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Hon. Sam J. Ervin, Jr.,
Chairman, Subcommittee on Constitutional Rights,
Committee on the Judiciary,
U.S. Senate,
Washington, D.C.

Dear Mr. Chairman: Thank you for your letter of April 2, 1974 in which you request information on any biomedical and behavioral research designed to alter the behavior of human subjects. I apologize for the delay in answering your questions.

The Environmental Protection Agency neither conducts nor is planning to conduct any biomedical or behavioral research designed to alter the behavior of human subjects. EPA's research is aimed at studying and abating the effects of pollutants on human health and welfare. In that sense, we are studying the biomedical and, sometimes, the behavioral effects of certain pollutants on human health, for example, the effects of noise pollution, non-ionizing radiation, and toxic substances. These research studies are to determine whether behavioral effects exist or are detectable, and at what pollutant exposure levels. The studies are not designed to alter the behavior of human subjects.

I trust that this information is of use to you. Should you desire further information please do not hesitate to call on us.

Sincerely yours,

John Quarles,
(For Russell E. Train).

Hon. Sam J. Ervin, Jr.,
Chairman, Subcommittee on Constitutional Rights, Committee on the Judiciary,
U.S. Senate, Washington, D.C.

Dear Senator Ervin: Thank you for your letter of April 2 requesting information on biomedical and behavioral research designed to alter the behavior of human subjects. We have assumed that your reference to research designed to alter the behavior of human subjects does not encompass research projects that: (1) involve animals as subjects, even though the principles derived from such research may eventually have application to human beings; (2) involve observation only; or (3) deal with the broad field of improvements in the learning process, even though such improvements may be viewed as alterations of behavior.

Within these assumptions, we can state that the National Science Foundation does not support any biomedical or behavioral research designed to alter the behavior of human subjects. The Foundation does, however, support a substantial amount of research in social sciences, psychobiology and neurobiology directed at understanding human behavior, and this research often requires the participation of human subjects. If you wish, I shall be pleased to provide detailed information regarding research projects we support in any or all of the three categories we have excluded.

With respect to the information requested in your numbered paragraph 2, the Foundation's policy with respect to rights of human research subjects is governed by the following 1967 resolution of the National Science Board:

"The Board unanimously authorized the Foundation to (1) make known to grantees engaged in biomedical, social and behavioral research its concern over the rights of privacy of persons individually or collectively involved in such research, and (2) as necessary, satisfy itself that grantees are taking appropriate measures for securing the subject's informed consent, maintaining the confidentiality of data and otherwise safeguarding his right to privacy."

This policy has been implemented by paragraph 272 of the NSF Grants Administration Manual (NSF 73-20, copy attached) which states that safeguarding the rights and welfare of human subjects involved in activities...
supported by NSF grants is the responsibility of the grantee institution, and that pending promulgation of NSF guidelines the Foundation subscribes to the DHEW's publication (NIH 72-102) entitled "The Institutional Guide to DHEW Policy on Protection of Human Subjects". In this connection the Foundation is studying the proposed amended guidelines of HEW entitled "Protection of Human Subjects—Policies and Procedures", which appeared in the Federal Register on October 9 and November 16, 1973, Volume 38, Numbers 194 and 222.

Administration and enforcement of the foregoing policy and regulation are conducted at the divisional and program levels of the Foundation. During the grant review process, ethical questions involving protection of the rights of human research subjects are given careful consideration, and before a grant is made necessary assurances that the rights of human subjects will be safeguarded are obtained from the prospective grantees. However, in accordance with paragraph 270 of the NSF Grants Administration Manual, it is not Foundation policy to police the implementation of these safeguards after the grant is made.

We hope that the foregoing information is responsive to the questions raised in your letter. The Foundation is deeply committed to continuing concern over the ethical and human value implications of science and technology, and I thoroughly concur in your view that the federal government has a special responsibility to protect the rights and safety of subjects of human experimentation involved in federally-supported research projects.

Sincerely yours,

H. GUYFORD STEVER, Director.

270 MISCELLANEOUS

271 Data Collection. When an NSF-supported project involves the collection of information from 10 or more persons, the plan or report form(s) to be used in such data collection may be subject, with certain specified exceptions, to the prior clearance requirements prescribed by OMB Circular A-40, revised. If data collection is contemplated, such activity should be clearly set forth in the proposal. This will facilitate the processing of any clearance action required in time to avoid delay in the performance of the grant. Guidance in this area will be provided by the NSF Program Officer, in coordination with the NSF clearance office.

272 Human Subjects. Safeguarding the rights and welfare of human subjects involved in activities supported by NSF grants is the responsibility of the grantee institution. Pending promulgation of NSF guidelines, grantees are referred to DHEW Publication No. (NIH) 72-102, the "Institutional Guide to DHEW Policy on Protection of Human Subjects." NSF grantees shall not conduct or support research on a human fetus which is outside the womb of its mother and which has a beating heart.

273 Liabilities and Losses. NSF assumes no liability with respect to accidents, bodily injury, illness, breach of contract or any other damages or loss, or with respect to any claims arising out of any activities undertaken with the financial support of an NSF grant, whether with respect to persons or property of the grantee or third parties. The grantee is advised to insure or otherwise protect itself or others as it may seem desirable. (See 318.7, "Insurance Costs.")
The data is being collected. A report will be sent to you as soon as possible.

Sincerely,

GERALD D. GRIFFIN,
Assistant Administrator for Legislative Affairs.

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION,

Hon. SAM J. ERVIN, Jr.,
Chairman, Subcommittee on Constitutional Rights, Committee on the Judiciary,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: In response to your inquiry of April 2, 1974, concerning research involving alterations of the behavior of human subjects, NASA is engaged in no such activity.

Our Behavioral Research Program is a very small one, focusing primarily on the areas of small group performance and circadian rhythms (work-rest-sleep cycles). In the neuro-behavioral area our work centers almost exclusively on studies of alertness, sleep, and the special senses with strong emphasis on vestibular function; i.e., space motion sickness. None of our work involves the modification of behavioral states.

If we can be of further assistance to you or the Subcommittee, please do not hesitate to call on us.

Sincerely,

GERALD D. GRIFFIN,
Assistant Administrator for Legislative Affairs.

[Item V.A.10]

EXECUTIVE OFFICE OF THE PRESIDENT,
SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION,

Hon. SAM J. ERVIN, Jr.,
Chairman, Subcommittee on Constitutional Rights,
U.S. Senate, Washington, D.C.

DEAR SENATOR ERVIN: I am writing in response to your letter of inquiry concerning biomedical and/or behavioral research which is designed to alter the behavior of human subjects.

In the broadest sense, of course, all of the research conducted or supported by the Special Action Office for Drug Abuse Prevention has, as its ultimate goal, the reduction of drug abuse in the United States, and is to that extent designed to alter the behavior of human subjects. I am assuming, however, that you have reference to psychological conditioning techniques as such.

This agency neither conducts nor directly supports any such research. To the extent that any such research related to drug abuse is conducted by the Federal Government, it is through the Department of Health, Education, and Welfare, and I understand that that Department is making a separate report to you on the matter.

If I can supply any further information, please do not hesitate to call on me.

Sincerely yours,

ROBERT L. DuPONT, M.D., Director.
The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocuurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical, and legal concepts:

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

2. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

3. The experiment should be such as to yield fruitful results for the good of society, unprocuurable by other methods or means of study, and not random and unnecessary in nature.

4. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

5. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

6. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

7. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

8. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

9. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

10. During the course of the experiment the scientist in charge must be prepared...
pared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill, and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

B. Court Cases

[Item VI.B.1]

In the Circuit Court for the County of Wayne, State of Michigan

Civil Action No. 73-19434-AW

GABE KAIMOWITZ, REPRESENTING HIMSELF AND CERTAIN INDIVIDUAL MEMBERS OF THE MEDICAL COMMITTEE FOR HUMAN RIGHTS ON BEHALF OF JOHN DOE AND AT LEAST 23 OTHERS SIMILARLY SITUATED WHO ARE HELD OR COMMITTED VOLUNTARILY IN PUBLIC INSTITUTIONS IN MICHIGAN, PETITIONERS-PLAINTIFFS, AND JOHN DOE, INTERVENOR-PLAINTIFF

vs.

DEPARTMENT OF MENTAL HEALTH FOR THE STATE OF MICHIGAN, DR. E. G. YUDASHIKIN, DIRECTOR, STATE DEPARTMENT OF MENTAL HEALTH; DR. J. S. GOTTLIEB, DIRECTOR LAFAYETTE CLINIC; DR. ERNEST RODIN, ASSOCIATE OF DR. GOTTLIEB AT THE CLINIC, IN THEIR OFFICIAL CAPACITIES, AS WELL AS THEIR AGENTS, ASSIGNEES, EMPLOYEES, AND SUCCESSORS IN OFFICE, RESPONDENTS-DEFENDANTS, AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, AMICUS CURIAE

Opinion

This case came to this Court originally on a complaint for a Writ of Habeas Corpus brought by Plaintiff Kaimowitz on behalf of John Doe and the Medical Committee for Human Rights, alleging that John Doe was being illegally detained in the Lafayette Clinic for the purpose of experimental psychosurgery.1

John Doe had been committed by the Kalamazoo County Circuit Court on January 11, 1955, to the Ionia State Hospital as a Criminal Sexual Psychopath, without a trial of criminal charges, under the terms of the then existing Criminal Sexual Psychopathic law.2 He had been charged with the murder and subsequent rape of a student nurse at the Kalamazoo State Hospital while he was confined there as a mental patient.

In 1972, Drs. Ernst Rodin and Jacques Gottlieb of the Lafayette Clinic, a facility of the Michigan Department of Mental Health, had filed a proposal "For the Study of Treatment of Uncontrollable Aggression," 3 This was funded by the Legislature of the State of Michigan for the fiscal year 1972. After more than 17 years at the Ionia State Hospital, John Doe was transferred to the Lafayette Clinic in November of 1972 as a suitable research subject for the Clinic's study of uncontrollable aggression.

Under the terms of the study, 24 criminal sexual psychopaths in the State's mental health system were to be subjects of experiment. The experiment was to compare the effects of surgery on the amygdaloid portion of the limbic system of the brain with the effect of the drug cyproterone acetate on the male

1 See Appendix to Opinion, Item 1.
hormone flow. The comparison was intended to show which, if either, could be used in controlling aggression of males in an institutional setting, and to afford lasting permanent relief from such aggression to the patient.

Substantial difficulties were encountered in locating a suitable patient population for the surgical procedures and a matched controlled group for the treatment by the anti-androgen drug. As a matter of fact, it was concluded that John Doe was the only known appropriate candidate available within the state mental health system for the surgical experiment.

John Doe signed an "informed consent" form to become an experimental subject prior to his transfer from the Ionia State State Hospital. He had obtained signatures from his parents giving consent for the experimental and innovative surgical procedures to be performed on his brain, and two separate three-man review committees were established by Dr. Rodin to review the scientific worthiness of the study and the validity of the consent obtained from Doe.

The Scientific Review Committee, headed by Dr. Elliot Luby, approved of the procedure, and the Human Rights Review Committee, consisting of Ralph Slovenko, a Professor of Law and Psychiatry at Wayne State University, Monsignor Clifford Sawher, and Frank Moran, a Certified Public Accountant, gave their approval to the procedure.

Even though no experimental subjects were found to be available in the state mental health system other than John Doe, Dr. Rodin prepared to proceed with the experiment on Doe, and depth electrodes were to be inserted into his brain on or about January 15, 1973.

Early in January, 1973, Plaintiff Kaimowits became aware of the work being contemplated on John Doe and made his concern known to the Detroit Free Press. Considerable newspaper publicity ensued and this action was filed shortly thereafter.

