have an affirmative constitutional duty to provide them with the necessary means for obtaining access to courts.

Prison law libraries are a basic means of assisting inmates to that end. Gilmore v. Lynch, 319 F. Supp. 105 (N.D. Cal.1970), affirmed, Younger v. Gilmore, 404 U.S. 15, 92 S. Ct. 250, 30 L. Ed. 2d 142 (1971); Hooks v. Wainwright, 352 F. Supp. 163 (M.D.Fla. 1972). The defendants have, at various times and in various ways, attempted to provide some form of legal assistance to inmates The Court concludes however that the law library and legal assistance program at the Oklahoma State Penitentiary have failed to provide these disadvantaged inmates with constitutionally adequate access to the courts. Johnson v. Avery *supra*; Gilmore v. Lynch, *supra*; Hooks v. Wainwright, *supra.* "The constitutional guarantee of due process of law has as a corollary the requirement that

prisoners be afforded access to the courts in order to challenge unlawful convictions *and to seek redress for violations of their constitutional rights.*" Procunier v. Martinez, supra. (emphasis added). Accordingly, the Court concludes that the requirement levied on the State of Oklahoma in this area of constitutional application extends to insuring adequate access to the courts regarding at least habeas corpus actions, civil rights actions under 42 U.S.C. § 1983 and out-of-time appeals. *Cf.* Justice After Trial: Prisoners' Need for Legal Services in the Criminal Correctional Process, 18 Kan. L. Rev. 493 (1970).

[47] 36. A state may not prohibit inmate self-help or mutual inmate assistance in legal matters unless it provides them with some reasonable, alternative means of protecting their right of access to the courts. Johnson v. Avery, *supra*. Defendants in this case have unconstitutionally interfered with inmates' protected attempts to obtain timely, effective access to the courts in numerous ways. This unconstitutional interference has extended to attempts by inmates to seek and receive the assistance of attorneys, Procunier v. Martinez, *supra*; to acquire, retain and use personal legal materials such as law books, legal periodicals, and such other assets as are used in the course of working on one's personal legal problems, Cruz v. Hauck, 404 U.S. 59, 92 S. Ct. 313, 30 L. Ed. 2d 217 (1971), Adams v. Carlson, 488 F.2d 619 (C.A. 7, 1973), and to assist one another in the preparation of legal documents in the absence of a constitutionally adequate alternative. Johnson v. Avery, *supra*; See also, Procunier v. Martinez, *supra*.

Religious freedom

[48] 37. Where the precepts of a religious sect call for its adherents to engage in a religious practice which does not present a threat to the security, discipline and good order of the institution, the state has the burden of justifying policies or practices which prevent such inmates from engaging in such religious practices. See, Cooper v. Pate, 378 U.S. 546, 84 S.Ct. 1733, 12 L.Ed.2d 1030 (1964); Cruz v. Beto, 405 U.S. 319, 92 S.Ct. 1079, 31 L.Ed.2d 263 (1972); Long v. Parker, 390 F. 2d 816 (C.A. 3, 1968); Brown v. Peyton, 437 F. 2d 1228 (C.A. 4, 1971).

[49] 38. The court finds no valid justification for defendants continuing policy of denying inmates including Muslims the opportunity to gather together for corporate religious services. Walker v. Blackwell, 411 F.2d 23 (C.A. 5, 1969); Long. v. Parker, 390 F.2d 816; Northern v. Nelson, 315 F.Supp. 687 (N.D.Cal. 1970); affirmed, 448 F.2d 1266 (C.A. 9, 1971); Banks v. Havener, 234 F.Supp. 27 (E.D.Va. 1964); Williford v. California, 352 F. 2d 474 (C.A. 9, 1965).

[50] 39. In the instant case, the defendants have not offered any justification to support their food distribution practices which prevent Muslim inmates from adhering to their religious practice of abstaining from the consumption of pork and pork by-products. Such practices cannot be squared with the First Amendment rights of the inmates and, on the basis of the record in this case, are an unconstitutional application of state power. See, Barnett v. Rodgers, 133 U.S. App.D.C. 296, 410 F.2d 995 (1969).

[51, 52] 40. In order to justify a proscription against religious publications, including Muslim literature, officials have the burden of showing that such publications present a threat to security, discipline and good order within the institution that cannot otherwise be overcome. Rowland v. Jones, 452 F.2d 1005 (C.A. 8, 1971); Brown v. Peyton, *supra*; Long v. Parker, *supra*. In the instant case no such showing has been made with respect to the prohibited publications entitled "Message to the Black Man" and "Muhammad Speaks."

Relief

[53, 54] 41. It is within the authority and is indeed the responsibility of this court to order that all violations of federal constitutional and civil rights, and of rights and privileges secured by the laws, regulations and policies of the State of Oklahoma, cease forthwith. The Court is loath to consider the necessity of closing the Oklahoma State Penitentiary at McAlester as a direct or indirect result of its orders. Inmates v. Eisanstadt, 360 F.Supp. 676, 691 (D.Mass. 1973) affirmed, 494 F.2d 1196 (C.A. 1, 1974); *Cf.* Hamilton v. Love, 328 F.Supp. 1182, 1194 (E.D. Ark 1971). Notwithstanding the grossly offensive conditions and treatment of inmates found to exist at the Oklahoma State Penitentiary at McAlester, it is also within the authority of this Court to refrain, in its discretion, from entering at this time any order that would require or have the effect of requiring the closing of the penitentiary. The Court concludes that, at this time, the interests of all parties to the case and the public interest would be best served by the Court affording the authorities of the State of Oklahoma and of the Oklahoma State

Penitentiary the opportunity to bring conditions and treatment of inmates at the penitentiary into conformity with the requirements of the United States Constitution, federal civil rights laws, and the laws, regulations and policies of the State of Oklahoma.

JUDGMENT, DECREE, INJUNCTION AND ORDER FOR REMEDIAL ACTION

In accordance with the findings of fact and conclusions of law set forth above, and because of the determination by the Court that it is necessary for an order to issue in this case and to be in effect during the time that may be necessary for the formulation, approval and implementation of plans for complete relief, it is

Ordered that the defendants, their officers, agents, servants, employees and all other persons in active concert or participation with them, and all their successors in office, who receive actual or constructive notice of this Order by personal service or otherwise as hereinafter provided, are hereby enjoined from operating the facilities of the Oklahoma State Penitentiary McAlester, Oklahoma, in any manner inconsistent with the following provision of this Order:

Order on racial segregation and discrimination

1. Racial discrimination in any aspect of the operations of the Oklahoma State Penitentiary shall cease forthwith and forever.

2. All future cell or other housing assignments at the penitentiary, whether initial or subsequent, shall be made in accordance with a classification and assignment system in which the race of the inmate is not a factor considered. All requests by inmates for transfers from one cell or other housing assignment to another shall also be processed and decided without regard for the race of the inmate making the transfer request.

In order to insure that the mandates set forth in this paragraph are not allowed to operate so as to perpetuate segregation or facilitate resegregation, the warden shall set as a goal that all major housing units (cell blocks, dormitories, runs, etc.) should generally approximate in their respective racial compositions the racial composition of the inmate population as a whole. This is not to be an inflexible rule, as legitimate considerations within the operating scope of a valid, non-racially biased classification and assignment system may well produce some imbalances in this regard. The warden shall, however, on a quarterly basis, report to the Director of the Department of Corrections, with copies to all counsel of record in this case,[1] a detailed justification for each major housing unit that deviates more than 10 percent in either direction in the racial composition of its population from the racial composition of the inmate population as a whole. The warden of the penitentiary shall insure that there is no segregation within major housing units of the penitentiary.

3. All inmates shall have an equal opportunity to be considered fairly for assignment to and advancement within all jobs that are or may become available at the pententiary. To assist in insuring that this is achieved, no preference shall be given in future job assignments on the basis of any inmate's previous work experience at the penitentiary, where such preference would have a racially discriminatory effect. Validly applicable work experience prior to entering the penitentiary and any relevant formal education or training may of course be considered.

4. Records will hereafter be maintained at the penitentiary which will include the identity of the person(s) making each initial or subsequent job or housing assignment and the basis for such assignment. If the previous practice of assigning inmates only to departments or industries for work is reinstituted, with the specific job assignments being made within the gaining department or industry, the records of the penitentiary shall include this same information regarding each job assignment or reassignment within each department or industry. If there are job promotions available to inmates, the records concerning each promotion actually effected shall include the reason(s) why the promoted inmate was selected and the name(s) of the other inmate(s) considered for that promotion.

5. Affirmative action to overcome the effects of past discrimination in the operation of housing, dining and recreational facilities, job assignments and the dis-

[1] For purposes of ailings, counsel of record will include Mary E. Bane, Quinlan J. Shea, Jr. and Paul Crowe.

ciplinary system shall be formulated and implemented. Conceding that certain of these operations are either not carried on at the present time, or are carried on at a level far below that which was in effect prior to July 27, 1973, it must nonetheless be recognized that the restoration of normal operations at the penitentiary could present the grave likelihood of the past pattern and practice of pervasive racial discrimination being restored as well.

The defendants shall, within 60 days from the date of this Order, formulate and submit to counsel for the plaintiffs and the plaintiff-intervenor for comment, and to the court for consideration and approval, their plan for the total eradication of any present segregation and other forms of racial discrimination, for overcoming the continuing present effects of segregation and other forms of racial discrimination as heretofore practiced at the Oklahoma State Penitentiary, and for precluding the reinstitution of any discriminatory practices which were in effect prior to July 27, 1973.

The plan so submitted shall include, but not be limited to, provisions for the on-going examination of all operating procedures within the penitentiary for possible discriminatory effects; provisions for training present and future staff in the area of human relations, and the timetable for conducting such training; provisions for effective statistical and other checks and reviews at the administration level within the penitentiary; and provisions for additional checks and reviews within the Department of Corrections.

The plan so submitted shall also include the details of a procedure for the review and analysis of records maintained pursuant to paragraph 4 of this order. To overcome the effects of past discrimination in job assignments, the plan will also include a requirement, as to any specific job category wherein the racial composition of the inmate group assigned to that job category deviates more than 10 percent in either direction from the racial composition of the inmate population as a whole, that a detailed justification for each such deviation be prepared on a quarterly basis. Such justifications shall be submitted over the signature of the warden of the penitentiary to the director of the Department of Corrections and to all counsel of record in this case.

To insure the eradication of discrimination in the operation of the penitentiary disciplinary system, the plan shall also include provision for appropriate training for all individuals who prepare, investigate, review or process inmate disciplinary reports, as well as all individuals who sit on or review the results of the proceedings of disciplinary committees, and all individuals who review, approve or consider appeals from the results of such disciplianry proceedings.

Order of procedural due process

6. The Findings of Fact and Conclusions of Law pertaining to this subject make it indisputably clear that the disciplinary system as it existed and exists at the Oklahoma State Penitentiary has failed to meet constitutional requirements in almost every possible regard. Nonetheless, the Court is not unmindful of the disparate views that exist among judges, penologists and experts as to precisely what quantum of process is "due" in all of the different kinds of disciplinary proceedings that necessarily go on in a penitentiary. A similar disparity of views exists with regard to many of the administrative decisions that must be made in the ordinary course of prison administration, but which can have serious effects on the inmates concerned. The Court is firmly of the opinion that the best disciplinary system is one that is universal, in the sense of being carefully constructed to deal appropriately, but nonetheless fairly, with all of the varying kinds and degrees of offenses and rules infractions that can be and are committed in this or any other penitentiary. The same is true with regard to the administrative decision-making process by means of which significant administrative decisions affecting inmates are made.