With the rush of publicity on the filing of the original suit, funds for the research project were stopped by Dr. Gordon Yudashkin, Director of the Department of Mental Health, and the investigators, Drs. Gottlieb and Rodin, dropped their plans to pursue the research set out in the proposal. They reaffirmed the "Informed Consent" form signed by John Doe is as follows:

"Since conventional treatment efforts over a period of several years have not enabled me to control my outbursts of rage and anti-social behavior, I submit an application to be a subject in a research project which may offer me a form of effective therapy. This therapy is based upon the idea that episodes of anti-social rage and sexuality might be triggered by a disturbance in certain portions of my brain. I understand that in order to be certain that a significant brain disturbance exists, which might relate to my anti-social behavior, an initial operation will have to be performed. This procedure consists of placing fine wires into my brain which will record the electrical activity from those structures which play a part in anger and sexuality. These electrical waves can then be studied to determine the presence of an abnormality.

In an additional electrical stimulation with weak currents passed through these wires will be done in order to find out if one or several points in the brain can trigger my episodes of violence or unlawful sexuality. In other words this stimulation may cause me to want to commit an aggressive or sexual act, but every effort will be made to have a sufficient number of people present to control me. If the brain disturbance is limited to a small area, I understand that the investigators will destroy this part of my brain with an electrical current. If the abnormality comes from a larger part of my brain, I agree that it should be surgically removed, if the doctors determine that it can be done so, without risk of side effects. Should the electrical activity from the parts of my brain into which the wires have been placed reveal that there is no significant abnormality, the wires will simply be withdrawn.

I realize that any operation on the brain carries a number of risks which may be slight, but could be potentially serious. These risks include infection, bleeding, temporary or permanent weakness or paralysis of one or more of my legs or arms, difficulties with speech and thinking, as well as the ability to feel, touch, pain and temperature. Under extraordinary circumstances, it is also possible that I might not survive the operation.

Fully aware of the risks detailed in the paragraphs above, I authorize the physicians of Lafayette Clinic and Providence Hospital to perform the procedures as outlined above.

Date: October 27, 1972
Calvin Vallee, Witness.

/8/ LOUIS M. SMITH, Signature.

/8/ EMILY T. SMITH/HARRY L. SMITH, Signature of responsible relative or guardian.

4 There is some dispute in the record as to whether his parents gave consent for the innovative surgical procedures. They testified they gave consent only to the insertion of depth electrodes.
firmed at trial, however, their belief in the scientific, medical and ethical soundness of the proposal.

Upon the request of counsel, a Three-Judge Court was empanelled, Judges John D. O'Hair and George E. Bowles joining Judge Horace W. Gilmore. Dean Francis A. Allen and Prof. Robert A. Burt of the University of Michigan Law School were appointed as counsel for John Doe.

Approximately the same time Amicus Curiae, the American Orthopsychiatric Society, sought to enter the case with the right to offer testimony. This was granted by the Court.

Three ultimate issues were framed for consideration by the Court. The first related to the constitutionality of the detention of Doe. The full statement of the second and third questions, to which this Opinion is addressed, are set forth in the text below.

The first issue relating to the constitutionality of the detention of John Doe was considered by the Court, and on March 23, 1973, an Opinion was rendered by the Court holding the detention unconstitutional. Subsequently, after hearing testimony of John Doe's present condition, the Court directed his release.

In the meantime, since it appeared unlikely that no project would go forward because of the withdrawal of approval by Dr. Yudashikill, the Court raised the question as to whether the rest of the case had become moot. All counsel, except counsel representing the Department of Mental Health, stated the matter was not moot, and that the basic issues involved were ripe for declaratory judgment. Counsel for the Department of Mental Health contended the matter was moot.

Full argument was had and the Court on March 15, 1973, rendered an oral Opinion, holding that the matter was not moot and that the case should proceed as to the two framed issues for declaratory judgment. The Court held that even though the original experimental program was terminated, there was not even the remotest possibility of its being instituted again in the near future, and therefore the matter was ripe for declaratory judgment.

The facts concerning the original experiment and the involvement of John Doe were to be considered by the Court as illustrative in determining whether legally adequate consent could be obtained from adults involuntarily confined in the state mental health system for experimental or innovative procedures on the brain to ameliorate behavior, and, it could be whether the State should allow such experimentation on human subjects to proceed.

The two issues framed for decision in this declaratory judgment action are as follows:

1. After failure of established therapies, may an adult or a legally appointed guardian, if the adult is involuntarily detained, at a facility within the jurisdiction of the State Department of Mental Health give legally adequate consent to an innovative or experimental surgical procedure on the brain, if there is demonstrable physical abnormality of the brain, and the procedure is designed to ameliorate behavior, which is either personally tormenting to the patient, or so profoundly disruptive that the patient cannot safely live, or live with others?

'The release was directed after the testimony of John Doe in open court and the testimony of Dr. Andrew S. Watson, who felt that John Doe could be safely released to society.

8 On Thursday, March 15, 1973, after full argument, the Court held in an Opinion rendered from the bench that the matter was not moot, relying upon United States v. Phosphate Export Association, 393 U.S. 199. There the United States Supreme Court said: "The test for mootness *** is a stringent one. Mere voluntary cessation of allegedly illegal conduct does not moot a case; if it did, the courts would be compelled to leave the defendant free to return to his old ways." A case might become moot if subsequent events made it absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur.

The Court also relied upon Milford v. People's Community Hospital Authority, 880 Mich. 49, where the Court said on page 05: "The nature of the case is such that we are unlikely to again receive the question in the near future, and doctors and other people dealing with public hospital corporations cannot hope to have an answer to the questions raised until we proceed to decision. For these reasons, we conclude the case is of sufficient importance to warrant our decision."

It should also be noted that Defendant Department of Mental Health sought an Order of Superintending Control for a Stay of Proceedings in the Court of Appeals on the ground the case was moot. On March 20, 1973, the Court of Appeals denied the Stay.

As the trial proceeded, it was learned that John Doe himself withdrew his consent to such experimentation. This still did not render the proceeding moot because of the questions framed for declaratory judgment.
2. If the answer to the above is yes, then is it legal in this State to undertake an innovative or experimental surgical procedure on the brain of an adult who is involuntarily detained at a facility within the jurisdiction of the State Department of Mental Health, if there is demonstrable physical abnormality of the brain, and the procedure is designed to ameliorate behavior, which is either personally tormenting to the patient, or so profoundly disruptive that the patient cannot safely live, or live with others?

Throughout this Opinion, the Court will use the term psychosurgery to describe the proposed innovative or experimental surgical procedure defined in the questions for consideration by the Court.

At least two definitions of psychosurgery have been furnished the Court. Dr. Bertram S. Brown, Director of the National Institute of Mental Health, defined the term as follows in his prepared statement before the United States Senate Subcommittee on Health of the Committee on Labor and Public Welfare on February 23, 1973:

"Psychosurgery can best be defined as a surgical removal or destruction of brain tissue or the cutting of brain tissue to disconnect one part of the brain from another, with the intent of altering the behavior, even though there may be no direct evidence of structural disease or damage to the brain."

Dr. Peter Breggin, a witness at the trial, defined psychosurgery as the destruction of normal brain tissue for the control of emotions or behavior; or the destruction of abnormal brain tissue for the control of emotions or behavior, where the abnormal tissue has not been shown to be the cause of the emotions or behavior in question.

The psychosurgery involved in this litigation is a subclass, narrower than that defined by Dr. Brown. The proposed psychosurgery we are concerned with encompasses only experimental psychosurgery where there are demonstrable physical abnormalities in the brain. Therefore, temporal lobectomy, an established therapy for relief of clearly diagnosed epilepsy is not involved, nor are accepted neurological surgical procedures, for example, operations for Parkinsonism, or operations for the removal of tumors or the relief of stroke.

We start with the indisputable medical fact that no significant activity in the brain occurs in isolation without correlated activity in other parts of the brain. As the level of complexity of human behavior increases so does the degree of interaction and integration. Dr. Ayub Ommaya, a witness in the case, illustrated this through the phenomenon of vision. Pure visual sensation is one of the functions highly localized in the occipital lobe in the back of the brain. However vision in its broader sense, such as the ability to recognize a face, does not depend upon this area of the brain alone. It requires the integration of that small part of the brain with the rest of the brain. Memory mechanisms interact with the visual sensation to permit the recognition of the face. Dr. Ommaya pointed out that the more we know about brain function, the more we realize with certainty that many functions are highly integrated, even for relatively simple activity.

It is clear from the record in this case that the understanding of the limbic system of the brain and its function is very limited. Practically every witness and exhibit established how little is known of the relationship of the limbic system to human behavior, in the absence of some clearly defined clinical disease such as epilepsy. Drs. Mark, Sweet and Ervin have noted repeatedly the primitive state of our understanding of the amygdala, for example, remarking that it is an area made up of nine to fourteen different nuclear structures, with many functions, some of which are competitive with others. They state

On this point, Amicus Curiae Exhibit 4 is of great interest. This exhibit in a memo to Dr. Peter from Dr. Rodin, dated August 9, 1972, contains the following: Dr. Rodin, in his Memo, stated:

When I informed Dr. Mark of our project, namely, doing amygdalotomies on patients who do not have epilepsy, he became extremely concerned and stated, we had no ethical right in so doing. This, of course, opened Pandora's box, because then I retorted that he was misleading us with his previously cited book and he had no right at all from a scientific point of view to state that in the human, aggression is accompanied by seizure discharges in the amygdala, because he is dealing with only patients who have susceptibility, namely, temporal lobe epilepsy.

He stated categorically that as far as present evidence is concerned, one has no right, to make lesions in a 'healthy brain' when the individual suffers from rage attacks only.
that there are not even reliable guesses as to the functional location of some of the nuclei.11

The testimony showed that any physical intervention in the brain must always be approached with extreme caution. Brain surgery is always irreversible in the sense that any intrusion into the brain destroys the brain cells and such cells do not regenerate. Dr. Ommaya testified that in the absence of well defined pathological signs, such as blood clots pressing on the brain due to trauma, or tumor in the brain, brain surgery is viewed as a treatment of last resort.

The record in this case demonstrates that animal experimentation and non-intrusive human experimentation have not been exhausted in determining and studying brain function. Any experimentation on the human brain, especially when it involves an intrusive, irreversible procedure in a none life-threatening situation, should be undertaken with extreme caution, and then only when answers cannot be obtained from animal experimentation and from non-intrusive human experimentation.

Psychosurgery should never be undertaken upon involuntarily committed populations, when there is a high-risk low-benefit ratio as demonstrated in this case. This is because of the impossibility of obtaining truly informed consent from such populations. The reasons such informed consent cannot be obtained are set forth in detail subsequently in this Opinion.

There is widespread concern about violence. Personal violence, whether in a domestic setting or reflected in street violence, tends to increase. Violence in group confrontations appears to have culminated in the late 60's but still invites study and suggested solutions. Violence, personal and group, has engaged the criminal law courts and the correctional systems, and has inspired the appointment of national commissions. The late President Lyndon B. Johnson convened a commission on violence under the chairmanship of Dr. Milton Eisenhower. It was a commission that had fifty consultants representing various fields of law, sociology, criminology, history, government, social psychiatry, and social psychology. Conscious by their absence were any professionals concerned with the human brain. It is not surprising, then, that of recent date, there has been theorizing as to violence and the brain, and just over two years ago, Frank Ervin, a psychiatrist, and Vernon H. Mark, a neurosurgeon, wrote Violence and the Brain 12 detailing the application of brain surgery to problems of violent behavior.

Problems of violence are not strangers to this Court. Over many years we have studied personal and group violence in a court context. Nor are we unconcerned about the tragedies growing out of personal or group confrontations. Deep-seated public concerns begets an impatient desire for miracle solutions. And necessarily, we deal here not only with legal and medical issues, but with ethical and social issues as well.