7. Accordingly, the Court will make no effort at this time to prescribe a complete set of rules and regulations regarding procedural due process, or even to provide detailed guidelines as to what would constitute an appropriate and constitutional disciplinary system for the Oklahoma State Penitentiary, nor will it do so regarding those aspects of the penitentiary's administrative decision-making process that have led to constitutional violations in the past. If it is possible to do so, it is far preferable for those provisions necessary to overcome past constitutional deficiencies to be fashioned as part of an organic whole—that is, of a comprehensive system.

8. In the course of the preparation for and presentation of this case, counsel for the plaintiffs, the plaintiff-intervenor and the defendants have gained a possi-

bly unique perception of the problems herein involved. The Court therefore directs counsel for the parties to confer and attempt in good faith and in a spirit of cooperation to fashion a detailed, comprehensive disciplinary system for the penitentiary system to which all parties can agree in a submission to the Court. The Court further directs counsel so to confer regarding the administrative mechanism(s) by means of which decisions are made that significantly impinge upon the rights, interest, welfare and rehabilitative potential of the inmates of the penitentiary. Even if total agreement concerning these matters is not promptly achieved, the Court directs that counsel persist in their efforts and insure that as much as possible is worked out through the process of negotiation and agreement. The final product of this undertaking will be submitted to the Court for consideration and approval not more than 60 days from the date of this decree, and will be accompanied by (if necessary) submissions on behalf of each party regarding those points concerning which agreement has not been possible and constitutional interests are involved.

9. The purpose of the Court in promulgating the foregoing portion of its decree is to attempt to insure that the disciplinary system and the administrative decision-making machinery at the Oklahoma State Penitentiary are constitutional in all respects, but are at the same time adequate to fulfill the real needs of discipline and administration within the penitentiary. These goals are not mutually exclusive.

10. In the interim, the following rules shall apply:

a. No inmate shall be disciplined in any manner except for violation of a written rule, promulgated prior to the commission of the offense charged, which, in general terms at least, was adequate to have given the inmate reasonable notice that the conduct subsequently alleged as the basis for the charge could constitute a punishable act; this does not, of course, require that every possible set of facts that could be charged must be set forth with particularly, but it does prohibit punishing an inmate for conduct that he did not reasonably know could be the basis for punishment;

b. No summary punishment shall be inflicted, although this does not preclude a correctional officer from reprimanding or warning an inmate that repetition or continuation of particular conduct could or will result in a disciplinary charge being filed;

c. Inmates charged with infractions must be given official written notice of the charges against them and, in reasonably specific terms, the conduct that formed the basis for the charge, said notice to be given a reasonable time prior to any hearing that must or may be held on such charges;

d. No written charge shall be disposed of nor significant disciplinary sanction imposed on any inmate without a hearing at which the inmate is accorded a reasonable opportunity to be heard and to present his defense to, explanation of, or matters in mitigation regarding the charge(s) against him;

e. The members of the disciplinary hearing shall be impartial; as a minimum no person who was involved in bringing, investigating or processing any charge shall sit on the panel that determines the guilt of the inmate of that charge or the punishment, if any, to be imposed as a result.

f. Disciplinary charges against inmates shall be disposed of, by hearing or otherwise, as soon as practicable and such disposition shall not be delayed pending possible action in the civil court concerning the same or related matters.

g. If disciplinary sanctions are imposed that include indefinite terms in lockup, disciplinary segregation, etc., there shall be a review of the need for the continuation of such status on a regular basis, either by the disciplinary panel that imposed the sanction, by an alternate or amended panel the members of which are impartial as defined above, or by a high-ranking, disinterested administrative official at the penitentiary; no correctional officer performing duty in the lockup area where the inmate is confined shall participate in the process of deciding whether continued confinement is warranted, except that he may make such reports as to the inmate's behavior as are routinely required by penitentiary regulations and may make recommendations, with reasons therefor, as to whether continued confinement is so warranted;

h. Inmates on disciplinary lockup shall not be subjected to significant additional restrictions or sanctions except in accordance with a procedure that comports with the requirements of paragraph 10 a–f, *supra.*

i. Inmates who allegedly commit offenses or other rules infractions shall not be placed in pre-hearing detention unless a reasonable basis exists therefor, such

as the fact that their continued presence in general population poses an actual threat to the security of the institution; absent unusual and sufficient circumstances, pre-hearing detention in excess of 48 hours (72 hours if a weekend is involved) shall be presumptive evidence of a vioation of paragraph 10f of this Order; and

j. To insure that no inmate is punished in violation of the provisions of this paragraph through a process of denominating the procedure employed "administrative," rather than "disciplinary" in nature, the provisions of this paragraph shall apply generally to any administrative action to be taken that could result in the inmate being confined under punitive conditions; if an inmate is placed in administrative segregation pending investigation of serious charges against him, the review process required by paragraph 10g shall insure that the investigation is being conducted with all practicable expedition, or the inmate shall be released from such status.

Order on conditions of confinement

11. Any future use of that form of disciplinary status which was known officially as "72 hour detention" and which involved confinement in the subterranean isolation are commonly known as "the hole" is prohibited.

12. Effective immediately, before any inmate is confined in an isolation cell in the Maximum Security Unit, compliance with the procedures of paragraph 10, *supra*, is required.

Within 60 days of the date of this decree, the defendants shall submit to counsel for the plaintiff and the plaintiff-intervenor for comment, and to the court for consideration and approval, a proposed set of comprehensive regulations intended to govern future confinement in the isolation cells in the Maximum Security Unit. These proposed regulations shall set forth the conditions and treatment to be provided inmates confined in such cells and a maximum time limit for the duration of such confinement. Prior to submitting these proposed regulations to the Court, the defendants shall have said regulations reviewed by competent medical authorities, not employed by or connected with the Department of Corrections, who shall also inspect the isolation cells themselves. No proposed set of regulations shall be submitted to the Court that is not accompanied by a statement from said medical authorities to the effect that confinement in these cells, under the conditions included in the proposed regulations and found to exist at the time the cells are inspected by said medical authorities, under the treatment procedures called for in the proposed regulations, and for the maximum duration provided for in the proposed regulations, does not constitute an unreasonable risk to the physical or psychological well-being of an inmate so confined.

13. Inmates who are confined in any form of administrative segregation shall be accorded as many of the privileges enjoyed by general population inmates, to the extent enjoyed by those inmates, as the nature and purpose of their confinement in administrative segregation will allow. This provision applies, not withstanding the fact of compliance, where appropriate, with the provisions of paragraph 10, *supra*.

14. All inmates shall be afforded a reasonable time outside their cells, daily, for the purpose of exercise or other form of recreation. This provision shall be effective 10 days from the date of this decree. Weather permitting, general population inmates shall be allowed outdoors at least part of this exercise period. If at all possible, inmates in administrative segregation and discipilnary segregation shall also be allowed outdoors for this purpose.

15. Within 60 days of the date of this decree, the defendants shall cause to be made a study of the actual diet being furnished to the inmates at the Oklahoma State Penitentiary. This study shall be conducted by an individual(s) qualified in the areas of diet and nutrition. The results of this study shall be submitted in the form of a report to the Court, with copies to counsel for the plaintiff and the plaintiff-intervenor, and shall cover at least the caloric and nutritional adequacy of said diet. The report shall also address itself to the specific question of whether Muslim inmates are receiving the opportunity to be adequately fed (in terms of both calories and nutrition), without having to eat items prepared with pork or pork by-products.

16. Until other programs for the useful and constructive occupation of the general population are instituted or resumed, defendants shall undertake to

provide inmates with all practicable means for mental diversion and/or self-improvement while confined to their cells.

This portion of the Court's decree could be satisfied by offering inmates an opportunity to participate in "cell study" programs, similar to those offered to invalid students in other state institutions.

Order on use of chemical agents

17. The unjustified use of chemical agents against inmates is prohibited. They shall not be used against individual inmates, or against small groups of them, except as authorized by the policy statement of the Oklahoma State Department of Corrections dated January 4, 1973. To support the use of this form of physical force, the requirement of that policy statement that there be an actual and imminent threat of death or bodily harm must be present. Chemical agents may also be used to quell an actual or incipient riot involving a large number of unconfined inmates, where there is present an actual and imminent threat of death or bodily harm, or an actual and imminent threat of serious damage to or the destruction of property which is substantial in quantity and/or value. They may also be used to thwart the imminent escape of an inmate or inmates.

18. Whenever chemical agents are used against an inmate or inmates, all reasonable precautions shall be taken to avoid or minimize inflicting the effects thereof on innocent inmates.

19. Chemical agents shall not be used to enforce silence or otherwise to enforce the rules and regulations of the penitentiary, unless the conditions set forth in paragraph 17 are present. It will be an exceptional situation in which the use of these agents can be justified against an inmate locked in his cell. Even where a large number of inmates locked in their cells are involved in a disturbance, chemical agents shall not be used if they are merely noisy, or shaking the doors of their cells (so long as the doors remain secure), or because of anything they may say to or shout at any member of the penitentiary staff. These and similar rules infractions on the part of inmates are properly dealt with by means of the penitentiary disciplinary system, with due process safeguards, rather than summarily.

20. As is the case with any use of physical force against inmates, the use of chemical agents must never exceed that reasonably required to effect the legitimate ends of penitentiary officials. Accordingly, the use of chemical agents against inmates, on the rationale that the actual situation is one which could develop into—although it has not yet become—one in which the use of such agents is permitted, constitutes the excessive use of physical force and is prohibited both by the departmental policy statement of January 4, 1973, and by this Order.

21. Every incident involving the use of any chemical agent against any one or more inmates shall be reported in writing by the warden to the director, with copies to all counsel of record in this case, within three days of the incident until further order of the Court. A full and complete statement of all relevant circumstances shall be included in such reports. If, in the opinion of the warden, further investigation is required, he shall denominate the report an interim report and shall submit a final report when the entire investigation is completed, but not less than ten days after the incident. Any justified modification of the factual statement set forth in the interim report shall be included in this final report.

22. Within the parameters delineated by this Order, there remains great scope for the proper exercise of judgment and sound discretion on the part of penitentiary officials. The proper exercise of such judgment and discretion should not be superseded by any Court and will not be by this one. The contrary proposition is equally necessary, however; the unconstitutional use of chemical agents against inmates can neither be permitted nor condoned. What the Court has condemned in this Order is not the use of chemical agents in situations where the use of physical force against inmates is justified, but where reasonable men might differ on the kind or degree of necessary force. The Court has condemned the use of chemical agents in situations where the use of any physical force is unjustified.

Order on medical care

23. Within 60 days from the date of this Order, the defendants shall formulate a comprehensive plan for providing constitutionally adequate routine and emergency medical care (including psychiatric care) to all inmates at the Okla-

homa State Penitentiary. This plan shall be submitted to counsel for the plaintiffs and for the plaintiff-intervenor for comment, and to the Court for consideration and approval.