Is brain function related to abnormal aggressive behavior? This, fundamentally, is what the case is about. But, one cannot segment or simplify that which is inherently complex. As Vernon H Mark has written, "Moral values are social concerns, not medical ones, in any presently recognized sense." 13

Violent behavior not associated with brain disease should not be dealt with surgically. At best, neurosurgery rightfully should concern itself with medical problems and not the behavior problems of a social etiology.

The Court does not in any way desire to impede medical progress. We are much concerned with violence and the possible effect of brain disease on violence. Much research on the brain is necessary and must be carried on, but when it takes the form of psychosurgery, it cannot be undertaken on involuntarily detained populations. Other avenues of research must be utilized and developed.

Although extensive psychosurgery has been performed in the United States and throughout the world in recent years to attempt change of objectionable behavior, there is no medically recognized syndrome for aggression and objectionable behavior associated with nonorganic brain abnormality.


The psychosurgery that has been done has in varying degrees blunted emotions and reduced spontaneous behavior. Dr. V. Balasubramaniam, a leading psychosurgeon, has characterized psychosurgery as "sedative neurosurgery," a procedure by which patients are made quiet and manageable. The amygdalotomy, for example, has been used to calm hyperactive children, to make retarded children more manageable in institutions, to blunt the emotions of people with depression, and to attempt to make schizophrenics more manageable.

As pointed out above, psychosurgery is clearly experimental, poses substantial danger to research subjects, and carries substantial unknown risks. There is no persuasive showing on this record that the type of psychosurgery we are concerned with would necessarily confer any substantial benefit on research subjects or significantly increase the body of scientific knowledge by providing answers to problems of deviant behavior.

The dangers of such surgery are undisputed. Though it may be urged, as did some of the witnesses in this case, that the incidents of morbidity and mortality are low from the procedures, all agree dangers are involved, and the benefits to the patient are uncertain.

Absent a clearly defined medical syndrome, nothing pinpoints the exact location in the brain of the cause of undesirable behavior so as to enable a surgeon to make a lesion, remove that portion of the brain, and thus affect undesirable behavior.

Psychosurgery flattens emotional responses, leads to lack of abstract reasoning ability, leads to a loss of capacity for new learning and causes general sedation and apathy. It can lead to impairment of memory, and in some instances expected responses to psychosurgery are observed. It has been found, for example, that heightened rage reaction can follow surgical intervention on the amygdala, just as placidity can.

It was unanimously agreed by all witnesses that psychosurgery does not, given the present state of the art, provide any assurance that a dangerously violent person can be restored to the community.

Simply stated, on this record there is no scientific basis for establishing that the removal or destruction of an area of the limbic brain would have any direct therapeutic effect in controlling aggressivity or improving tormenting personal behavior, absent the showing of a well defined clinical syndrome such as epilepsy.

To advance scientific knowledge, it is true that doctors may desire to experiment on human beings, but the need for scientific inquiry must be reconciled with the inviolability which our society provides for a person's mind and body. Under a free government, one of a person's greatest rights is the right to inviolability of his person, and it is axiomatic that this right necessarily forbids the physician or surgeon from violating, without permission, the bodily integrity of his patient.

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See Defendant's Exhibit 38, Sedative Neurosurgery by V. Balasubramaniam, T. S. Kanaka, P. V. Ramanaun, and B. Ramamurthi, 58 Journal of the Indian Medical Association (1960), page 381, the writer said:

"The main purpose of this communication is to show that this new form of surgery called sedative neurosurgery is available for the treatment of certain groups of disorders. These disorders are primarily characterized by restlessness, low threshold for anger and violent or destructive tendencies."

"By operating on the areas one can make these patients quiet and manageable."

The classical lobotomy of which thousands were performed in the 1940's and 1950's is very rarely used these days. The development of drug therapy pretty well did away with the classical lobotomy. Follow-up studies show that the lobotomy procedure was overused and caused a great deal of damage to the patients who were subjected to it. A coma was induced and the operations were associated with loss of drive and concentration. Dr. Brown in his testimony before the United States Senate, supra, page 9, stated: "No responsible scientist today would condone a classical lobotomy operation."

Sweet, Mark & Ervin found this to be true in experiments with monkeys. Other evidence indicated it is possible in human beings.

Testimony in the case from Dr. Rodin, Dr. Lowing, Dr. Breggin, and Dr. Walter, all pointed up that it is very difficult to find the risks, deficits and benefits from psychosurgery because of the failure of the literature to provide adequate research information about research subjects before and after surgery.

See the language of the late Justice Cardozo in Schleindorf v. Society of New York Hospitals, 211 N.Y. 120, 106 N.E. 92, 93 (1914) where he said, "Every human being of adult years or sound mind has a right to determine what shall be done with his own body."
Generally, individuals are allowed free choice about whether to undergo experimental medical procedures. But the State has the power to modify this free choice concerning experimental medical procedures when it cannot be freely given, or when the result would be contrary to public policy. For example, it is obvious that a person may not consent to acts that will constitute murder, manslaughter, or mayhem upon himself. In short, there are times when the State for good reason should withhold a person's ability to consent to certain medical procedures.

It is elementary tort law that consent is the mechanism by which the patient grants the physician the power to act, and which protects the patient against unauthorized invasions of his person. This requirement protects one of society's most fundamental values, the inviolability of the individual. An operation performed upon a patient without his informed consent is the tort of battery, and a doctor and a hospital have no right to impose compulsory medical treatment against the patient's will. These elementary statements of tort law need no citation.

Jay Katz, in his outstanding book "Experimentation with Human Beings" (Russell Sage Foundation. N.Y. (1972)) points out on page 523 that the concept of informed consent has been accepted as a cardinal principle for judging the propriety of research with human beings.

He points out that in the experimental setting, informed consent serves multiple purposes. He states (page 522 and 524):

"Most clearly, requiring informed consent serves society's desire to respect each individual's autonomy, and his right to make choices concerning his own life.

"Second, providing a subject with information about an experiment will encourage him to be an active partner and the process may also increase the rationality of the experimentation process.

"Third, securing informed consent protects the experimentation process by encouraging the investigator to question the value of the proposed project and the adequacy of the measures he has taken to protect subjects, by reducing civil and criminal liability for nonnegligent injury to the subjects, and by diminishing adverse public reaction to an experiment.

"Finally, informed consent may serve the function of increasing society's awareness about human research."

It is obvious that there must be close scrutiny of the adequacy of the consent when an experiment, as in this case, is dangerous, intrusive, irreversible, and of uncertain benefit to the patient and society.

Counsel for Drs. Rodin and Gottlieb argues that anyone who has ever been treated by a doctor for any relatively serious illness is likely to acknowledge that a competent doctor can get almost any patient to consent to almost anything. Counsel claims this is true because patients do not want to make decisions about complex medical matters and because there is the general problem of avoiding decision making in stress situations, characteristic of all human beings.

He further argues that a patient is always under duress when hospitalized and that in a hospital or institutional setting there is no such thing as a volunteer. Dr. Ingelfinger in Volume 287, page 466, of the New England Journal of Medicine (August 31, 1972) states:

"* * * The process of obtaining 'informed consent' with all its regulations and conditions, is no more than an elaborate ritual, a device that when the subject is uneducated and uncomprehending, confers more than the semblance of propriety on human experimentation. The subject's only real protection, the public as well as the medical profession must recognize, depends on the conscience and compassion of the investigator and his peers."

...
Everything defendants' counsel argues militates against the obtaining of informed consent from involuntarily detained mental patients. If, as he argues, truly informed consent cannot be given for regular surgical procedures by non-institutionalized persons, then certainly an adequate informed consent cannot be given by the involuntarily detained mental patient.

We do not agree that a truly informed consent cannot be given for a regular surgical procedure by a patient, institutionalized or not. The law has long recognized that such valid consent can be given. But we do hold that informed consent cannot be given by an involuntarily detained mental patient for experimental psychosurgery for the reasons set forth below.

The Michigan Supreme Court has considered in a tort case the problems of experimentation with humans. In Hortner v. Koch, 272 Mich. 273, 261 N.W. 782 (1935), the issue turned on whether the doctor had taken proper diagnostic steps before prescribing an experimental treatment for cancer. Discussing medical experimentation, the Court said at page 282:

"We recognize the fact that if the general practice of medicine and surgery to progress, there must be a certain amount of experimentation carried on; but such experiments must be done with the knowledge and consent of the patient or those responsible for him, and must not vary too radically from the accepted method of procedure. (Emphasis added).

This means that the physician cannot experiment without restraint or restriction. He must consider that of all the welfare of his patient. This concept is universally accepted by the medical profession, the legal profession, and responsible persons who have thought and written on the matter.

Furthermore, he must weigh the risk to the patient against the benefit to be obtained by trying something new. The risk-benefit ratio is an important ratio in considering any experimental surgery upon a human being. The risk must always be relatively low, in the non-life threatening situation to justify human experimentation.

Informed consent is a requirement of variable demands. Being certain that a patient has consented adequately to an operation, for example, is much more important when doctors are going to undertake an experimental, dangerous, and intrusive procedure than, for example, when they are going to remove an appendix. When a procedure is experimental, dangerous, and intrusive, procedure must be done with the knowledge and consent of the patient, or those responsible for him, and must not vary too radically from the accepted method of procedure. (Emphasis added).

Informed consent is a requirement of variable demands. Being certain that a patient has consented adequately to an operation, for example, is much more important than when doctors are going to undertake an experimental, dangerous, and intrusive procedure. When a procedure is experimental, dangerous, and intrusive, special safeguards are necessary. The risk-benefit ratio must be carefully considered, and the question of consent thoroughly explored.

To be legally adequate, a subject's informed consent must be competent, knowing and voluntary.

In considering consent for experimentation, the ten principles known as the Nuremberg Code give guidance. They are found in the Judgment of the Court in United States v. Karl Brandt.21

There the Court said:

"** Certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:

1. The voluntary consent of the human subject is absolutely essential.

This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other inferior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject, there should be made known to him the nature, duration and purpose of the experiment; the methods and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is

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a personal duty and responsibility which may not be delegated to another with impunity.

"2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

"3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

"4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

"5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

"6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

"7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

"8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

"9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

"10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill, and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

In the Nuremberg Judgment, the elements of what must guide us in decision are found. The involuntarily detained mental patient must have legal capacity to give consent. He must be so situated as to be able to exercise free power of choice without any element of force, fraud, deceit, duress, overreaching, or other ulterior form of restraint or coercion. He must have sufficient knowledge and comprehension of the subject matter to enable him to make an understanding decision. The decision must be a totally voluntary one on his part.

We must first look to the competency of the involuntarily detained mental patient to consent. Competency requires the ability of the subject to understand rationally the nature of the procedure, its risks, and other relevant information. The standard governing required disclosure by a doctor is what a reasonable patient needs to know in order to make an intelligent decision. See Waltz and Scheunerman, "Informed Consent Therapy," 64 Northwestern Law Review 628 (1969).22

Although an involuntarily detained mental patient may have a sufficient I.Q. to intellectually comprehend his circumstances (in Dr. Rodin's experiment, a person was required to have at least an I.Q. of 80), the very nature of his incarceration diminishes the capacity to consent to psychosurgery. He is particularly vulnerable as a result of his mental condition, the deprivation stemming from involuntary confinement, and the effects of the phenomenon of institutionalization.

The very moving testimony of John Doe in the instant case establishes this beyond any doubt. The fact of institutional confinement has special force in undermining the capacity of the mental patient to make a competent decision on this issue, even though he be intellectually competent to do so. In the routine of institutional life, most decisions are made for patients. For example, John Doe testified how extraordinary it was for him to be approached by Dr. Yudanshkin about the possible submission to psychosurgery, and how unusual it was to be consulted by a physician about his preferences.

Institutionalization tends to strip the individual of the support which permit him to maintain his sense of self-worth and the value of his own physical and mental health.

22 Blackstone's Law Dictionary (Second Edition) (1948), competency is equated with capacity and capacity is defined as "a person's ability to understand the nature and effect of the act in which he is engaged and the business in which he is transacting."
mental integrity. An involuntarily confined mental patient clearly has diminished capacity for making a decision about irreversible experimental psychosurgery.

Equally great problems are found when the involuntarily detained mental patient is incompetent, and consent is sought from a guardian or parent. Although guardian or parental consent may be legally adequate when arising out of traditional circumstances, it is legally ineffective in the psychosurgery situation. The guardian or parent cannot do that which the patient, absent a guardian, would be legally unable to do.

The second element of an informed consent is knowledge of the risk involved and the procedures to be undertaken. It was obvious from the record made in this case that the facts surrounding experimental brain surgery are profoundly uncertain, and the lack of knowledge on the subject makes a knowledgeable consent to psychosurgery literally impossible.

We turn now to the third element of an informed consent, that of voluntariness. It is obvious that the most important thing to a large number of involuntarily detained mental patients incarcerated for an unknown length of time, is freedom.

The Nuremberg standards require that the experimental subjects be so situated as to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion. It is impossible for an involuntarily detained mental patient to exercise of ulterior forms of restraint or coercion when his re-release from the institution may depend upon his cooperating with the institutional authorities and giving consent to experimental surgery.

The privileges of an involuntarily detained patient and the rights he exercises in the institution are within the control of the institutional authorities. As was pointed out in the testimony of John Doe, such minor things as the right to have a lamp in his room, or the right to have ground privileges to go for a picnic with his family assumed major proportions. For 17 years he lived completely under the control of the hospital. Nearly every important aspect of his life was decided without any opportunity on his part to participate in the decision-making process.

The involuntarily detained mental patient is in an inherently coercive atmosphere even though no direct pressures may be placed upon him. He finds himself stripped of customary amenities and defenses. Free movement is restricted. He becomes a part of communal living subject to the control of the institutional authorities.

As pointed out in the testimony in this case, John Doe consented to this psychosurgery partly because of his effort to show the doctors in the hospital that he was a cooperative patient. Even Dr. Yudashkin, in his testimony, pointed out that involuntarily confined patients tend to tell their doctors what the patient thinks these people want to hear.

The inherently coercive atmosphere to which the involuntarily detained mental patient is subjected has bearing upon the voluntariness of his consent. This was pointed up graphically by Dr. Watson in his testimony (page 67, April 4.) There he was asked if there was any significant difference between the kinds of coercion that exist in an open hospital setting and the kinds of coercion that exist on involuntarily detained patients in a state mental institution.

Dr. Watson answered in this way:

"There is an enormous difference. My perception of the patients at Ionia is that they are willing almost to try anything to somehow or other improve their lot, which is—you know—not bad. It is just plain normal—you know—that kind of desire. Again, that pressure—again—I don't like to use the word 'coercion' because it implies a kind of deliberateness and that is not what we are talking about—the pressure to accede is perhaps the more accurate way, I think—the pressure is perhaps so severe that it probably ought to cause us to be not willing to permit experimentation that has questionable gain and high risk from the standpoint of the patient's posture, which is, you see, the formula that I mentioned we hashed out in our Human Use Committee."

Involuntarily confined mental patients live in an inherently coercive institutional environment. Indirect and subtle psychological coercion has profound effect upon the patient population. Involuntarily confined patients cannot reason as equals with the doctors and administrators over whether they should
undergo psychosurgery. They are not able to voluntarily give informed consent because of the inherent inequality in their position.\textsuperscript{23}

It has been argued by defendants that because 18 criminal sexual psychopaths in the Ionia State Hospital wrote a letter indicating they did not want to be subjects of psychosurgery, consent can be obtained and that the arguments about coercive pressure are not valid.

The Court does not feel that this necessarily follows. There is no showing of the circumstances under which the refusal of these thirteen patients was obtained, and no showing that any effort was made to obtain the consent of these patients for such experimentation.

The fact that thirteen patients unilaterally wrote a letter saying they did not want to be subjects of psychosurgery is irrelevant to the question of whether they can consent to that which they are legally precluded from doing.

The law has always been meticulous in scrutinizing inequality in bargaining power and the possibility of undue influence in commercial fields and in the law of wills. It also has been most careful in excluding from criminal cases confessions where there was no clear showing of their completely voluntary nature after full understanding of the consequences.\textsuperscript{24} No lesser standard can apply to involuntarily detained mental patients.

The keynote to any intrusion upon the body of a person must be full, adequate and informed consent. The integrity of the individual must be protected from invasion into his body and personality not voluntarily agreed to. Consent is not an idle or symbolic act; it is a fundamental requirement for the protection of the individual's integrity.

We therefore conclude that involuntarily detained mental patients cannot give informed and adequate consent to experimental psychosurgical procedures on the brain.

The three basic elements of informed consent—competency, knowledge, and voluntariness—cannot be ascertained with a degree of reliability warranting resort to use of such an invasive procedure.\textsuperscript{25}

To this point, the Court's central concern has primarily been the ability of an involuntarily detained mental patient to give a factually informed, legally adequate consent to psychosurgery. However, there are also compelling constitutional considerations that preclude the involuntarily detained mental patient from giving effective consent to this type of surgery.

We deal here with State action in view of the fact the question relates to involuntarily detained mental patients who are confined because of the action of the State.

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\textsuperscript{23} It should be emphasized that once John Doe was released in this case and returned to the community he withdrew all consent to the performance of the proposed experiment. His withdrawal of consent under these circumstances should be compared with his answers on January 12, 1973, to questions placed by members of the Human Rights Committee. These answers are part of exhibit 22 and were given after extensive publicity about this case, and while John Doe was in Lafayette Clinic waiting the implantation of depth electrodes. The significant questions and answers are as follows:

1. Would you seek psychosurgery if you were not confined in an institution?
   A. Yes, if after testing this showed it would be of help.

2. Do you believe that psychosurgery is a way to obtain your release from the institution?
   A. No, but it would be a step in obtaining my release. It is like any other therapy or program to help persons to function again.

3. Would you seek psychosurgery if there were other ways to obtain your release?
   A. Yes. If psychosurgery were the only means of helping my physical problem after a period of testing.


Prof. Paul Freund of the Harvard Law School has expressed the following opinion:

\textquote{I suggest that [prison] experiments should not involve any promise of parole or of commutation of sentence; this would be what is called in the law of confessions undue influence or duress through promise of reward, which can be as effective in overbearing the will as threats of harm. Nor should there be a pressure to conform within the prison generated by the pattern of rejecting parole applications of those who do not participate . . .} P. A. Freund, \textit{Ethical Problems in Human Experimentation}, New England Journal of Medicine, Volume 273 (1965) pages 897-92.

\textsuperscript{25} It should be noted that Dr. Vernon H. Mark, a leading psychosurgeon, states that psychosurgery should not be performed on prisoners who are epileptic because of the problem of obtaining adequate consent. He states in \textit{"Brain Surgery in Aggressive Personality"}, American Journal of Psychiatry, Vol. 100, No. 1 (February, 1973): "Prison inmates suffering from epilepsy should receive only medical treatment; surgical therapy should not be carried out because of the difficulty in obtaining truly informed consent."
Initially, we consider the application of the First Amendment to the problem before the Court, recognizing that when the State's interest is in conflict with the Federal Constitution, the State's interest, even though declared by statute or court rule, must give way. See NAACP v. Button, 371 U. S. 416 (1963) and United Transportation Workers' Union v. State Bar of Michigan, 401 U. S. 576 (1971).

A person's mental processes, the communication of ideas, and the generation of ideas, come within the ambit of the First Amendment. To the extent that the First Amendment protects the dissemination of ideas and the expression of thoughts, it equally must protect the individual's right to generate ideas.

As Justice Cardozo pointed out: "We are free only if we know, and so in proportion to our knowledge. There is no freedom without choice, and there is no choice without knowledge—or none that is illogical. Implicit, therefore, in the very notion of liberty is the liberty of the mind to choose and to beget. The mind is in chains when it is without the opportunity to choose. One may argue, if one please, that opportunity to choose is more an evil than a good. One is guilty of a contradiction if one says that the opportunity can be denied, and liberty subsist. At the root of all liberty is the liberty to know * * *

"Experimentation there may be in many things of deep concern, but not in setting boundaries to thought, for thought freely communicated is the indispensable condition of intelligent experimentation, the one test of its validity," Cardozo, The Paradoxes of Legal Science, Columbia University Lectures, reprinted in Selected Writings of Benjamin Nathan Cardozo. (Fallon Publications (1947)), pages 317 and 318:

Justice Holmes expressed the basic theory of the First Amendment in Abrams v. United States, 250 U. S. 616, 630 (1919) when he said: "* * * The ultimate good desired is better reached by free trade in ideas—that the best test of truth is the power of the thought to get itself accepted in the competition of the market, and that truth is the only ground upon which their wishes safely can be carried out. That at any rate is the theory of our Constitution. * * * We should be eternally vigilant against attempts to check expressions of opinions that we loathe and believe to be fraught with death, unless they so imminently threaten immediate interference with the lawful and pressing purposes of the law that an immediate check is required to save the country * * *

Justice Brandeis in Whitney v. Cal. 274 U. S. 357, 375 (1927), put it this way:

"Those who won our independence believed that the final end of the State was to make men free to value their faculties; and that in its government the deliberative force should prevail over the arbitrary. They believed that freedom to think as you will and to speak as you think are means indispensable to the discovery and spread of political truth; that without free speech and assembly discussion would be futile; that with them, discussion affords ordinarily adequate protection against the dissemination of noxious doctrine; that the greatest menace to freedom is an inert people; that public discussion is a political duty; and that this should be a fundamental principle of the American government * * *"


"The function of the legal process is not only to provide a means whereby a society shapes and controls the behavior of its individual members in the interests of the whole, it also supplies one of the principal methods by which a society controls itself, limiting its own powers in the interest of the individual. The role of the law here is to mark the guide and line between the sphere of social power, organized in the form of the state, and the area of private right. The legal problems involved in maintaining a system of free expression fall largely into this realm. In essence legal support for such a society involves the protection of individual rights against interference of unwarranted control by the government. More specifically, the legal structure must provide:

"1. Protection of the individual's right to freedom of expression against interference by the government in its efforts to achieve other social objectives or to advance its own interests * * *
"3. Restriction of the government in so far as the government itself participates in the system of expression.

"All these requirements involve control over the state. The use of law to achieve this kind of control has been one of the central concerns of freedom-seeking societies over the ages. Legal recognition of individual rights, enforced through the legal processes, has become the core of free society."

In Stanley v. Georgia, 397 U.S. 557 (1969), the Supreme Court once again addressed the free dissemination of ideas. It said at page 565-66:

"Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds... Whatever the power of the state to control dissemination of ideas inimical to public morality, it cannot constitutionally premise legislation on the desirability of controlling a person's private thoughts."

Freedom of speech and expression, and the right of all men to disseminate ideas, popular or unpopular, are fundamental to ordered liberty. Government has no power or right to control men's minds, thoughts, and expressions. This is the command of the First Amendment. And we adhere to it in holding an involuntarily detained mental patient may not consent to experimental psychosurgery.

For, if the First Amendment protects the freedom to express ideas, it necessarily follows that it must protect the freedom to generate ideas. Without the latter protection, the former is meaningless.

Experimental psychosurgery, which is irreversible and intrusive, often leads to the blunting of emotions, the deadening of memory, the reduction of affect, and limits the ability to generate new ideas. Its potential for injury to the creativity of the individual is great and can impinge upon the right of the individual to be free from interference with his mental processes.