24. This plan shall include, but need not be limited to, the provisions necessary for the operation of an in-patient medical facility within the secured area of the penitentiary (or in such close proximity thereto that security considerations will not unreasonably delay the receipt of needed medical care by inmates in the security area). This in-patient facility shall comply in its operating procedures, staffing, equipment and physical plant with the regulations of the Oklahoma State Department of Health governing the licensure of hospitals and related institutions, or with some other set of comprehensive standards generally accepted within the medical profession.

The staffing provisions of the plan shall provide as a minimum:

(*a*) nursing care 24 hours a day, seven days a week;

(*b*) a full-time Chief Medical Officer;

(*c*) the equivalent of one additional full-time doctor;

(*d*) an adequate support staff of qualified generalist or specialist medical para-professionals;

(*e*) such additional dental and dental support staff as will bring dental care in the penitentiary system to an acceptable level; and

(*f*) a designated staff member to be responsible for insuring that adequate in-patient psychiatric care and treatment are provided.

The plan shall also specify the extent ot which medical facilities and personnel outside the penitentiary system are being relied upon to provide medical care for inmates and the specific means by which such outside care will be secured. Also included will be appropriate provisions pertaining to the control, storage, handling and distribution of all medications.

25. Pending the formulation, approval and implementation of such plan, the defendants shall insure that each inmate who goes on sick call is seen by a medical doctor or by a fully-qualified health para-professional (*e.g.*, physician's assistant, medical technican, etc.). No individual member of the staff or inmate population who is not a fully-qualified health professional or para-professional shall inhibit, prevent or obstruct any inmate from going on sick call.

Order on correspondence and publications

26. The confidentiality of any inmate's outgoing correspondence to any attorney, court, or government official or agency shall not be abridged. This provision is specifically applicable to mail to be sent to any court which is required by that court to be notarized. Incoming correspondence from any of these sources may be opened and inspected for contraband, but only in the presence of the inmate-addressee, and may not be delayed or read.

27. With respect to all other correspondence to and from inmates of the penitentiary system, the Court has previously noted with approval the recent, significant improvement in defendants' policies. Within 60 days from the date of this decree, defendants shall submit whatever modifications of their existing policies, specific practices or operating procedures in this area are deemed by them to be required or warranted in the light of the provisions of Conclusions of Law 29–31, inclusive, *supra*, or the recent decision of the United States Supreme Court in the case of *Procunier* v. *Martinez*, — U.S. —, 94 S.Ct. 1800, 40 L.Ed2d 224 (1974). Such shall be submitted, together with a written presentation of their unmodified policies, practices and operating procedures in the form of a single, proposed comprehensive regulation for consideration and approval by the Court. Copies of this submission shall also be sent to counsel for the plaintiffs and the plaintiff-intervenor for comment. No inmate, whether enjoying unrestricted or restricted correspondence status under defendants' existing policy statement, shall be subjected to any arbitrary limitations on the number of approved correspondents, the identity thereof, etc.

28. With respect to general circulation publications, such as newspapers and magazines, a comprehensive regulation, consistent with all aspects of Conclusion of Law 32, *supra*, shall be submitted within 60 days from the date of this decree, to counsel for the plaintiffs and the plaintiff-intervenor for comment, and to the Court for consideration and approval. This plan shall include all of the necessary and reasonable rules with which an inmate must comply in order to subscribe to any such general circulation publication. It shall also in-

clude those detailed internal operating procedures necessary to insure that any present, continuing effects of past arbitrary and capricious practices in this area are overcome.

29. No decision shall be made to exclude any publication except as may be required by the needs of security, good order, or rehabilitation; nor shall any such decision be made by any penitentiary official other than the Warden or Deputy Warden, and then only after full compliance with the applicable provisions of Conclusion of Law 32, *supra*, regarding notice, opportunity to submit additional facts, etc. Any decision to exclude shall be made solely on the basis of the content of the specific publication in question and the official actually making the decision shall prepare and retain on file a detailed statement of the specific basis for each such exclusion.

Order on access to the courts

30. Within 60 days from the date of this Order, the defendants shall prepare and submit to counsel for the plaintiff and plaintiff-intervenor for comment, and to the Court for consideration and approval, a comprehensive plan for insuring that inmates at the Oklahoma State Penitentiary have adequate and effective access to the Courts. The plan shall consider and address the problem of reasonable access in terms of habeas corpus petitions, § 1983 and other civil rights matters, out-of-time appeals, and such other matters as are addressed more particularly in the Findings of Fact and Conclusions of Law, *supra*. In order to insure that effective access is available throughout the penitentiary system, appropriate consideration shall be given to the number of inmates in the penitentiary system, the fact of their geographic dispersion, the anticipated number of requests for post-conviction legal assistance, and the educational level of the overall inmate population.

31. Pending the information, approval and implementation of such a plan, the defendants shall forthwith refrain from interfering with the acquisition or possession by inmates of legal materials, including transcripts, lawbooks, legal periodicals, paper, etc. They shall also arrange for capable and experienced inmates to be allowed to help those who require assistance in order to be able effectively to frame and present legal issues and relevant facts for judicial consideration.

32. The defendants shall forthwith advise all inmates that they are permitted to subscribe to any legal periodical and to seek to obtain lawbooks and legal assistance by mail. The defendants shall insure that the inmates understand that they are permitted to purchase and possess legal periodicals and books specifically dealing with the legal problems of inmates and that they are authorized to write to organizations concentrating on such problems in an effort to obtain legal assistance, reference materials, etc.

Order on religious freedom

33. Defendants shall forthwith cease all unreasonable interference with the provision to inmates of spiritual counselling and the opportunity to engage in group religious services.

34. Defendant shall forthwith advise all inmates of the penitentiary system that they may subscribe to and receive religious publications, including books, newspapers and magazines, unless any such publication demonstrably presents a threat to security, discipline and good order within the institution that cannot otherwise be overcome.

Muslim inmates shall forthwith be advised specifically that the above authority to subscribe to and receive religious publications extends to the publications entitled "Message to the Black Man" and "Muhammad Speaks." They shall also be advised of every food item served to the inmates of the penitentiary that is known or believed by the defendants to contain pork or pork by-products.

35. Within 60 days of the date of this decree, the defendants shall advise the Court, in writing, with copies to counsel for plaintiff and plaintiff-intervenor, of the progress to date and of all future plans for providing religious counselling and group services, and of the fact of compliance with the remaining provisions of this portion of the Court's decree.

Order on security and staffing

36. The Court has found that there were and are serious deficiencies in the level of overall security within the Oklahoma State Penitentiary. In different

ways, this involves the security of the institution itself, the personal security of the members of the staff and the inmates who, as wards of the state, are entitled to and indeed must look to the state to reasonably insure their safety. The Court has further found that these security deficiencies are in large measure due to both a serious shortage of staff at the penitentiary and to a very high turnover among staff members. Many of the unconstitutional conditions and practices that exist at the penitentiary (or which existed in the recent past and have present continuing effects) cannot be corrected without a considerable improvement in these areas of security and staffing.

37. Accordingly, counsel for the defendants shall, within 60 days of the date of this Order, submit to counsel for the plaintiffs and the plaintiff-intervenor for comment, and to the Court for consideration and approval, a plan for effecting promptly all necessary improvement in the areas of security and staffing.

38. In the interim, the defendants are advised that alleged shortages of staff shall not be deemed to constitute an acceptable reason for the failure to comply fully with any provision of this decree. Unless specifically provided to the contrary herein, alleged security considerations shall also be deemed not to constitute an acceptable reason for the failure to comply fully with any provision of this decree.

Order on general provisions

39. Certain difficulties that arose in the course of the trial of this case would have been more readily resolved if permanent records had previously been maintained of inmate housing assignments, by cell-block and cell, beginning with each inmate's initial assignment and showing the inclusive dates of it and all subsequent assignments. Furthermore, compliance with certain provisions of this decree will be more readily determined if such records are maintained. Accordingly, the defendants are directed to annotate the permanent records kept on each inmate with his present housing assignment and to insure that subsequent assignments are also recorded therein.

40. Counsel for plaintiffs and plaintiff-intervenor will have access at all reasonable times to such records as are maintained concerning penitentiary inmates, whether or not required to be kept by this decree. They shall also have unimpeded access to individual inmates at all reasonable times for purposes of conducting interviews to ascertain whether there has been compliance with all provisions of this decree. Counsel for plaintiff-intervenor are specifically authorized to utilize Special Agents of the Federal Bureau of Investigation for these purposes.

41. If any of the defendants shall have any doubt or question as to the meaning, scope or application of any provision of this decree, the inquiry shall be submitted to the Court in writing in a communication from counsel for the defendant(s). The responsive communication from the Court will also be in writing. Copies of all such communications shall be placed in the file of this case and concurrently served upon counsel for the plaintiffs and plaintiff-intervenor. The same procedure shall apply to any such inquiries that may be deemed necessary by counsel for the plaintiffs or the plaintiff-intervenor.

The defendants are charged with the duty of fully explaining the terms of this decree to all of their agents, servants, representatives and employees, including penitentiary staff, guards and other personnel, and to assure their understanding of the court's requirements and the necessity for strict compliance therewith.

42. The Court retains jurisdiction of this case for all purposes and specifically reserves the power to issue further and supplemental orders in aid of the provisions of this injunction or any of its terms. The Court also reserves for determination all issues not dealt with expressly herein.

43. In lieu of service by the United States Marshal, the Clerk of this Court is hereby directed to send by United States mail a certified copy of this Order to each of the defendants in this case and to any other individuals identified in the Preliminary Statement as having succeeded in office any of the named defendants.

[APPENDIX 33]

Cite as 419 F. Supp. 358 (D. Md. 1976)

United States of America

v.

Dr. Neil Solomon, Secretary of Health and Mental Hygiene of the State of Maryland, et al.

Civ. A. No. N-74-181.

United States District Court, D. Maryland.

July 8, 1976.

The Attorney General sought on behalf of the United States to enjoin certain practices and policies of Maryland mental health administrators that were allegedly in violation of the constitutional rights of mentally retarded citizens. On motion of defendants to dismiss, the District Court, Northrop, Chief Judge, held that where, in regard to the protection of the rights of the mentally retarded citizens of Maryland the executive failed to establish anything approaching a situation of national emergency, the appropriate response to which could only be made independently by the executive branch of the federal Government, the executive's severe burden to justify independent action in the face of congressional disapproval of such action was not met, and the executive, therefore, lacked standing to bring suit.

Motion granted.

Company, supra, at 270–271. International was an active advisor to the Local, and sat in on most of the Local's negotiations with the Company for collective-bargaining agreements.

1. Constitutional Law ⟹27

The branches of the federal Government have no natural power, but only such power as is provided by the Constitution itself.

2. United States ⟹134

The executive branch of the federal Government has no power and, therefore, no legal standing to bring a suit before the judiciary unless such authority can be found, either explicitly or implicitly, in the scheme of government laid out by the Constitution.

3. Constitutional Law ⟹62(5)

Though the Constitution says nothing explicitly about the power of the executive to bring a suit before the judiciary, the Congress, in exercise of its delegated powers, particularly the "necessary and proper" powers, can authorize the executive to sue. U.S.C.A. Const. art. 1, § 8.