The State's interest in performing psychosurgery and the legal ability of the involuntarily detained mental patient to give consent must bow to the First Amendment, which protects the generation and free flow of ideas from unwarranted interference with one's mental processes.

To allow an involuntarily detained mental patient to consent to the type of psychosurgery proposed in this case, and to permit the State to perform it, would be to condone State action in violation of basic First Amendment rights of such patients, because impairing the power to generate ideas inhibits the full dissemination of ideas.

There is no showing in this case that the State has met its burden of demonstrating such a compelling State interest in the use of experimental psychosurgery on involuntarily detained mental patients to overcome its proscription by the First Amendment of the United States Constitution.

In recent years, the Supreme Court of the United States has developed a constitutional concept of right to privacy, relying upon the First, Fifth and Fourteenth Amendments. It was found in the marital bed in Griswold v. Connecticut, 381 U.S. 479 (1966); in the right to view obscenity in the privacy of one's home in Stanley v. Georgia, 395 U.S. 557 (1969); and in the right of a woman to control her own body by determining whether she wishes to terminate a pregnancy in Roe v. Wade, 410 U.S. 113 (1973).

The concept was also recognized in the case of a prison inmate subjected to shock treatment and an experimental drug without his consent in Mackey v. Procunier, 426 U.S. 381 (1976).

In that case, the 9th Circuit noted that the prison officials treated the action as a malpractice claim and had dismissed it. The 9th Circuit reversed, saying, inter alia:

"It is asserted in memoranda that the staff at Vacaville is engaged in medical and psychiatric experimentation with 'aversion treatment' of criminal offenders, including the use of succinylcholine on fully conscious patients. It is emphasized the plaintiff was subject to experimentation without consent."

"Proof of such matters could, in our judgment, raise serious constitutional questions respecting cruel and unusual punishment of impermissible tinkering with the mental processes. (Citing Stanley among other cases) In our judgment it was error to dismiss the case without ascertaining at least the extent to which such charges can be substantiated... (Emphasis added).

Much of the rationale for the developing constitutional concept of right to privacy is found in Justice Brandeis' famous dissent in Olmstead v. United States, 277 U.S. 438 (1928) at 478, where he said:
"The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure, and satisfaction of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men."

There is no privacy more deserving of constitutional protection than that of one's mind. As pointed out by the Court in 

Hite v. United States, 406 F. 2d 366 (OM), at page 382, footnote 84:

"... Nor are the intimate internal areas of the physical habitation of mind and soul any less deserving of previous preservation from unwarranted and forcible intrusions than are the intimate internal areas of the physical habitation of wife and family. Is not the sanctity of the body even more important and therefore, more to be honored in its protection than the sanctity of the home?..."

Intrusion into one's intellect, when one is involuntarily detained and subjected to the control of institutional authorities, is an intrusion into one's constitutionally protected right of privacy. If one is not protected in his thoughts, behavior, personality and identity, then the right of privacy becomes meaningless.

Before a State can violate one's constitutionally protected right of privacy and obtain a valid consent for experimental psychosurgery on involuntarily detained mental patients, a compelling State interest must be shown. None has been shown here.

To hold that the right of privacy prevents laws against dissemination of contraceptive material as in Griswold v. Conn. (supra), or the right to view obscenity in the privacy of one's home as in Stanley v. Georgia (supra), but that it does not extend to the physical intrusion in an experimental manner upon the brain of an involuntarily detained mental patient is to denigrate the right. In the hierarchy of values, it is more important to protect one's mental processes than to protect even the privacy of the marital bed. To authorize an involuntarily detained mental patient to consent to experimental psychosurgery would be to fail to recognize and follow the mandates of the Supreme Court of the United States, which has constitutionally protected the privacy of body and mind.

Counsel for John Doe has argued persuasively that the use of the psychosurgery proposed in the instant case would constitute cruel and unusual punishment and should be barred under the Eighth Amendment. A determination of this issue is not necessary to decision, because of the many other legal and constitutional reasons for holding that the involuntarily detained mental patient may not give an informed and valid consent to experimental psychosurgery. We therefore do not pass on the issue of whether the psychosurgery proposed in this case constitutes cruel and unusual punishment within the meaning of the Eighth Amendment.

For the reasons given, we conclude that the answer to question number one posed for decision is no.

In reaching this conclusion, we emphasize two things.

First, the conclusion is based upon the state of the knowledge as of the time of the writing of this Opinion. When the state of medical knowledge develops to the extent that the type of psychosurgical intervention proposed here becomes an accepted neurosurgical procedure and is no longer experimental, it is possible, with appropriate review mechanisms, that involuntarily detained mental patients may give informed consent to such an operation.

Second, we specifically hold that an involuntarily detained mental patient today can give adequate consent to accepted neurosurgical procedures.

In view of the fact we have answered the first question in the negative, it is not necessary to proceed to a consideration of the second question, although we cannot refrain from noting that had the answer to the first question been yes, serious constitutional problems would have arisen with reference to the second question.

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28 See Note: 45 So. Cal. 2d 616, 663 (1972).

29 For example, see Guidelines of the Department of Health, Education and Welfare, AC Exhibit 17.
One final word. The Court thanks all counsel for the excellent, lawyer-like manner in which they have conducted themselves. Seldom, if ever, has any member of this panel presided over a case where the lawyers were so well-prepared and so helpful to the Court.

The findings in this Opinion shall constitute the findings of fact and conclusions of law upon the issues framed pursuant to the provisions of G.C.R. (1963) 517.1

A judgment embodying the findings of the Court in this Opinion may be presented.

HORACE W. GILMORE,
GEORGE E. BOWLES,
JOHN D. O'HAIR,
Circuit Judges.

JULY 10, 1973, Detroit, Michigan.

(Item VII.B.2)

United States District Court, M.D. Alabama, N.D.

April 13, 1972.

Civ. A. No. 319-N.

RICKY WYATT, BY AND THROUGH HIS AUNT AND LEGAL GUARDIAN, MRS. W. C. RAWLINS, JR., ET AL., FOR THEMSELVES JOINTLY AND SEVERALLY AND FOR ALL OTHERS SIMILARLY SITUATED, PLAINTIFFS

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.

Class action on behalf of patients involuntarily confined for mental treatment purposes in Alabama mental institutions. The District Court entered an order which, inter alia, provided for a further hearing to establish proper standards for treatment, 334 F.Supp. 1 41. Thereafter the District Court, Johnson, C. J., held, inter alia, that court would withhold decision on prayer for appointment of a master and professional advisory committee to oversee the implementation of the court-ordered minimum constitutional standards, under rule that federal courts are reluctant to assume control of any organization, especially one operated by a state, combined with defendants' expressed intent that the court order would be implemented forthwith and in good faith, and that unavailability of funds, staff or facilities would not justify a default by defendants.

Order accordingly.

See also D.C., 344 F.Supp. 387.

1. Mental Health

In class action on behalf of patients involuntarily confined for mental treatment purposes in Alabama mental institutions, initiation of human rights committees would be ordered to function as standing committees of such facilities, and the court would appoint the members of such committees, who would have power to review all research proposals and all rehabilitation programs to ensure that the dignity and human rights of the patients are preserved.

2. Courts

In class action on behalf of patients involuntarily confined for mental treatment purposes in Alabama mental institutions, court would withhold decision on prayer for appointment of a master and professional advisory committee to oversee the implementation of the court-ordered minimum constitutional standards, under rule that federal courts are reluctant to assume control of any organization, especially one operated by a state, combined with defendants' expressed intent that the court order would be implemented forthwith and in good faith.
3. Mental Health

Unavailability of funds, staff or facilities would not justify a default by defendants, in class action on behalf of patients involuntarily confined for mental treatment purposes in Alabama mental institutions, in the provision of suitable treatment for the mentally ill.

4. Mental Health

Despite possibility that defendants, in class action on behalf of patients involuntarily confined for mental treatment purposes in Alabama mental institutions, would encounter financial difficulties in the implementation of court order, which set forth minimum standards of patient treatment, court would reserve ruling on motion by plaintiffs that defendant Mental Health Board be directed to sell or encumber portions of its landholdings in order to raise funds, and similarly would reserve ruling on motion seeking an injunction against treasurer and comptroller of the state authorizing expenditures for non-essential state functions, and on other aspects of plaintiffs' requested relief designed to ameliorate the financial problems incident to implementation of court's order.

5. Courts

Court would not, in class action on behalf of patients involuntarily confined for mental treatment purposes in Alabama mental institutions, enjoin further commitment to such institutions until such time as adequate treatment was supplied in such institutions, where, because of the alternatives to commitment commonly utilized in Alabama, granting of plaintiffs' request might serve only to punish and further deprive Alabama's mentally ill.

6. Federal Civil Procedure

Reasonable attorney fees should be awarded to counsel for plaintiffs who brought class action on behalf of patients involuntarily confined for mental treatment purposes in Alabama mental institutions.

George W. Dean, Jr., Destin, Fla., Jack Drake (Drake, Knowles & Still), Tuscaloosa, Ala., Reber F. Boutil, Jr., Atlanta, Ga., Morton Birnbaum, Brooklyn, N.Y., for plaintiffs.


ORDER AND DECREE

JOHNSON, Chief Judge.

This class action originally was filed on October 23, 1970, in behalf of patients involuntarily confined for mental treatment purposes at Bryce Hospital, Tuscaloosa, Alabama. On March 12, 1971, in a formal opinion and decree, this Court held that these involuntarily committed patients "unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition." The Court further held that patients at Bryce were being denied their right to treatment and that defendants, per their request, would be allowed six months in which to raise the level of care at Bryce to the constitutionally required minimum. Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971). In this decree the Court ordered defendants to file reports defining the mission and functions of Bryce Hospital, specifying the objective and subjective standards required to furnish adequate care to the treatable mentally ill and detailing the hospital's progress toward the implementation of minimum constitutional standards. Subsequent to this order, plaintiffs, by motion to amend granted
August 12, 1971, enlarged their class to include patients involuntarily confined for mental treatment at Searcy Hospital and at Partlow State School and Hospital for the mentally retarded.2

On September 23, 1971, defendants filed their final report, from which this Court concluded on December 16, 1971, 334 F. Supp. 1841, that defendants had failed to promulgate and implement a treatment program satisfying minimum medical and constitutional requisites. Generally, the Court found that defendants' treatment program was deficient in three fundamental areas. It failed to provide: (1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment and (3) individualized treatment plans. More specifically, the Court found that many conditions, such as nontherapeutic, uncompensated work assignments, and the absence of any semblance of privacy, constituted dehumanizing factors contributing to the degeneration of the patients' self-esteem. The physical facilities at Bryce were overcrowded and plagued by fire and other emergency hazards. The Court found also that most staff members were poorly trained and that staffing ratios were so inadequate as to render the administration of effective treatment impossible. The Court concluded therefore, that whatever treatment was provided at Bryce was grossly deficient and failed to satisfy minimum medical and constitutional standards. Based upon this conclusion, the Court ordered that a formal hearing be held at which the parties and amici3 would have the opportunity to submit proposed standards for constitutionally adequate treatment and to present expert testimony in support of their proposals.

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

1 Searcy Hospital, located in Mount Vernon, Alabama, is also a State institution designed to treat the mentally ill. On September 2, 1971, defendants answered plaintiffs' amended complaint, as it related to Searcy, with the following language: "Defendants agree to be bound by the objective and subjective standards ultimately ordered by this Honorable Court in this cause at Bryce and Searcy.'

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

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

3 The amici in this case, including the United States of America, the American Orthopsychiatric Association, the American Psychological Association, the American Civil Liberties Union, and the American Association on Mental Deficiency, have performed exemplary service for defendants and the Court. Defendants and amici have stipulated that the Court would have the opportunity to submit proposed standards for constitutionally adequate treatment and to present expert testimony in support of their proposals.