4. Attorney General ⟹7

Statutes which reserve to officers of the Department of Justice the conduct of litigation in which the United States is a party or is interested and which authorize the Attorney General to argue any case in a court of the United States in which the United States is interested do not grant authority to the Attorney General to bring an action concerning any matter in which he thinks that the United States might be interested and, thus, constitute no authority for concluding that Congress has explicitly authorized the executive to bring suits generally under the Thirteenth and Fourteenth Amendments. 28 U.S.C.A. §§ 516, 518; U.S.C.A. Const. Amends. 13, 14.

5. United States ⟹124

The executive does have authority to bring suit in some situations, such as those involving proprietary and contractual interests of the federal Government, grievous wrongs upon the general public, or burdens upon interstate commerce, even though the Constitution says nothing explicitly concerning such power even though Congress has not expressly granted such power. U.S.C.A.Const. art. 1, § 8.

6. United States ⚷124

The nonstatutory authority of the executive to sue, though extended to situations involving burdens on interstate commerce, may not be extended to the broadest reaches of that commerce, since it is one thing to give the executive an independent role when there is an emergency threat to interstate commerce to which only the executive branch of Government has the capacity to respond with appropriate alacrity, but quite another thing to give the executive an independent role where the "emergency" is debatable and all that may be at stake is the development of policy concerning interstate commerce. U.S.C.A.Const. art. 1, § 8.

7. Attorney General ⚷7

The same considerations which militated against extending the principle respecting the nonstatutory power of the executive to sue to the limits of the notion of burdens on interstate commerce also dictated against acceptance of the argument that the principle should be extended beyond interstate commerce into the area of Thirteenth or Fourteenth Amendment enforcement so as to allow the Attorney General to bring suit on behalf of the United States to enjoin certain practices and policies of Maryland mental health administrators that were allegedly in violation of constitutional rights of mentally retarded citizens. U.S.C.A.Const. art. 1, § 8; Amends. 13, 14.

8. United States ⚷124

Just as the nonstatutory executive power to sue based on the broad notion of burdens on intestate commerce insinuates the federal legal bureaucracy into practically every conceivable affair of state policy making, thereby destroying federalism, so too does a power to sue based on notions of deprivation of Thirteenth and Fourteenth Amendment rights. U.S.C.A.Const. art. 1, § 8; Amends. 13, 14.

9. Constitutional Law ⚷76

Any extension of independent authority to the executive in enforcing the Thirteenth and Fourteenth Amendments is fraught with potential for undoing the balance of powers between the branches of the Government. U.S.C.A.Const. Amends. 13, 14.

10. Attorney General ⚷7

Various specific authorizations given by the Congress for suits by the Attorney General cannot be characterized as merely "legislative direction" for the exercise of the sweeping power which the Congress otherwise generally intends the Attorney General to have in Thirteenth and Fourteenth Amendment cases. U.S.C.A. Const. Amends. 13–15; 18 U.S.C.A. § 242; Civil Rights Act of 1964, §§ 206, 301, 407, 707, 902, 1103, 42 U.S.C.A. §§ 2000a–5, 2000b, 2000c–6, 2000e, 2000h–2, 2000h–3; 42 U.S.C.A. § 1971; Voting Rights Act of 1965, § 2, 42 U.S.C.A. § 1973; Civil Rights Act of 1960, § 301, 42 U.S.C.A. § 1974.

11. Mental Health ⚷2

Congress did not intend or expect that while an elaborate plan to improve the lot of the mentally retarded was being implemented by one federal agency, namely, the Department of Health, Education and Welfare with expertise in the field of mental retardation, another government agency, the Department of Justice, with no expertise in the solution of the very difficult problems posed by mental retardation, could simultaneously make wholesale attacks on a states' mental retardation programs under the guise of protecting Thirteenth and Fourteenth Amendment rights. Developmentally Disabled Assistance and Bill of Rights Act, §§ 109, 133, 135, 42 U.S.C.A. §§ 6008, 6063, 6065; U.S.C.A. Const. Amends. 13, 14.

12. Attorney General ⚷7

It may not be inferred from the various congressional enactments aimed at helping the mentally retarded and protecting civil rights that Congress tacitly sanctions a broad authority to sue for the Attorney General, inasmuch as Congress on several occasions explicitly considered and rejected the idea of broadening the Attorney General's powers to sue to protect citizens' rights under the Thirteenth and Fourteenth Amendments. Developmentally Disabled Assistance and Bill of Rights Act, §§ 109, 133, 135, 42 U.S.C.A. §§ 6008, 6063, 6065; U.S.C.A. Const. Amends. 13, 14.

94-420—77——72

13. United States ⚿134

When the apparent will of Congress is that the executive should not have an independent power to sue, the burden of the executive to show that it should nevertheless have the power is an extremely heavy one, and though the executive's burden may be eased somewhat when the independent authority or power is sought to be exercised in an area of concern, such as national security, when the executive's constitutional role is equal, if not superior, to that of Congress, when the independent executive authority is sought to be exercised in an area of concern, such as the protection of Fourteenth Amendment rights or the development of interstate commerce policy, an area in which the role of Congress is predominant under the Constitution, the executive's burden of showing the need for independent authority to act is most severe. U.S.C.A.Const. art. 1, § 8; Amend. 14.

14. Constitutional Law ⚿76

The duty of the executive to "take Care that the Laws be faithfully executed" is a duty that does not go beyond the laws or require the executive to achieve more than Congress sees fit to leave within the power of the executive. U.S.C.A. Const. art. 2, § 3.

15. Attorney General ⚿7

Where, with regard to protection of rights of the mentally retarded citizens of Maryland, the Attorney General of the United States, seeking to enjoin certain practices and policies of mental health administrators that were allegedly violative to the constitutional rights of mentally retarded failed to show anything approaching a situation of national emergency, the appropriate response to which could only be made independently by the executive branch of the federal Government, the severe burden of the executive to justify independent action in the face of congressional disapproval of such action was not met, and the federal executive, therefore, lacked standing to bring the action. Developmentally Disabled Assistance and Bill of Rights Act, §§ 109, 133, 135, 42 U.S.C.A. §§ 6008, 6063, 6065; U.S.C.A.Const. art. 1 § 8; Amends. 13, 14.

Edward H. Levi, Atty. Gen., J. Stanley Pottinger, Asst. Atty. Gen., Civil Rights Div., Louis M. Thrasher, Director of Office of Special Litigation, Civil Rights Div., Washington, D.C., Jesse H. Queen, Michael S. Lottman, Mickey A. Steiman, Susan Lentz, Attys., Dept. of Justice, Washington, D.C., and Jervis S. Finney, U.S. Atty. for the District of Maryland, Baltimore, Md. (Louis M. Thrasher, Washington, D.C., presenting oral argument at hearing), for plaintiff.

Francis B. Burch, Atty. Gen. of Maryland and Paul Walter, Paul M. Vettori, Stephen Sfekas and Judith K. Sykes, Asst. Attys. Gen., Baltimore, Md. (Paul Walter, Stephen Sfekas and Judith K. Sykes, Baltimore, Md., participating in presentation of oral argument), for defendants.

Robert P. Kane, Atty. Gen. of Pennsylvania, J. Justin Blewitt, Jr., Chief, Civ. Litigation, Harrisburg, Pa., Norman J. Watkins, Jeffrey Cooper, Deputy Attys. Gen. Harrisburg, Pa., on amicus curiae brief in behalf of the Commonwealth of Pennsylvania.

John L. Hill, Atty. Gen. of Texas, Austin, Tex., David M. Kendall, Thomas W. Choate, and Richel Rivers, Asst. Attys. Gen., Austin, Tex., on amicus curiae brief in behalf of the State of Texas.

NORTHROP, Chief Judge.

The Attorney General of the United States has brought this suit on behalf of the United States seeking to enjoin certain practices and policies of the officials of the State of Maryland primarily charged with the responsibility of administering Maryland's programs for the care and training of mentally retarded citizens. The Complaint alleges that the defendants' policies and practices have resulted in severe and widespread deprivation of the rights guaranteed by the eighth, thirteenth, and fourteenth amendments of the Constitution to residents of Rosewood State Hospital, Maryland's major facility for the residence of the mentally retarded.

The defendants have filed a Motion to Dismiss, contending that the Attorney General has no authority or standing to bring this action on behalf of the United States. The states of Pennsylvania and Texas have filed amicus curiae briefs in support of the defendants' position. Plaintiff, of course, sharply disputes the contention that it does not have the authority and standing to prosecute this action.

The issue of executive authority which has thus been joined by this Motion to Dismiss has far-reaching implications for the functioning of a system of constitutional, democratic government based on a balance of powers. See *Estelle* v. *Justice*, 426 U.S. 925, 929, 96 S.Ct. 2637, 49 L.Ed.2d 380 (1976) (Rehnquist, J., dissenting from a denial of certiorari). After exhaustive consideration of the relevant arguments and authorities, this Court has reached the emphatic conclusion that the power of the executive branch of government does not extend to bringing a suit such as this one and that defendants' Motion to Dismiss should therefore be granted.

Before detailing the reasons for this conclusion, this Court wants to emphasize that it is expressing no opinion on the merits of the underlying issue regarding the care and treatment of the mentally retarded in Maryland. The proper habilitation of mentally retarded citizens is a matter of acute concern to this Court, as indeed it should be to all decent and civilized persons. This Court has no doubt that the instant lawsuit stems from a benevolent desire on the part of officials of the Department of Justice to improve the lot of the mentally retarded. Important and compelling as a charitable aspiration for helping the mentally retarded achieve a meaningful existence may be, however, it must not be allowed to impel a procedural result which by implication, if not by direct effect, would threaten the delicate balance of power which the Constitution conceives among the various branches of the federal government and between the federal and state governments. This conclusion does not have the mentally retarded without remedy for violations of their constitutional rights; it simply means that lawsuits aimed at protecting these rights must be brought by proper plaintiff. It is noteworthy that several such lawsuits have been brought in recent years in Maryland. *See Maryland Association for Retarded Citizens, Inc.* v. *Solomon*, Civ. No. N-74-228 (D.Md., filed Mar. 6, 1974); *Maryland Association for Retarded Citizens* v. *Maryland*, Civ. No. 72-733-M (D.Md., filed July 19, 1972); *Bauer* v. *Mandel*, Docket 30, Folio 61, File 22871 (Circ.Ct. of Anne Arundel County, filed Sept. 11, 1975); *Maryland Association for Retarded Citizens* v. *Department of Health & Mental Hygiene*, Docket 100, Folio 182, File 77676 (Circuit Court of Baltimore County, Maryland; decided for plaintiff, May 3, 1974).

This, then, is not in any sense a decision about the rights and needs of the mentally retarded. It is a decision about the proper limitation of the power of the executive branch of the United States Government.

[1, 2] Basic to the philosophy of the American Constitution is the notion that the branches of the federal government have no "natural" power, but only such power as is provided by the Constitution itself. *See generally* Hamilton, Madison, and Jay, *The Federalist*, included in Scott, *The Federalist and Other Constitutional Papers* (2 vol. ed. 1894; 1 vol. ed. 1898). So central was this concept in the thinking of the founders of our country that they went to the trouble of making it explicit by means of the ninth and tenth amendments of the Bill of Rights. Thus, the discussion of executive power in this case must start from the premise that the executive branch of the federal government has no power and therefore no legal standing to bring this suit unless such authority can be found, either explicitly or implicitly, in the scheme of government laid out by the Constitution.

[3] The Constitution says nothing explicitly about the power of the executive to bring a suit before the judiciary.[1] Despite this, there has never been much question that the Congress, in exercise of its delegated powers (particularly the "necessary and proper" powers of Article I, Section 8), can authorize the executive to sue. *See, e.g., United States* v. *Raines*, 362 U.S. 17, 27, 80 S.Ct. 519, 4 L.Ed.2d 524 (1960). Indeed, such legislative authorization abounds.

In the instant case, the government contends that Congress, by means of Sections 516 and 518 of Title 28 of the United States Code, has explicitly authorized the Attorney General to bring this suit. Section 516 is entitled "Conduct of litigation reserved to Department of Justice" and provides as follows:

"Except as otherwise authorized by law, the conduct of litigation in which the United States, an agency, or officer thereof is a party, or is interested, and securing evidence therefor, is reserved to officers of the Department of Justice, under the direction of the Attorney General."

Section 518 is entitled "Conduct and argument of cases" and provides in pertinent part as follows:

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[1] It can perhaps be argued that such a power is contemplated, at least in some circumstances, by Article III, Section 2, which extends the judicial power to "controversies to which the United States shall be a party."

"When the Attorney General considers it in the interests of the United States, he may personally conduct and argue any case in a court of the United States in which the United States is interested, or he may direct the Solicitor General or any officer of the Department of Justice to do so."

[4] These sections, however, do not grant authority to the Attorney General to bring an action concerning any matter in which he thinks that the United States might be "interested." *United States* v. *Daniel, Urbahn, Seelye and Fuller*, 357 F.Supp. 853, 858 (N.D.Ill.1973); *see Allen* v. *County School Board of Prince Edward County*, 28 F.R.D. 358, 362–63 (E.D.Va. 1961). The sections tell us nothing about the nature of "interest" which will activiate the Attorney General's discretion to act. These sections, therefore, constitute no authority on which to base a conclusion that Congress has explicitly authorized the executive to bring suits generally under the thirteenth and fourteenth amendments.

[5] The Supreme Court long ago made it clear that the executive does have authority to bring suit in some situations even though the Constitution says nothing explicitly concerning such power and even though Congress has not expressly granted such power. The first of such situations recognized by the Court involved the proprietary and contractual interests of the federal government. *Dugan* v. *United States*, 16 U.S. (3 Wheat.) 172, 4 L.Ed. 362 (1818) (suit on a bill of exchange); *United States* v. *Tingey*, 30 U.S. (5 Pet.) 115, 8 L.Ed. 66 (1831) (suit for breach of contract); *Cotton* v. *United States*, 52 U.S. (11 How.) 229, 13 L.Ed. 675 (1850) (suit for trespass). Broadly speaking, the Supreme Court concluded that the power to bring suit was a logical and necessary adjunct to the executive's power to oversee the national government's proprietary and contractual interest. *See also United States* v. *California*, 332 U.S. 19, 27, 67 S.Ct. 1658, 91 L.Ed. 1889 (1947).

This limited view of the executive's power to sue was expanded somewhat in *United States* v. *San Jacinto Tin Co.*, 125 U.S. 273, 8 S.Ct. 850, 31 L.Ed. 747 (1888), to allow suit to set aside a land patent based on alleged fraud. *Accord*, *Kern River Co.* v. *United States*, 257 U.S. 147, 155, 42 S.Ct. 60, 66 L.Ed. 175 (1921). *San Jacinto Tin* seemed to require that the government have some "pecuniary interest in the remedy sought," 125 U.S. at 286, 8 S.Ct. at 857, but such a limitation was apparently abandoned in *United States* v. *American Bell Telephone Co.*, 128 U.S. 315, 9 S.Ct. 90, 32 L.Ed. 450 (1888), where a right of action was granted to the executive to protect the government from fraud in the issuance of a patent of invention. The Court in *Bell Telephone* concluded that, despite the lack of any pecuniary interest of the government in rescinding the patent, it would be a "strange anomaly" to make the government stand by while "a party may practice an intentional fraud upon the officers of the government who are authorized and whose duty it is to decide upon his right to a patent, and he may by means of that fraud perpetrate a grievous wrong upon the general public." *Id.* at 357, 9 S.Ct. at 93.

This idea of basing the executive's nonstatutory power to sue on the notion of a "grievous wrong upon the general public," as opposed to basing it on an invasion of the executive's proprietary, contractual, or pecuniary interest, was brought to full flower in the watershed case of *In re Debs*, 158 U.S. 564, 15 S.Ct. 900, 39 L.Ed. 1092 (1895). The case involved the question of whether the Attorney General had authority to bring a suit for injunction against activities of union leaders, including conspiracy to use violence to interrupt the mails, during the Pullman strike of 1894. The Supreme Court found that he did. The Court could have rested its decision solely on the executive's proprietary interest in protecting the mails, but Justice Brewer, after citing that basis for suit, went on to conclude the following:

"We do not care to place our decision upon this ground [protecting the mails] alone. Every government, intrusted by the very terms of its being with powers and duties to be exercised and discharged for the general welfare, has a right to apply to its own courts for any proper assistance in the exercise of the one and the discharge of the other, and it is no sufficient answer to its appeal to one of those courts that it has no pecuniary interest in the matter. The obligations which it is under to promote the interest of all and to prevent the wrongdoing of one, resulting in injury to the general welfare, is often of itself sufficient to give it a standing in court. This proposition in some of its relations has heretofore received the sanction of this court."

[Whereupon, the Court discussed *San Jacinto Tin and Bell Telephone*] . . .

* * * * * * *

"It is obvious from these decisions that while it is not the provision of the government to interfere in any mere matter of private controversy between individuals, or to use its great powers to enforce the rights of one against another, yet, whenever the wrongs complained of are such as affect the public at large, and are in respect of matters which by the constitution are intrusted to the care of the nation, and concerning which the nation owes the duty to all the citizens of securing to them their common rights, then the mere fact that the government has no pecuniary interest in the controversy is not sufficient to exclude it from the courts, or prevent it from taking measures therein to fully discharge those constitutional duties.

"The national government, given by the constitution power to regulate interstate commerce, has by express statute assumed jurisdiction over such commerce when carried upon railroads. It is charged, threfore, with the duty of keeping those highways of interstate commerce free from obstruction, for it has always been recognized as one of the powers and duties of a government to remove obstructions from the highways under its control." *Id.* at 584–86, 15 S.Ct. at 906–907.

It is not clear from the langauage of *Debs* just exactly how expansive a meaning the Court intended to attach to the concept of "wrongs . . . such as affect the public at large, and are in respect of matters which by the constitution are intrusted to the care of the nation, and concerning which the nation owes the duty to all the citizens of securing to them their common rights." In decisions subsequent to *Debs*, the court has applied the concept primarily to situations involving emergency obstructions to interstate commerce. For example, in *Sanitary District of Chicago* v. *United States*, 266 U.S. 405, 45 S.Ct. 176, 69 L.Ed. 352 (1925), the Court allowed a suit by the executive for an injunction against reversal of the flow of the Chicago River which threatened the water level of the Great Lakes. *See also Wyandotte Transportation Co.* v. *United States*, 389 U.S. 191, 201–02, 88 S.Ct. 379, 19 L.Ed.2d 407 (1967); *United States* v. *Republic Steel Corp.*, 362 U.S. 482, 492, 80 S.Ct. 884, 4 L.Ed.2d 903 (1960).

Some lower federal courts have determined that the *Debs* holding would have application in situations involving national security. *E. g.*, *United States* v. *Marchetti* 466 F.2d 1309, 1313 (4th Cir. 1972), *cert. denied*, 409 U.S. 1063, 93 S.Ct. 553, 34 L.Ed.2d 516 (1972); *United States* v. *Arlington County, Commonwealth of Virginia*, 326 F.2d 929 (4th Cir. 1964); *United States* v. *New York Times Co.*, 328 F. Supp. 324, 327–28 (S.D.N.Y. 1971), *rev'd on other grounds*, 444 F.2d 544 (2d Cir. 1971), *rev'd*, 403 U.S. 713, 91 S.Ct. 2140, 29 L.Ed.2d 822 (1971); *United States* v. *Brittain*, 319 F.Supp. 1058, 1961 (N.D.Ala. 1970). Such as application might be implied by the Supreme Court's alternate holding in *Sanitary District* that the implementation of treaty obligations would also justify a suit by the executive without legislative authorization. *United States* v. *City of Glen Cove*, 322 F.Supp. 149 (E.D.N.Y. 1971), *aff'd*, 450 F.2d 844 (2d Cir. 1971). However, the Court itself recently avoided an opportunity to decide explicitly whether the *Debs* concept extends to national security matters. *New York Times Co.* v. *United States*, 403 U.S. 713, 91 S.Ct. 2140, 29 L.Ed.2d 822 (1971) (the "Pentagon Papers" case); *see also Sullivan* v. *United States*, 395 U.S. 169, 89 S.Ct. 1648, 23 L.Ed.2d 182 (1969); *Paul* v. *United States*, 371 U.S. 245, 83 S.Ct. 426, 9 L.Ed.2d 292 (1963). That the executive's constitutional role in protecting national security is arguably much broader than its constitutional role in developing interstate commerce policy may be justification for extending the *Debs* principlle into areas of national security, at least when dire emergencies are involved. Be that as it may, it sufficies to note that no allegations concerning national security have been made in the instant case.

Despite the susceptibiity of *Debs* to the interpretation that the government's non-statutory right to sue with regard to interstate commerce matters is activated only in situations involving severe obstructions in the nature of emergency public nuisances, a series of civil rights cases brought by the Attorney General in states of the South in the early 1960's raised the possibility that *Debs* might have a much wider interstate commerce application. *United States* v. *City of Jackson*, 318 F.2d 1, 11–16 (5th Cir. 1963), *reh. denied*, 320 F.2d 870 (1963) (per curiam); *United States by Katzenbach* v. *Original Knights of the Ku Klux Klan*, 250 F.Supp. 330, 356 (E.D. La. 1965); *United States* v. *City of Shreveport*, 210 F.Supp. 36 (W.D.La. 1962); *United States* v. *Lassiter*, 203 F.Supp. 20 (W.D.La. 1962), *aff'd*, 371 U.S. 10, 83 S.Ct. 21, 9 L.Ed.2d 47 (1962) (per curiam); *United States* v. *City of Montgomery*, 201 F.Supp. 590 (M.D.Ala. 1962); *United States* v.

U. S. Klans, Knights of Ku Klux Klan, Inc., 194 F. Supp. 897, 902 (M.D. Ala. 1961). A basic thrust of these cases was that racial discrimination in public accommodations and interference with travel on the basis of race constituted obstructions of interstate commerce which the Attorney General could sue to remove without Congressional authorization.