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4 Moreover, the parties and amici have stipulated to a broad spectrum of conditions they feel are mandatory for a constitutionally ac-
ceptable minimum treatment program. This Court, having considered the evidence in the case, as well as the briefs, proposed standards and stipulations of the parties, has concluded that the standards set out in Appendix A to this decree are medical and constitutional minimums. Consequently, the Court will order their implementation. In so ordering, however, the Court emphasizes that these standards are, indeed, both medical and constitutional minimums and should be viewed as such. The Court urges that once this order is effectuated, defendants not become complacent and self-satisfied. Rather, they should dedicate themselves to providing physical conditions and treatment programs at Alabama's mental institutions that substantially exceed medical and constitutional minimums.

[1] In addition to asking that their proposed standards be effectuated, plaintiffs and amici have requested other relief designed to guarantee the provision of constitutional and humane treatment. Pursuant to one such request for relief, this Court has determined that it is appropriate to order the initiation of human rights committees to function as standing committees of the Bryce and Searcy facilities. The Court will appoint the members of these committees who shall have review of all research proposals and all rehabilitation programs, to ensure that the dignity and the human rights of patients are preserved. The committees shall advise and assist patients who allege that their legal rights have been infringed or that the Mental Health Board has failed to comply with judicially ordered guidelines. At their discretion, the committees may consult appropriate, independent specialists who shall be compensated by the defendant Board. Seven members shall comprise the human rights committee for each institution, the names and addresses of whom are set forth in Appendix B to this decree. Those who serve on the committees shall be paid on a per diem basis and be reimbursed for travel expenses at the same rate as members of the Alabama Board of Mental Health.

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

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

"There can be no legal (or moral) justification for the State of Alabama's failure to afford treatment—and adequate treatment from a medical standpoint—to the several thousand patients who have been civilly committed to Bryce's for treatment purposes. To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process." Wyatt v. Stickney, 325 F.Supp. at 785.

From the above, it follows consistently, of course, that the unavailability of either funds, nor staff and facilities, will justify a default by defendants in the provision of suitable treatment for the mentally ill.
Despite the possibility that defendants will encounter financial difficulties in the implementation of this order, this Court has decided to 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 Court stresses, however, the extreme importance and the grave immediacy of the need for proper funding of the State's public mental health facilities. The responsibility for appropriate funding ultimately must fall, of course, upon the State Legislature and, to a lesser degree, upon the defendant Mental Health Board of Alabama. For the present time, the Court will defer to those bodies in hopes that they will proceed with the realization and understanding that what is involved in this case is not representative of ordinary governmental functions such as paving roads and maintaining buildings. Rather, what is so inextricably intertwined with how the Legislature and Mental Health Board respond to the revelations of this litigation is the very preservation of human life and dignity. Not only are the lives of the patients currently confined at Bryce and Searcy at stake, but also at issue are the well-being and security of every citizen of Alabama. As is true in the case of any disease, no one is immune from the peril of mental illness. The problem, therefore, cannot be overemphasized and a prompt response from the Legislature, the Mental Health Board and other responsible State officials, is imperative.

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

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

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

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

Accordingly, it is the order, judgment and decree of this Court:

\[\text{See n. 4, supra. The evidence presented in this case reflects that the land holdings and other assets of the defendant Board are extensive.}\]

\[\text{The Court understands and appreciates that the Legislature is not due back in regular session until May, 1973. Nevertheless, special sessions of the Legislature are frequent occurrences in Alabama, and there has never been a time when such a session was more urgently required. If the Legislature does not act promptly to appropriate the necessary funding for mental health, the Court will be compelled to grant plaintiffs' motion to add various State officials and agencies as additional parties to this litigation and to utilize other avenues of fund raising.}\]
1. That defendants be and they are hereby enjoined from failing to implement fully and with dispatch each of the standards set forth in Appendix A attached hereto and incorporated as a part of this decree;

2. That human rights committees be and are hereby designated and appointed. The members thereof are listed in Appendix B attached hereto and incorporated herein. These committees shall have the purposes, functions, and spheres of operation previously set forth in this order. The members of the committees shall be paid on a per diem basis and be reimbursed for travel expenses at the same rate as members of the Alabama Board of Mental Health;

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

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

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

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

[Appendix A]

MINIMUM CONSTITUTIONAL STANDARDS FOR ADEQUATE TREATMENT OF THE MENTALLY ILL

I. DEFINITIONS

a. "Hospital"—Bryce and Searcy Hospitals.

b. "Patients"—all persons who are now confined and all persons who may in the future be confined at Bryce and Searcy Hospitals pursuant to an involuntary civil commitment procedure.

c. "Qualified Mental Health Professional"—
   (1) a psychiatrist with three years of residency training in psychiatry;
   (2) a psychologist with a doctoral degree from an accredited program;
   (3) a social worker with a master's degree from an accredited program and two years of clinical experience under the supervision of a Qualified Mental Health Professional;
   (4) a registered nurse with a graduate degree in psychiatric nursing and two years of clinical experience under the supervision of a Qualified Mental Health Professional;

d. "Non-Professional Staff Member" an employee of the hospital, other than a Qualified Mental Health Professional, whose duties require contact with or supervision of patients.

II. HUMANE PSYCHOLOGICAL AND PHYSICAL ENVIRONMENT

1. Patients have a right to privacy and dignity.

2. Patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment.

3. No person shall be deemed incompetent to manage his affairs, to contract, to hold professional or occupational or vehicle operator's licenses, to marry and obtain a divorce, to register and vote, or to make a will solely by reason of his admission or commitment to the hospital.

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

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

6. Patients have a right to be free from unnecessary or excessive medication. No medication shall be administered unless at the written order of a physician. The superintendent of the hospital and the attending physician shall be responsible for all medication given or administered to a patient. The use of medication shall not exceed standards of use that are promulgated by the United States Food and Drug Administration. Notation of each individual's medication shall be kept in his medical records. At least weekly the attending physician shall review the drug regimen of each patient under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the patient's treatment program.

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

8. Patients shall have a right not to be subjected to experimental research without the express and informed consent of the patient, if the patient is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such proposed research shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought. Prior to such approval the Committee shall determine that such research complies with the principles of the Statement on the Use of Human Subjects for Research of the American Association on Mental Deficiency and with the principles for research involving human subjects required by the United States Department of Health, Education and Welfare for projects supported by that agency.

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

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

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

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

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

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

15. Patients have a right to be outdoors at regular and frequent intervals, in the absence of medical considerations.
16. The right to religious worship shall be accorded to each patient who desires such opportunities. Provisions for such worship shall be made available to all patients on a nondiscriminatory basis. No individual shall be coerced into engaging in any religious activities.

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

18. The following rules shall govern patient labor:

A. **Hospital Maintenance**

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

B. **Therapeutic Tasks and Therapeutic Labor**

(1) Patients may be required to perform therapeutic tasks which do not involve the operation and maintenance of the hospital, provided the specific task or any change in assignment is:
   a. An integrated part of the patient's treatment plan and approved as a therapeutic activity by a Qualified Mental Health Professional responsible for supervising the patient's treatment; and
   b. Supervised by a staff member to oversee the therapeutic aspects of the activity.

(2) Patients may voluntarily engage in therapeutic labor for which the hospital would otherwise have to pay an employee, provided the specific labor or any change in labor assignment is:
   a. An integrated part of the patient's treatment plan and approved as a therapeutic activity by a Qualified Mental Health Professional responsible for supervising the patient's treatment; and
   b. Supervised by a staff member to oversee the therapeutic aspects of the activity; and

C. Personal Housekeeping

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

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

19. **Physical Facilities**

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

A. **Resident Unit**

The number of patients in a multipatient room shall not exceed six persons. There shall be allocated a minimum of 80 square feet of floor space per patient in a multi-patient room. Screens or curtains shall be provided to ensure privacy within the resident unit. Single rooms shall have a minimum of 100 square feet of floor space. Each patient will be furnished with a comfortable bed with adequate changes of linen, a closet or locker for his personal belongings, a chair, and a bedside table.

B. **Toilets and Lavatories**

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

C. **Showers**

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

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

E. Dining Facilities

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

F. Linen Servicing and Handling

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

G. Housekeeping

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

H. Geriatric and Other Nonambulatory Mental Patients

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

I. Physical Plant

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

2. Adequate heating, air conditioning and ventilation systems and equipment shall be afforded to maintain temperatures and air changes which are required for the comfort of patients at all times and the removal of undesired heat, steam and offensive odors. Such facilities shall ensure that the temperature in the hospital shall not exceed 88°F nor fall below 68°F.

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

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

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

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

20. Nutritional Standards

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

III. QUALIFIED STAFF IN NUMBERS SUFFICIENT TO ADMINISTER ADEQUATE TREATMENT

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

22. a. All Non-Professional Staff Members who have not had prior clinical experience in a mental institution shall have a substantial orientation training.

b. Staff members on all levels shall have regularly scheduled in-service training.

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

24. Staffing Ratios

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

Classification:

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<td>Cook I</td>
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</tr>
<tr>
<td>Food service worker</td>
<td>15</td>
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<tr>
<td>Vehicle driver</td>
<td>1</td>
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<tr>
<td>Housekeeper</td>
<td>10</td>
</tr>
<tr>
<td>Messenger</td>
<td>1</td>
</tr>
<tr>
<td>Maintenance repairman</td>
<td>2</td>
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38-744-74—35
IV. INDIVIDUALIZED TREATMENT PLANS

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

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

a. a statement of the nature of the specific problems and specific needs of the patient;

b. a statement of the least restrictive treatment conditions necessary to achieve the purposes of commitment;

c. a description of intermediate and long-range treatment goals, with a projected timetable for their attainment;

d. a statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;

e. a specification of staff responsibility and a description of proposed staff involvement with the patient in order to attain these treatment goals;

f. criteria for release to less restrictive treatment conditions, and criteria for discharge;

g. a notation of any therapeutic tasks and labor to be performed by the patient in accordance with Standard 18.

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

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

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

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

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

a. Identification data, including the patient’s legal status;

b. A patient history, including but not limited to: (1) family data, educational background, and employment record; (2) prior medical history, both physical and mental, including prior hospitalization;

c. The chief complaints of the patient and the chief complaints of others regarding the patient;

d. An evaluation which notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the patient’s assets in descriptive, not interpretative, fashion;

e. A summary of each physical examination which described the results of the examination;

f. A copy of the individual treatment plan and any modifications thereto;

1 Approximately 50 patients at Bryce-Scanry are tubercular as also are approximately four residents at Partlow.
g. A detailed summary of the findings made by the reviewing Qualified Mental Health Professional after each periodic review of the treatment plan which analyzes the successes and failures of the treatment program and directs whatever modifications are necessary;

h. A copy of the individualized post-hospitalization plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;

i. A medication history and status, which includes the signed orders of the prescribing physician. Nurses shall indicate by signature that orders have been carried out;

j. A detailed summary of each significant contact by a Qualified Mental Health Professional with the patient;

k. A detailed summary on at least a weekly basis by a Qualified Mental Health Professional involved in the patient's treatment of the patient's progress along the treatment plan;

l. A weekly summary of the extent and nature of the patient's work activities described in Standard 18, supra, and the effect of such activity upon the patient's progress along the treatment plan;

m. A signed order by a Qualified Mental Health Professional for any restrictions on visitations and communication, as provided in Standards 4 and 5, supra;

n. A signed order by a Qualified Mental Health Professional for any physical restraints and isolation as provided in Standard 7, supra;

o. A detailed summary of any extraordinary incident in the hospital involving the patient to be entered by a staff member noting that he has personal knowledge of the incident or specifying his other source of information, and initialed within 24 hours by a Qualified Mental Health Professional;

p. A summary by the superintendent of the hospital or his appointed agent of his findings after the 15-day review provided for in Standard 33 infra.