Such "obstructions" could be viewed as less emergent, less tangible, and less direct than the obstructions in *Debs*. So viewed, this line of civil rights cases constitutes an extension of *Debs*. On the other hand, it could be argued that owing to the extremely tense racial situation in the early 1960's, these "obstructions" which the Attorney General was attempting to enjoin constituted no less of an emergency threat to interstate commerce than the violent actions involved in *Debs*. In other words, it would not be illogical to conclude that these civil rights cases did not go beyond a narrow interpretation of the *Debs* concept at all. This conclusion is bolstered by the fact that when the Fifth Circuit panel in *City of Jackson* refused a reheiring, two judges took the opportunity to disavow any support for Judge Wisdom's prior opinion for the court insofar as it had suggested the possibility of broadened nonstatutory right for the executive to sue. These two judges instead concluded that a Congressional enactment had specifically authorized the suit before them. 320 F.2d at 871–73 (Bootle, J. and Ainsworth, J., specially concurring).

Nevertheless, a very broad reading of *Debs* and its civil rights progeny was adopted in the case of *United States v. Brand Jewelers, Inc.*, 318 F.Supp. 1293 (S.D.N.Y. 1970). The Attorney General had brought the suit to halt the scurrilous practice of "sewer service" in New York City. This practice involved the sale by unscrupulous retailers of consumer items on easy credit terms. The sales were quickly followed by lawsuits by the retailers claiming that credit payments had not been made. The retailers would employ private process servers in such suits with the apparent intention that service not actually be made (hence, the names "sewer service," for the alleged practice of the private process servers of simply throwing process papers into the gutter). The idea was to obtain a cheap default judgment with which to garnish the unknowing defendant's salary.

One of the government's arguments in favor of its being able to bring the suit without Congressional authorization in *Brand Jewelers* was that the practice of "sewer service" constituted a substantial burden on interstate commerce due to losses of employment from garnishments, burdens upon employers, and disruptions of labor-management relations. Responding to the defendant's argument that this "burden" was quite different from the obstructive crisis in *Debs*, Judge Frankel concluded that "no plausible reason" existed for attributing any significance to the distinction between physical and nonphysical burdens and between direct and indirect burdens. *Id.* at 1298–99. He cited the civil rights cases and the *Arlington County* decision dealing with national security as authority for this conclusion. His decision, therefore, stands for the notion that chronic, indirect, intangible burdens on interstate commerce are sufficient to give the federal executive nonstatutory authority to sue as emergent, physical obstructions of the *Debs* or *Santiary District* variety.

Judge Frankel's expansive application of *Debs* has been roughly criticized. *E. g.*, note: *Nonstatutory Executive Authority to Bring Suit*, 85 Harv.L.Rev. 1566 (1972); Recent Decision, *Federal Courts—Standing—United States Has Non-Statutory Authority Under Commerce and Due Process Clauses to Bring Suit to Enjoin "Sewer Service" Practices by Private Business— United States v. Brand Jewelers, Inc.*, 84 Harv.L.Rev. 1930 (1971); Note, *Constitutional Law—United States Government's Standing to Sue—A New Approach to Legal Assistance for Ghetto Residents or an Invitation to Executive Lawmaking?* 17 Wayne L.Rev. 1287 (1971). With all due respect to Judge Frankel, this Court finds itself in agreement with much of the criticism.

[6] The extension of the *Debs* principle toward the outer limits of the definition of "burdens" on interstate commerce works a subtle reorganization of the balance of power between the executive and legislative branches of the federal government. Congress has been specifically entrusted with primary responsibility for the regulation of interstate commerce. U.S. Const. art. I, § 8, cl. 3. It is one thing to give the executive anindependent role when these is an emergency threat to interstate commerce to which only the executive branch of government has the capacity to respond with appropriate alacrity, but it is quite another thing to give the executive an independent role where the "emergency" is debatable and all that may be at stake is the development of policy concerning interstate commrce. The commerce clause clearly anticipates that policy development is to be left to Congress.

It is no answer to this analysis of the structure of our government to suggest, as Judge Frankel did (see *Brand Jewelers, supra* at 1299), that the power to sue is not really an independent power because it is, after all, subject to the check and balance of the judiciary which adjudicates the merits of any suit. Lawsuits, especially ones brought by the federal government, unquestionably have an impact that transcends any adjudication which may occur. Settlement, particularly where it involves pure captiulation by the defendant, can result in a de facto policy which has never been subject to the check of final adjudication. More important, though, the wisdom of a judge, even if he gets a chance to exercise it, is no substitute in our system of representative government for the political process of the legislature in areas of important policy development such as interstate commerce.

It is also, no answer to the balance-of-powers problem to presume, see *id.*, that the legislature can and will correct nay result with which it does not concur. The policy effected by the lawsuit may be irreversible, or at least the reversial may prove more troublesome than the effort is worth. Action by Congress is usually time-consuming and quite arduous. To place a burden of response on the legislative process would undoubtedly result in the development of ambiguous policy situations in which, for whatever reasons, the legislature has been unable to grind out either an explicit approval or disapproval of the policy brought into being by an executive lawsuit.

Perhaps the strongest reason against allowing the nonstatutory authority of the executive to sue to extend to the broadest reaches of interstate commerce is the impact such power has on our system of federalism. Difficult indeed is the task of anyone who tries to demonstrate in this day and age that any action, especially a state program or policy, has no effect on interstate commerce. Thus, if the executive nonstatutory power to sue to protect interstate commerce is given its broadest application, no state policy or program will be safe from the questioning eyes of those few lawyer-bureaucrats who have the authority to devise government lawsuits. Such an affront to the federal system of shared powers should not be counteranced unless absolutely necessary. Cf. *Rizzo* v. *Goode*, 423 U.S. 362, 96 S.Ct. 598, 608, 46 L.Ed.2d 561 (1976).

Of course, this Court is fully cognizant of the fact that the Supreme Court has allowed the powers of Congress itself to reach into the farthest and darkest nooks and crannies of man's conception of "interstate commerce." *E. g.*, *Wickard* v. *Filburn*, 317 U.S. 111, 63 S.Ct. 82, 87 L.Ed. 122 (1942). This, too, can lead to serious debasement of the principle of federalism. See, *e.g.*, *Maryland* v. *Writz*, 269 F.Supp. 826, 852–55 (D.Md.1967) (Northrop, J. dissenting), *aff'd*, 392 U.S. 183, 201–05, 88 S.Ct. 2017, 20 L.Ed.2d 1020 (1968) (Douglas, J., dissenting). The Supreme Court, however, is now demonstrating a greater concern for Congressional assaults on federalism through the Commerce Clause. *The National League of Cities* v. *Usery*. —— U.S. ——, 96 S.Ct. 2465, 49 L.Ed2d 245 (1976) (which expressly overruled *Maryland* v. *Writz*). In any event, it can at least be said that Congressional impingement on state policy-making sovereignty is quite different from executive intrusion. The members of Congress are drawn from and maintain close ties with their respective states; thus, Congress cannot act without the states in a sense having some say in the matter. The same cannot be said when the executive branch of the federal government acts alone. It must also be noted that the legislative process is by its very nature less given to the influence of the whims and fancy of just one or two individuals. In short, troubling though the encroachment of Congress through the Commerce Clause on the integrity of state sovereignty may be, allowing the executive to exercise independent powers of encroachment would be far more troubling.

[7] Having said all of this, this Court hastens to recognize that the government in the instant case is not claiming that its powder to sue stems from a burden on interstate commerce. The foregoing analysis is not in vain, however, for the same considerations which limitate against extending *Debs* to the limits of the notion of burdens on interstate commerce also dictate against acceptance of the government's argument in this case that the *Debs* principle should be extended beyond interstate commerce into the area of thirteenth or fourteenth amendment enforcement.

Apparent authority for the government's position is found in *Brand Jewelers*. Judge Frankel not only extended the *Debs* principle as it applies to obstruction of commerce, but he alternatively held that the executive has a nonstatutory right to sue under the fourteenth amendment irrespective of any burdens on inter-

state commerce. In reaching this conclusion, the judge chose not to follow several courts which had determined that the Attorney General has no such sweeping power. *United States* v. *County School Board, Prince George County, Virginia*, 221 F.Supp. 93 103–04 (E.D.Va.1963) (dictum); *United States* v. *Biloxi Municipal School District*, 219 F.Supp. 691, 693–94 (S.D.Miss.1963) and *United States* v. *Madison County Board of Education*, 219 F.Supp. 60, 61 (N.D.Ala.1963), *both aff'd on other grounds*, 326 F.2d 237 (5th Cir. 1964), *cert. denied*, 379 U.S. 929, 85 S.Ct. 324, 13 L.Ed.2d 341 (1964). Instead, he relied on the more tenuous authority represented by Judge Wisdom's opinion in *City of Jackson, supra*, which, as previously pointed out, was rejected by the other two judges insofar as it suggested (and, indeed, it had only "suggested" without indicating total acceptance) application of the principles on which Judge Frankel wished to rely, and on a dissent in *United States* v. *Mississippi*, 229 F.Supp. 925, 976 (S.D.Miss.1964) (Brown, J., dissenting), *rev'd*, 380 U.S. 128, 85, S.Ct. 808, 13 L.Ed.2d 717 (1965) which relied entirely on Judge Wisdom's opinion.

Realizing that his holding was breaking new ground in the application of *Debs*, Judge Frankel offered the following justification for the expansion:

[T]his court finds no acceptable basis in principle for distinguishing today the authority of the Attorney General to protect against large-scale burdens on interstate commerce from his authority to protect against large-scale denials of due process. The dramatic history of how great judges participated in the building of a nation by imaginative unfolding of the commerce power needs no retelling here. Nor is it necessary now to be portentous about the new struggles for individual rights and decency that may be vital for the preservation of what our predecessors built. It seems sufficient for present purposes to say that there appears to be no pertinent constitutional difference between the national power to regulate commerce and the prohibition in the Fourteenth Amendment which the United States seeks in this suit to enforce."

United States v. *Brand Jewelers, supra* at 1300; *see also Alexander* v. *Hall*, 64 F.R.D. 152, 157 (D.S.C. 1974) (allowing government intervention in a suit challenging state commitment and detainment procedures for the mentally ill).

This Court respectfully declines to follow this "imaginative unfolding" of the *Debs* principle into the area of fourteenth amendment enforcement.

[8] Just as nonstatutory executive power to sue based on a broad notion of burdens on interstate commerce insinuates the federal legal bureaucracy into practically every conceivable affair of state policy-making, thereby destroying federalism, so too does a power to sue based on notions of deprivation of thirteenth and fourteenth amendment rights. Such a blow to federalism might arguably be justified if absolutely no other adequate protection for fourteenth amendment rights were available. This "absolute necessity" factor was perhaps a key in the application of the *Debs* principle in the civil rights cases of the early 1960's, for the pervasive racial discrimination which was in issue in those cases also worked as a mighty deterrent to any kind of effective court action by the aggrieved individuals themselves. No such "absolute necessity" obtains in the instant case. As evidenced by the suits which are presently pending in this court and in the state courts, the mentally retarded are certainly not without adequate resources for the protection of their civil rights.[2] *See Maryland Association for Retarded Citizens, Inc* v. *Solomon, supra; Maryland Association for Retarded Citizens, Inc.* v. *Maryland, supra; Bauer* v. *Mandel, supra; and Maryland Association for Retarded Citizens* v. *Department of Health & Mental Hygiene, supra.*

[9] As with interstate commerce, policy-making in the area of enforcement of the thirteenth and fourteenth amendments is primarily entrusted to Congress. U.S. Const., Amend. 13, § 2; Amend. 14, § 5. Thus, any extension of independent authority to the executive in enforcing the thirteenth and fourteenth amendments is fraught with potential for undoing the balance of powers between the branches of the government. With regard to this balance of power, it is extremely significant to note that the *Debs* extension of independent nonstatutory author-

[2] Of course, concerns about federalism can also play a significant role in civil rights suits brought by individuals, particularly where the remedy sought involves the creation of new state programs. *Rizzo* v. *Goode, supra*, or a major continuing intrusion of the Federal courts into the daily conduct of state affairs. *O'Shea* v. *Littleton*, 414 U.S. 488, 502, 94 S.Ct. 669, 38 L.Ed.2d 674 (1974). It would be premature to speculate at this point what the effect of such concerns might be in a suit brought by individuals which contains the type of allegations and requests for remedies present in the instant suit.

ity to the executive took place in the context of Congress not having expressed any opinion as to whether the executive should have such new power. *Debs*, and its predecessors and progeny, could in fact be read as finding that the non-statutory authority of the executive to sue extends only to situations in which it can be surmised that Congress wants the executive to sue. The instant case reveals a quite different picture of the will of Congress.

Pursuant to its power to regulate interstate commerce and to enforce, by appropriate legislation, the provisions of the thirteenth, fourteenth, and fifteenth amendments, Congress has enacted numerous enforcement schemes involving the Attorney General, See, e.g., 18 U.S.C. § 242; 42 U.S.C. §§ 1971, 1973, 1974, 2000a–5, 2000b, 2000c–6, 2000e–6, 2000h–2, 2000h–3. None of these authorizations covers the situation in the instant case. It could therefore be argued that Congress intended that the executive not sue in a case like the instant one.

[10] To counter this inference, the government contends, first of all, that Congress' various specific authorizations for suit by the Attorney General constitute merely "legislative direction" for the exercise of the sweeping power with Congress otherwise generally intends the Attorney General to have in thirteenth and fourteenth amendment cases. In other words, the specific authorizations are actually diminutions of the power Congress otherwise wants the executive to have. It can hardly be believed, however, that Congress would go to so much effort just to give "direction." *United States v. School District of Ferndale, Michigan*, 400 F. Supp. 1122, 1130 (E.D. Mich. 1975). In any events, as will be demonstrated *infra*, the tenor, as well as the substance, of the Congressional debates and reports regarding the various civil rights act belies any such notion.

The government also points out that Congress has passed much legislation evidencing concern for the mentally retarded. Although, like the civil rights legislation, none of the mental retardation legislation provides explicit authority for the instant suit, the government contends that the two types of legislation taken together impliedly sanction a suit like the instant one.

This Court recognizes that it is proper to infer in some situation that Congress tacitly intended a more wide-reaching scheme for the accomplishment of its goal than it was able to articulate. *Wyandotte, etc. v. United States, supra; United States v. Republic Steel Corp., supra.* This, however, is not an appropriate case for such an inference.

[11] First, in one of the enactments cited by the government, the Developmentally Disabled Assistance and Bill of Rights Act (the "Act"),[3] Congress has

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[3] 42 U.S.C. § 6001 *et seq.* This legislation pulls together and embellishes several prior enactments aimed at developing a meaningful federal program for assisting the states and private agencies in improving habilitative services for the mentally retarded and other developmentally disabled persons. The background of the legislation is succinctly presented in the following excerpt from the legislative history:

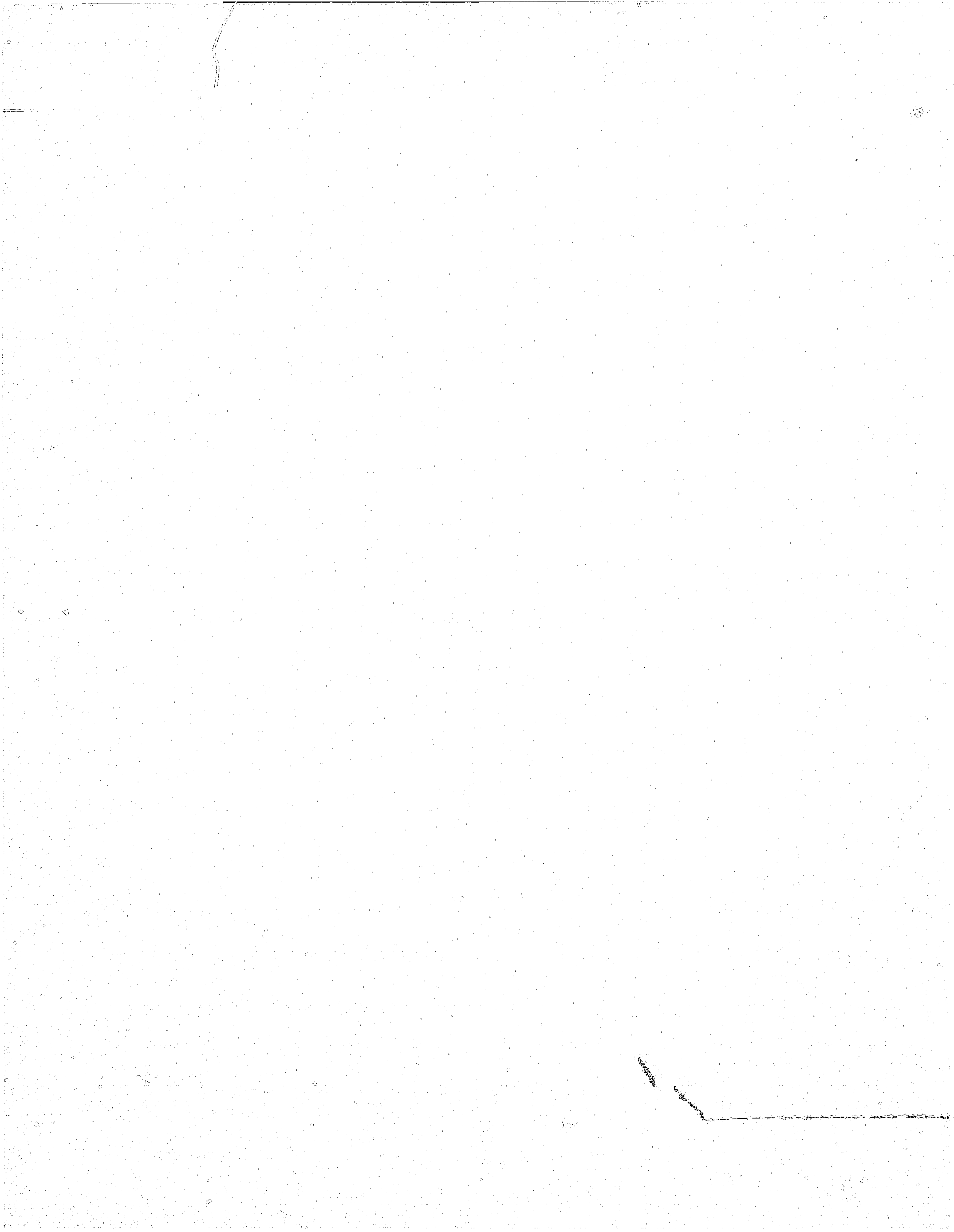
"Developmental disabilities are disabilities, such as mental retardation, cerebral palsy, epilepsy, autism, dyslexia and neurological conditions, which originate in childhood, continue indefinitely, and constitute a substantial handicap to the affected individual There are over 6 million people in the United States suffering from mental retardation and, depending on who is counted, an additional several million people suffering from other developmental disabilities. Citizens with developmental disabilities need support and assistance with learning and living so that they may function in our society as the citizens that they are with maximum effectiveness.

The Congress of the United States began to respond to the needs of these millions of people many years ago with an assortment of social security and rehabilitation programs. This response received new impetus in 1963 with the enactment of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88–164, October 31, 1963). This Act provided for centers for research on the mentally retarded, construction of university affiliated facilities for the mentally retarded, construction of other facilities for the mentally retarded, and training of teachers of mentally retarded and other handicapped children.

The legislation was continued with modest revisions by the Mental Retardation Amendments of 1967 (Public Law 90–170). This Act extended the authority for grants for the construction of facilities for the mentally retarded and university-affiliated facilities through June, 1970, added authority for grants for the costs of the professional and technical personnel of community mental retardation facilities, added authority for the training of physical educators and recreation personnel for such facilities, and broadened the definition of mental retardation to include neurological handicaps related to it.

The Act was subsequently rewritten in 1970 by he Development Disabilities Services and Facilities Construction Amendments (Public Law 91–517). This Act changed the title of the program and its direction to a broader and more inclusive concern for the developmentally disabled generally. It authorized formula grants to states for planning, administration, construction, and services, concerned with developmental disabilities, grants for interdisciplinary training programs in institutions of higher learning, grants for special projects of national significance, grants for the construction and operation of university-affiliated facilities for those with developmental disabilities, and provided for the establishment of a National Advisory Council on Services and Facilities for the Mentally Disabled."

H.R. Report No. 94–58, 94th Cong., 1st Sess. (1975), 1975 U.S. Code Cong. & Admin. News, pp. 921–22.



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provided a scheme whereby the executive branch of government can accomplish much of what the Attorney General hopes to accomplish in this suit. Under this Act, in order for a state to receive federal funds for construction of new facilities and provision of new services for the mentally retarded, it must agree to abide by qualitative standards for habilitative care prescribed in regulations promulgated by the Secretary of Health, Education & Welfare. 42 U.S.C. §§ 6008, 6063. A state's funds may be discontinued (after notice and opportunity for hearing) if the Secretary finds that the standards prescribed by the regulations are no longer being met. 42 U.S.C. § 6065.

This Congress has devised what it hopes will be an effective carrot-and-stick method of improving the lot of the mentally retarded in America.[4] This Court simply cannot believe that Congress intended or expected that while an elaborate plan to improve the lot of the mentally retarded was being implemented by the one federal agency (the Department of Health, Education & Welfare) with expertise in the field of mental retardation, another government agency (the Department of of Justice) with no expertise in the solution of the very difficullt problems posed by mental retardation would simultaneously be making wholesale attacks on a state's mental retardation programs under the guise of protecting thirteenth and fourteenth amendment rights. Surely, if Congress had wanted two agencies to be involved in ameliorating the states' efforts to help the mentally retarded, it would have at least provided some legislative guidance as to procedures for preventing the conflict and contradictory goals that can and do occur when two federal agencies independently act on the same matter.

[12] An even stronger reason for not inferring from the various Congressional enactment aimed at helping the mentally retarded and protecting civill rights that Congress tacitly sanctions a broad authority to sue for the Attorney General is that Congress has several times explicitly considered and rejected the idea of broadening the Attorney General's powers to sue to protect citizens' rights under the thirteenth and fourteenth amendments.

The bill passed by the House of Representatives which ultimately became the Civil Rights Act of 1957 included a section, Title III,[5] giving the Attorney General broad powers to seek civil remedies in civil rights cases involving violations of 42 U.S.C. § 1985. The inclusion of Title III was apparently in response to the then Attorney General's request that he be given the expanded powers. *See* Letter of Attorney General Herbert Brownell, H.R. Rep. No. 291, 85th Cong., 1st Sess. (1957), 1957 U.S. Code Cong. & Admin. News, pp. 1979–80. After vehement opposition to Title III on the floor of the Senate—opposition based in significant part on the effect such broad power might have on the balance of powers between the federal and state governments, see 103 Cong. Rec. 12530–12565 (daily ed. July 24, 1957)—it was deleted from the Senate version of the bill, and the Civil Rights Act of 1957 was subsequently enacted without it.