32. In addition to complying with all the other standards herein, a hospital shall make special provisions for the treatment of patients who are children and young adults. These provisions shall include but are not limited to:
   a. Opportunities for publicly supported education suitable to the educational needs of the patient. This program of education must, in the opinion of the attending Qualified Mental Health Professional, be compatible with the patient's mental condition and his treatment program, and otherwise be in the patient's best interest.
   b. A treatment plan which considers the chronological, maturational, and developmental level of the patient;
   c. Sufficient Qualified Mental Health Professionals, teachers, and staff members with specialized skills in the care and treatment of children and young adults;
   d. Recreation and play opportunities in the open air where possible and appropriate residential facilities;
   e. Arrangements for contact between the hospital and the family of the patient.

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

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

V. MISCELLANEOUS

35. Each patient and his family, guardian, or next friend shall promptly upon the patient's admission receive written notice, in language he unders-

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stands, of all the above standards for adequate treatment. In addition a copy of all the above standards shall be posted in each ward.

(Appendix B)

**BRYCE HUMAN RIGHTS COMMITTEE**

1. Mr. Bert Bank—Chairman—P.O. Box 2149, Tuscaloosa, Alabama 35401.
6. Mr. Junior Richardson—17 CW Bryce Hospital, Tuscaloosa, Alabama 35401.
7. Mr. John T. Waggon, Jr.—222 Fielder Avenue, Montgomery, Alabama 36106.

**SEARCY HUMAN RIGHTS COMMITTEE**

1. Dr. E. L. McCafferty, Jr.—Chairman—1653 Spring Hill Avenue, Mobile, Alabama 36604.
3. Hon. Thomas F. Gilmore—P. O. Box 109, Eutaw, Alabama 35462.
7. Ms. Joyce Nickels—c/o Searcy Hospital, Mount Vernon, Alabama.

Civ. A. No. 3195-N.

United States District Court, M. D. Alabama, N. D.

April 13, 1972.

**RIFFY WYATT BY AND THROUGH HIS AUNT AND LEGAL GUARDIAN, MRS. W. C. RAWLINS, JR., ET AL., FOR THEMSELVES JOINTLY AND SEVERALLY AND FOR ALL OTHERS SIMILARLY SITUATED, PLAINTIFFS**

**DR. STONEWALL B. STICKNEY, AS COMMISSIONER OF MENTAL HEALTH AND THE STATE OF ALABAMA MENTAL HEALTH OFFICER, ET AL., DEFENDANTS**

Attorneys’ Fees Taxed June 2, 1972.

Class action alleging that Alabama state school designed to habilitate the mentally retarded was being operated in a constitutionally impermissible fashion. The District Court, Johnson, C. J., held, inter alia, that conclusion was required that plaintiff had been denied the right to habilitation and that minimum standards for constitutional care and training must be effectuated at the institution, and that prompt institution of minimum standards to ensure provision of essential care and training for Alabama's mental retardates is mandatory, and no default excuse can be justified by reason of a lack of operating funds.

Order accordingly.

Supplementing opinion, D.C., 384 F.Supp. 1341.

See also D.C., 344 F.Supp. 373.

1. Mental Health

No viable distinction can be made between the mentally ill and the mentally retarded, and because the only constitutional justification for civilly committed a mental retardate is habilitation, it follows that once committed such a person is possessed of an inviolable constitutional right to habilitation.

2. Mental Health

Conclusion was required that plaintiffs, who brought class action alleging that state school and hospital designed to habilitate the mentally retarded was
being operated in a constitutionally impermissible fashion, and that, as a result, its residents were denied the right to adequate habilitation, and that minimum standards for constitutional care and training must be effectuated at the institution.

3. Mental Health

Prompt institution of minimum standards to ensure provision of essential care and training for Alabama's mental retardates is mandatory, and no default can be justified by reason of a lack of operating funds.

4. Mental Health

Defendants would be directed, in class action alleging that state school and hospital designed to habilitate the mentally retarded was being operated in a constitutionally impermissible fashion, to establish a standing human rights committee to guarantee that residents are afforded a constitutional and humane habilitation; such committee shall have power to review all research proposals and all habilitation programs to ensure that the dignity and human rights of the residents are preserved, and it shall also advise and assist residents who allege that their legal rights have been infringed or that the Mental Health Board of Alabama has failed to comply with judicially ordered guidelines.

5. Courts

Court would reserve ruling, in class action alleging that state school and hospital designed to habilitate the mentally retarded was being operated in a constitutionally impermissible fashion, on the appointment of a master and a professional advisory committee, under rule that federal courts are reluctant to assume control of any organization, especially one operated by a state.

6. Courts

Court would reserve ruling upon motion by plaintiffs, who brought class action alleging that Alabama state school and hospital designed to habilitate the mentally retarded was being operated in a constitutionally impermissible fashion, that defendant Mental Health Board be directed to sell or encumber portions of its extensive landholdings in order to raise funds and that injunction be granted against expenditure of state funds for nonessential state functions.

On Request for Attorney Fees

7. Federal Civil Procedure

Nonfeasance on part of defendants, who had knowledge of many of the inadequacies known to exist in Alabama's mental health institutions after study was made, and who made little if any progress toward upgrading conditions in such institutions, constituted bad faith which necessitated the expense of litigation, and such bad faith formed a valid basis for granting of attorney fees in action challenging constitutionality of conditions at Alabama mental institutions.

8. Federal Civil Procedure

In order to eliminate the impediments to pro bono publico litigation, and to carry out congressional policy, an award of attorney fees is not only essential but also legally required.

9. Federal Civil Procedure

Where plaintiffs in suit challenging constitutionality of standards at Alabama mental institutions benefitted many people, but neither sought nor recovered any damages, to burden plaintiffs, who incurred considerable expenses in vindicating the public good, with such costs would not only be unfair but also legally impermissible, and in such a case the most logical way to spread the burden among those benefitted would be to grant attorney fees.

10. Federal Civil Procedure

Factors relevant to determination as to what is a reasonable attorney fee in a public interest case generally are the same as those covering grants of attorney fees in commercial cases, and include the intricacy of the case, difficulty of proof, time reasonably expended in preparation and trial of the case, degree of competence displayed by attorneys seeking compensation, and the measure of success achieved by those attorneys.
11. Federal Civil Procedure

Courts should consider, in determining a reasonable attorney fee in a public interest case, the benefit inuring to the public, the personal hardships that bring such type of litigation causes plaintiffs and their lawyers, and the added responsibility of representing a class rather than only individual plaintiffs.

12. Federal Civil Procedure

Reasonable fee for attorneys for plaintiffs, who successfully attacked constitutionality of standards at Alabama mental institutions, would be set at $30 per in-court hour and $20 per out-of-court hour, and using such standard an attorney fee would be set for three attorneys involved at $30,764.62.

George W. Dean, Jr., Destin, Fla., Jack Drake (Drake, Knowles & Still), Tuscaloosa, Ala., Robert F. Boult, Jr., Atlanta, Ga., Morton Birnbaum, Brooklyn, N. Y., for plaintiffs.


Order and decree

This litigation originally pertained only to Alabama's mentally ill 1 but by motion to amend granted August 12, 1971, plaintiffs have expanded their class to include residents of Partlow State School and Hospital, a public institution located in Tuscaloosa, Alabama, designed to habilitate the mentally retarded. 2 In their amended complaint, plaintiffs have alleged that Partlow is being operated in a constitutionally impermissible fashion and that, as a result, its residents are denied the right to adequate habilitation and that, as a result, its residents are denied the right to adequate habilitation. Relying on these allegations, plaintiffs have asked that the Court promulgate and order the

1 On March 12, 1971, in a formal opinion and decree, this Court held that patients involuntarily committed to Bryce Hospital because of mental illness were being deprived of the constitutional right which they unquestionably possess, "to receive such individual treatment as [would] give each of them a realistic opportunity to be cured or to improve his or her mental condition." Wyatt v. Stickney, 329 F.Supp. 781 (M.D.Ala. 1971). On August 12, 1971, the Court granted plaintiffs motion to add to the lawsuit patients confined at Searcy Hospital, Mount Vernon, Alabama, another institution which, although designed to treat the mentally ill, failed to do so in accordance with constitutional standards. The Court having unwillingly afforded defendants an opportunity to promulgate and effectuate minimum standards for adequate treatment of the mentally ill, determined on December 10, 1971, that such standards had to be judicially formulated and ordered implemented. Wyatt v. Stickney, 334 F.Supp. 1541 (M.D.Ala. 1971). To that end, the Court conducted a hearing on February 3-4, 1972, at which the parties and amici submitted proposed standards for constitutionally adequate treatment, and presented expert testimony in support of the proposals. The aspect of the case relating to the Bryce-Searcy facilities will be considered by the Court in a decree separate from the present one.

2 As expressed by amici in their briefs and substantiated by the evidence in this case, mental retardation refers generally to subaverage intellectual functioning which is associated with impairment in adaptive behavior. This definitional approach to mental retardation is based upon dual criteria: reduced intellectual functioning and impairment in adaptation to the requirements of social living. The evidence presented reflects scientific advances in understanding the developmental processes of the mental retardate. The historical view of mental retardation was an immutable defect of intelligence has been supplanted by the recognition that a person may be mentally retarded at one age level and not at another: that he may change status as a result of changes in the level of his intellectual functioning; or that he may move from retarded to nonretarded as a result of a training program which has increased his level of adaptive behavior to a point where his behavior is no longer of concern to society. See United States President's Panel on Mental Retardation, Report of the Task Force on Law, 1968. (Judge David L. Bazelon, Chairman.)
implementation at Partlow of minimum medical and constitutional standards appropriate for the functioning of such an institution. Plaintiffs have asked also that the Court appoint a master and a professional advisory committee to oversee the implementation of judicially ordered guidelines and appoint a human rights committee to safeguard the personal rights and dignity of the residents. Finally plaintiffs have requested the Court to grant various forms of relief intended to ameliorate the financial difficulties certain to arise in connection with the upgrading of Alabama's public mental health institutions.3

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

[11] Initially, this Court has considered plaintiffs' position, not actively contested by defendants, 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. That this position is in accord with the applicable legal principles is clear beyond cavil. In an analogous situation involving the mentally ill at Bryce Hospital, this Court said:

"Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed into a penitentiary where one could be held indefinitely for no convicted offense." Ragsdale v. Overholser, [108 U.S.App.D.C. 308] 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 such as Bryce." Wyatt v. Stickney, 323 F. Supp. at 784.

In the context of the right to appropriate care for people civilly confined to public mental institutions, no viable distinction can be made between the mentally ill and the mentally retarded. Because the only constitutional justification for civilly committing a mental retardate, therefore, is habilitation, it follows inescapably that once committed such a person is possessed of an inviolable constitutional right to habilitation.5

Having recognized the existence of this right, the Court now must determine whether prevailing conditions at Partlow conform to minimum standards constitutionally required for mental retardation institution. The Court's conclusi

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

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

5 The Court will deal in this decree only with residents involuntarily committed to Partlow. It has not been adduced evidence to demonstrate that any resident of Partlow is voluntarily confined in that institution. The Court will presume, therefore, that every resident of Partlow is entitled to constitutionally minimum habilitation. The burden falls squarely on the institution to prove that a particular resident has not been involuntarily committed, and only if defendants satisfy this difficult burden of proof will the Court be confronted with whether the voluntarily committed resident is a right to habilitation.