An attempt to rejuvenate Title III in the Civil Rights Act of 1960 was also rejected. See H.R. Rep. No. 956, 86th Cong., 2d Sess. (1960), 1960 U.S. Code Cong. & Admin. News, p. 1940; 106 Cong. Rec. 5151–5182 (daily ed. Mar 10, 1960).

The Civil Rights Act of 1964 greatly broadened the Attorney's power to bring suits, but the House explicitly rejected in committee an attempt to incorporate broad, Title III-type powers for the Attorney General. See H.R. Rep. No.

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[4] A similar carrot-and-stick approach to improving services by the states is present in other enactments which affect the mentally retarded. *See, esp.*, 42 U.S.C. §§ 1395–96 ("Medicaid"). Maryland receives substantial amounts of funds under the Medicaid program for care of persons at Rosewood Hospital. Plaintiff's Brief, Addendum B. Significantly, as revealed at the hearing on the Motion to Dismiss, Maryland is at this very moment engaged in an effort to ensure that its programs at Rosewood meet the rigorous requirements of the Medicaid program. See also 42 U.S.C. § 1397.

[5] Title III read in pertinent part as follows:

"Section 121, Section 1980 of the Revised Statutes (42 U.S.C. 1985) is amended . . . to read as follows: Fourth. Whenever any persons have engaged or there are reasonable grounds to believe that any persons are about to engage in any acts or practices which would give rise to a cause of action pursuant to paragraphs 1st, 2nd, or 3rd, the Attorney-General may institute for the United States, or in the name of the United States, a civil action or other proper proceeding for preventive relief, including an application for a permanent or temporary injunction, restraining order, or other order. . ."

914, 88th Cong., 2d Sess. (1964), 1964 U.S. Code Cong. & Admin. News, pp. 2392–93, 2411.[6] Perhaps a significant factor in the House's rejection of the notion of expanding the Attorney General's power to bring suit to the ultimate limits allowed by the thirteenth and fourteenth amendments was the caution of then Attorney General Robert F. Kennedy, who made the following remarks to the Committee on the Judiciary:

"Title III would extend to claimed violations of constitutional rights in State criminal proceedings or in book or movie censorship; disputes involving church-state relations; economic questions such as allegedly confiscatory ratemaking or the constitutional requirement of just compensation in land acquisition cases; the propriety of incarceration in mental hospital; searches and seizures; and controversies involving freedom of worship, or speech, or of the press.

"Obviously, the proposal injects Federal executive authority into some areas which are not its legitimate concern and vests the Attorney General with broad discretion in matters of great political and social concern.

". . . Which types of disputes should the Attorney General make a matter of Federal concern? . . . (*Id.* at 2450 (emphasis added)).

Thus, since Congress has explicitly considered and rejected extending the authority of the Attorney General to sue generally in cases such as the instant one, the inference is strong that Congress feels the Attorney General should not have a power to sue broader than that it has specifically given.

The government attempts to overcome Congress' rejection of broader powers to sue by asserting that the authority to sue can be inferred even where Congress has explicitly considered and rejected such authority. The government cites as authority for this proposition the case of *United States* v. *California*, 332 U.S. 19, 27–28, 67 S.Ct. 1658, 91 L.Ed. 1889 (1947), in which the government's authority to sue to avoid leases improperly granted by California for oil exploration in offshore lands owned by the federal government was upheld in the face of two prior failures of Congress to grant such power to sue. A significant aspect of the Supreme Court's decision, however, was the explanation in a footnote that Congress had failed to grant such power to sue because it felt that the executive already had such power in the situation involved. *Id.* at 28 n. 4, 67 S.Ct. 1658. In the instant case, on the other hand, Congress has failed to grant the power to sue, not because it feels the executive already has such power, but because it apparently doubts whether the executive should have such power. *United States* v. *California* therefore does not constitute authority for allowing suit by the executive in this case.

[13] When the apparent will of Congress is that the executive should not have a power, the burden of the executive to show that it should nevertheless have the power is an extremely heavy one, "for what is at stake is the equilibrium established by our constitutional system." *Youngstown Sheet & Tube Co., Inc.* v. *Sawyer*, 343 U.S. 579, 637–38, 72 S.Ct. 863, 871, 96 L.Ed. 1153 (1952) (Jackson, J., concurring) (the "*Steel Seizure*" case). When the independent authority (or, as plaintiff terms it, the "inherent power") is sought to be exercised in an area of concern, such as national security, where the executive's Constitutional role is equal, if not superior, to that of Congress, the executive's burden may be eased somewhat. But when the independent executive authority is sought to be exercised in an area of concern, such as the protection of fourteenth amendment rights or the development of interstate commerce policy, where the role of Congress is predominant under the Constitution, the executive's burden of showing the need for an independent authority to act is most severe.

[14] That severe burden is not sustained in the instant case by the government's incantation of the Constitution's charge to the executive that it "take Care that the Laws be faithfully executed." Art. II, § 3. While this duty may provide a basis for independent action in certain very limited situations where Congress has not taken a position concerning such action, *see, e.g., In re Neagle*, 135 U.S. 1, 63–66, 10 S.Ct. 658, 34 L.Ed. 55 (1890), in general it is subject to the wise circumscription expressed by Justice Frankfurter in the *Steel Seizure* case:

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[6] The bill passed by Congress did provide broad power for the Attorney General to intervene in fourteenth amendment cases. 42 U.S.C. § 2000h–2. It is unnecessary at this time to decide whether this intervention authorization might justify a different line of analysis in a case where the government seeks authority to intervene in a situation outside the boundaries of this specific authorization. Consider, e.g., *In re Estelle*, 516 F.2d 480 (5th Cir. 1975), cert. denied, 426 U.S. 925, 96 S.Ct. 2637, 49 L.Ed.2d 380 (1976); *Alexander* v. *Hall*, *supra*.

"Apart from his vast share of responsibility for the conduct of our foreign relations, the embracing function of the President is that 'he shall take Care that the Laws be faithfully executed * * * 'Art. II, § 3. The nature of that authority has for me been comprehensively indicated by Mr. Justice Holmes. 'The duty of the President to see that the laws be executed is a duty that does not go beyond the laws or require him to achieve more than Congress sees fit to leave within his power.' *Myers* v. *United States*, 272 U.S. 52, 177, 47 S.Ct. 21, 85, 71 L.Ed. 160. The powers of the President are not as particularized as are those of Congress. But unenumerated powers do not mean undefined powers. The separation of powers built into our Constitution gives essential content to undefined provisions in the frame of our government." (*Youngstown Sheet & Tube Co., Inc.* v. *Sawyer*, *supra*, 343 U.S. at 610, 72 S.Ct. at 897 (Frankfurter, J., concurring)).

[15] In this case, the executive has not shown to exist with regard to the protection of the rights of the mentally retarded citizens of Maryland, anything approaching a situation of national emergency, the appropriate response to which can only be made independently by the executive branch of the federal government. Thus, this Court concludes that the executive's severe burden to justify independent action in the face of Congressional disapproval of such action has not been met, and the federal executive therefore lacks standing to bring the instant action.

Accordingly, it is, this 8th day of July, 1976, by the United States District Court for the District of Maryland, ordered:

1. That defendants' Motion to Dismiss this action BE, and the same hereby is, granted; and

2. That the within case be, and the same hereby is, dismissed.

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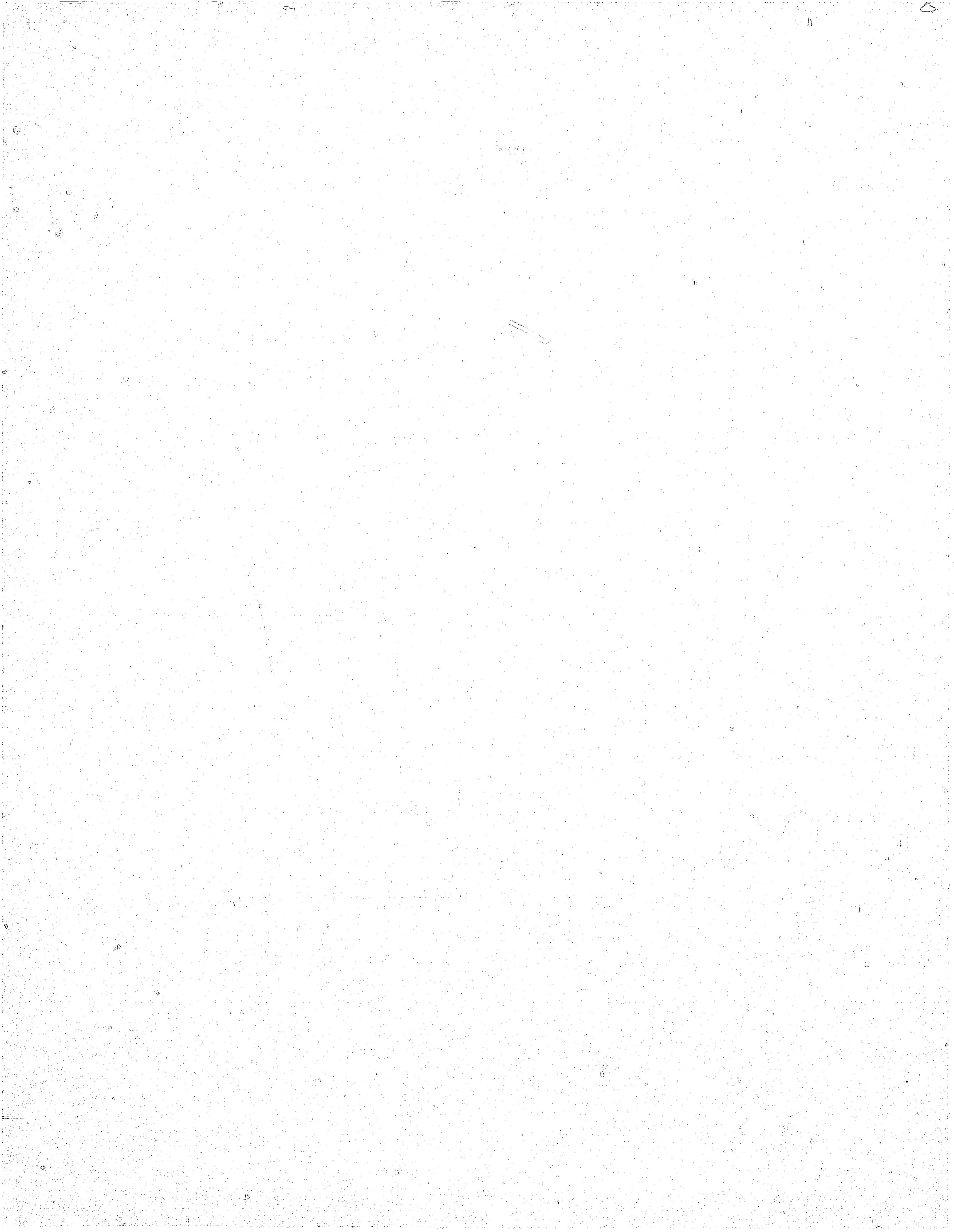

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13 OF 13