6 It is interesting to note that the Court's decision with regard to the right of the mentally retarded to habilitation is supported not only by applicable legal authority, but also by a resolution adopted on December 27, 1971, by the General Assembly of the United Nations. That resolution entitled "Declaration on the Rights of the Mentally Retarded", reads in pertinent part: "** The mentally retarded person has a right to proper medical care and medical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential."
sion, compelled by the evidence, is unmistakably clear. Put simply, conditions at Partlow are grossly substandard. Testimony presented by plaintiffs and amici has depicted hazardous and deplorable inadequacies in the institution’s operation.\(^7\) Commendably, defendants have offered no rebuttal.\(^8\) At the close of the testimony, the Court, having been impressed by the urgency of the situation, issued an interim emergency order “to protect the lives and well-being of the residents of Partlow.” In that order, the Court found that:

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

[2] Based upon these findings, the Court has concluded that plaintiffs have been denied their right to habilitation and that, pursuant to plaintiffs’ request, minimum standards for constitutional care and training must be effectuated at Partlow. Consequently, having determined from a careful study of the evidence that the standards set out in Appendix A to this decree are medical and constitutional minimums, this Court will order their implementation.\(^9\) In so ordering, it is not assumed that these standards are, indeed, minimums only peripherally approaching the ideal to which defendants should aspire. It is hoped that the revelations of this case will furnish impetus to defendants to provide physical facilities and habilitation programs at Partlow substantially exceeding medical and constitutional minimums.

[3] For the present, however, defendants must realize that the prompt institution of minimum standards to ensure the provision of essential care and training for Alabama’s mentally retarded is mandatory and that no default can be justified by a want of operating funds. In this regard, the principles applicable to the mentally ill apply with equal force to the mentally retarded. See Wyatt v. Stickney, 325 F.Supp. at 784-785.

[4] In addition to requesting that minimum standards be implemented, plaintiffs have asked that defendants be directed to establish a standing human rights committee to guarantee that residents are afforded constitutional and humane habilitation. The evidence reflects that such a committee is needed at Partlow today are generally dehumanizing, fostering deviancy, generating self-fulfilling prophecy of parasitism and helplessness. The conditions I would say are hazardous to psychological integrity, to health, and in some cases even to life. The administration, the physical plants, the programs, and the institution’s articulation with the community and with the consumers reflect destructive models of mental retardation. They harry back to decades ago when the retarded were misperceived as being sick, as being threats to society, or as being subhuman organisms. The new concepts in the field of mental retardation are unfortunately not reflected in Partlow as we see it today—concepts such as normalization, developmental model in orientation toward mental retardation, the three-way approach toward involvement in physical, intellectual, and social recreation and decentralization of services; none of these are clearly in evidence in the facility today.

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

“I feel that the institution and its programs as now conceived are incapable of providing habilitation of the residents. Incarceration, certainly for most of the residents, would I feel have adverse consequences; would tend to develop behaviors which would interfere with successful community functioning. I would anticipate to find stagnation or deterioration in physical, intellectual, and social recreation; The conditions at Partlow today are generally dehumanizing, fostering deviancy, generating self-fulfilling prophecy of parasitism and helplessness. The conditions I would say are hazardous to psychological integrity, health...”

\(^8\) Indeed, on February 22, 1972, defendants filed with the Court a statement of position, in relevant part, as follows:

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

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

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

\(^{[6]}\) F.4.5
Partlow, and this Court will order its initiation. This committee shall have re-
view of all research proposals and all habilitation programs to ensure that the
dignity and human rights of residents are preserved. The committee also shall
advise and assist residents who allege that their legal rights have been in-
fringed or that the Mental Health Board has failed to comply with judicially or-
dered guidelines. At reasonable times the committee may inspect the records of
the institution and interview residents and staff. At its discretion the commit-
tee may consult appropriate, independent specialists who shall be compensated
by the defendant Board.10 The Court will appoint seven members to comprise
Partlow’s human rights committee, the names and addresses of whom are set
forth in Appendix B to this decree. Those who serve on the committee shall be
paid on a per diem basis and be reimbursed for travel expenses at the same
rate as members of the Alabama Board of Mental Health.

[5] Plaintiffs, as well as amici, also have advocated the appointment of a
federal master and a professional advisory committee to oversee the implement-
tion of minimum constitutional standards. These parties maintain that condi-
tions at Partlow largely are the product of shameful neglect by the state
officials charged with responsibility for that institution. Consequently, plaintiffs
and amici insist, these state officials have proved themselves incapable of insti-
tuting a constitutional habilitation program. Although this Court acknowledges
the intolerable conditions at Partlow and recognizes defendants’ past noncom-
formance, it, nevertheless, reserves ruling on the appointment of a master and a
professional advisory committee.11 Federal courts are reluctant to assure con-
trol of any organization, but especially one operated by a state. This Court, al-
ways having shared that reluctance, has adhered to a policy of allowing state
officials one final opportunity to perform the duties imposed upon them by law.
See e.g., Sims v. Amos, 336 F.Supp. 924 (M.D.Ala.1972); Nixon v. Wallace,
C.A. No. 3479-N, M.D.Ala., January 22, 1972. Additionally, since the entry of
the interim emergency order of March 2, 1972, defendants have worked diffi-
gently to upgrade conditions at Partlow in conformity with court-established
deadlines. These factors, combined with defendants’ expressed intent that the
present order will be implemented forthwith and in good faith, cause the
Court to withhold its decision on the appointments. Nevertheless, this Court
notes, and the ev.
10 The recitation of the licenses of this committee, and similarly, of the committees to
be inaugurated at the Bryce and Searcy facilities, is not intended to be inclusive. The
human rights committee of each mental health institution shall be authorized, within
the limits of reasonableness, to pursue whatever action is necessary to accomplish its
function.

11 The Court’s decision to reserve ruling on the appointment of a master causes it to
reserve ruling also on the appointment of a professional advisory committee to aid the
master. Nevertheless, the Court notes that the professional mental health community in
the state has responded to this expressed need and the proposed initiation of such a
committee to assist in the upgrading of Alabama’s mental retardation services. Conse-
quently, this Court strongly recommends to defendants that they develop a professional
advisory committee comprised of amenable professionals from throughout the country
who are able to provide the expertise the evidence reflects is important to the success-
ful implementation of this order.
and despair which envelop both staff and residents at Partlow, can be attributed largely to dire shortages of operating funds. By withholding its decisions, the Court continues to observe its longstanding policy of deferring to state organizations and officials charged by law with specified responsibilities. The responsibility for appropriate funding ultimately must fall, of course, upon the State Legislature and, only to a lesser degree, upon the defendant Mental Health Board. Unfortunately, never, since the founding of Partlow in 1923, has the Legislature adequately provided for that institution. The result of almost fifty years of legislative neglect has been catastrophic; atrocities occur daily. Although, in fairness, the present State Legislature can be faulted relatively little for the crisis situation at Partlow, only that body can rectify the gross omissions of past Legislatures. To shrink from its constitutional obligation at this critical juncture would be to sanction the inhumane conditions which plague the mentally retarded of Alabama. The gravity and immediacy of the situation cannot be overemphasized. At stake is the very preservation of human life and dignity. Consequently, a prompt response from the State Legislature, as well as from the Mental Health Board and other responsible state officials, is imperative.

In the event, though, that the Legislature fails to satisfy its 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 habilitation is available for the mentally retarded of Alabama.

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

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

Accordingly, it is the order, judgment, and decree of this Court:

1. That defendants be and they are hereby enjoined from failing to implement fully and with dispatch each of the standards set forth in Appendix A attached hereto and incorporated as a part of this decree;
2. That a human rights committee for Partlow State School and Hospital be and is hereby designated and appointed. The members thereof are listed in Appendix B attached hereto and incorporated herein. This committee shall have the purposes, functions, and spheres of operation previously set forth in this order. The members of the committee shall be paid on a per diem basis and be

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

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

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

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

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

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

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

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

[Appendix A]

MINIMUM CONSTITUTIONAL STANDARDS FOR ADEQUATE HABILITATION OF THE MENTALLY RETARDED

I. DEFINITIONS

The terms used herein below are defined as follows:

a. "Institution"—Partlow State School and Hospital.

b. "Residents"—All persons who are now confined and all persons who may in the future be confined at Partlow State School and Hospital.

c. "Qualified Mental Retardation Professional"—(1) a psychologist with a doctoral or master's degree from an accredited program and with specialized training or one year's experience in treating the mentally retarded; (2) a physician licensed to practice in the State of Alabama, with specialized training or one year's experience in treating the mentally retarded;

(1) a psychologist with a doctoral or master's degree from an accredited program and with specialized training or one year's experience in treating the mentally retarded;

(2) a physician licensed to practice in the State of Alabama, with specialized training or one year's experience in treating the mentally retarded;

(3) an educator with a master's degree in special education from an accredited program;

(4) a social worker with a master's degree from an accredited program and with specialized training or one year's experience in working with the mentally retarded;

(5) a physical, vocational or occupational therapist licensed to practice in the State of Alabama who is a graduate of an accredited program in physical, vocational or occupational therapy, with specialized training or one year's experience in treating the mentally retarded;

(6) a registered nurse with specialized training or one year of experience treating the mentally retarded under the supervision of a Qualified Mental Retardation Professional.

d. "Resident Care Worker"—an employee of the institution, other than a Qualified Mental Retardation Professional, whose duties require regular contact with or supervision of residents.

e. "Habilitation"—the process by which the staff of the institution assists the resident to acquire and maintain those life skills which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental, and social efficiency. Habilitation includes but it not limited to programs of formal structured education and treatment.

f. "Education"—the process of formal training and instruction to facilitate the intellectual and emotional development of residents.

g. "Treatment"—the prevention, amelioration and/or cure of a resident's physical disabilities or illnesses.

h. "Guardian"—a general guardian of a resident, unless the general guardian is missing, indifferent to the welfare of the resident or has an interest ad-
verse to the resident. In such a case, guardian shall be defined as an individual appointed by an appropriate court on the motion of the superintendent, such guardian not to be in the control or in the employ of the Alabama Board of Mental Health.

1. "Express and Informed Consent"—the uncoerced decision of a resident who has comprehension and can signify assent or dissent.

II. ADEQUATE HABILITATION OF RESIDENTS

1. Resident shall have a right to habilitation, including medical treatment, education and care, suited to their needs, regardless of age, degree of retardation or handicapping condition.

2. Each resident has a right to a habilitation program which will maximize his human abilities and enhance his ability to cope with his environment. The institution shall recognize that each resident, regardless of ability or status, is entitled to develop and realize his fullest potential. The institution shall implement the principle of normalization so that each resident may live as normally as possible.

3. a. No person shall be admitted to the institution unless a prior determination shall have been made that residence in the institution is the least restrictive habilitation setting feasible for that person.

b. No mentally retarded person shall be admitted to the institution if services and programs in the community can afford adequate habilitation to such person.

c. Residents shall have a right to the least restrictive conditions necessary to achieve the purposes of habilitation. To this end, the institution shall make every attempt to move residents from (1) more to less structured living; (2) larger to smaller facilities; (3) larger to smaller living units; (4) group to individual residence; (5) segregated from the community to integrated into the community living; (6) dependent to independent living.

4. A borderline or mildly mentally retarded person shall be a resident of the institution. For purposes of this standard, a borderline retarded person is defined as an individual who is functioning between one and two standard deviations below the mean on a standardized intelligence test such as the Stanford Binet Scale and on measures of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale. A mildly retarded person is defined as an individual who is functioning between two and three standard deviations below the mean on a standardized intelligence test such as the Stanford Binet Scale and on a measure of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale.

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

a. The institution shall formulate a written statement of educational objectives that is consistent with the institution's mission as set forth in Standard 2, supra, and the other standards proposed herein.

b. School-age residents shall be provided a full and suitable educational program. Such educational program shall meet the following minimum standards.

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe/ Profound</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Class size</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>2. Length of school year (in months)</td>
<td>9-10</td>
<td>9-10</td>
</tr>
<tr>
<td>3. Minimum length of school day (in hours)</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

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

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

1 See Standard 7, infra.