UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

FOURTH DIVISION

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10-1-74

Patricia Welsch, by her father and natural guardian, Richard W. Welsch, et al, Plaintiffs, vs. Vera J. Likins, individually and as Commissioner of Public Welfare for the State of Minnesota, et al, Defendants.	MEMORANDUM FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER FOR JUDGMENT No. 4-72-Civil 451

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This is a class action suit brought by six mentally retarded residents of the Minnesota State Hospitals seeking declaratory and injunctive relief regarding treatment and conditions in six State-owned and operated facilities for the mentally retarded and alternatives to placement in these institutions.

The plaintiffs all have been judicially committed as mentally deficient persons pursuant to the Minnesota Hospitalization and Commitment Act, M.S.A. § 253A.01, et seq., a civil commitment statute. The named plaintiffs, each of whom is represented by his or her natural guardian(s) or next friend, are as follows: Patricia Welsch, who has been a resident at Cambridge State Hospital since May, 1971; Barbara Coons, who has been a resident at Faribault State Hospital since May, 1972; Kristine Nygaard, who has been a resident of the Northwest Achievement Center at Fergus Falls State Hospital since October, 1971; Lisa Tymesen, who has been a resident at Cambridge State Hospital since 1961; Carole Odland, who has been a resident at Hastings State Hospital since 1969 and previously resided at Faribault State Hospital; and Olen Cowen, Jr., who has been a resident at Faribault State Hospital since 1970 and previously resided at Cambridge State Hospital. They represent a class under Rule 23 of the Federal Rules of Civil Procedure composed of themselves and all other judicially committed mentally retarded residents of Minnesota State Hospitals at Brainerd, Cambridge (including the Lake Owasso Annex), Faribault, Fergus Falls, Hastings, and Moose Lake. Additionally, a subclass has been created under Rule 23(c)(4) for the purposes of this action consisting of all judicially committed mentally retarded residents at Cambridge State Hospital.

The defendants are public officials and administrators charged with responsibilities for the care and custody of the plaintiff class. They are as follows: Vera J. Likins, Commissioner of the Department of Public Welfare of the State of Minnesota (hereinafter DPW), who is responsible for the care and custody of mentally deficient persons committed to her and also responsible, pursuant to M.S.A. § 246.01, for the supervision and management of the State Hospitals for the mentally retarded; Ove Wangensteen, the former Acting Commissioner and now Assistant Commissioner of DPW; Harold Gillespie, Administrator of Brainerd State Hospital; Dale Offerman, Administrator of Cambridge State Hospital; Charles Turnbull, Administrator of Faribault State Hospital; Robert Hoffman, Administrator of Fergus Falls State Hospital; James Brunsgaard, Administrator of Hastings State Hospital; and Harvey G. Caldwell, Administrator of Moose Lake State Hospital.

A twelve day trial was conducted in September and October, 1973. Various professional experts in mental retardation were among the witnesses testifying for both sides. Much documentary evidence also was received. Upon completion of the presentation of evidence, the Court on October 17, 1973, made an unannounced one day tour of the facilities at Cambridge, accompanied by counsel for both sides as well as certain administrative personnel at the institution.

On February 15, 1974, the Court entered a declaratory judgment resolving certain threshold legal questions. Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974). The Court held that persons civilly committed for reasons of mental retardation have a right under the due process clause of the Fourteenth Amendment to minimally adequate treatment designed to afford each of them a realistic opportunity to be cured, or at least to improve upon his or her mental and physical condition. It further held that these persons have a similar right to receive adequate care and treatment under the Minnesota Hospitalization and Commitment Act. The Court also ruled that the plaintiffs are entitled under the due process clause to have the State officials charged with responsibilities for their care and custody conduct good faith efforts to place the plaintiffs in the least restrictive conditions that are feasible and consonant with the physical and mental conditions of the committed persons. Finally, the Court held that certain practices and conditions at Cambridge may be violative of plaintiffs' constitutional rights under the cruel and unusual punishment clause of the Eighth Amendment and the due process clause. The Court deferred ruling

on these claims pending the herein Findings of Fact, Conclusions of Law, and Order for Judgment. It also deferred ruling on what relief, if any, may be accorded until entry of these Findings, Conclusions, and Order.

Following issuance of the declaratory judgment, the parties have met with the Court on several occasions and have conferred with each other in attempts to resolve some, or all, of their differences. Additionally, post-trial proceedings were conducted on May 10, 1974, at which time the defendants offered testimony of the defendant Commissioner and two other officials within DPW. Certain other evidence in the form of depositions and exhibits have been admitted into evidence. While the parties have reached agreement on some matters pertaining to the nature of relief, there remain several major unresolved areas.

The matter now before the Court is limited in applicability to the subclass of judicially (or civilly) committed mentally retarded residents at Cambridge State Hospital. The Hospital is a State-owned and operated facility for the mentally retarded located in Cambridge, Minnesota, about 45 miles north of the Minneapolis-St. Paul metropolitan area, in Isanti County. Cambridge is one of ten State hospitals for the mentally retarded run by the DPW.[1] The others housing members of the plaintiff class are located at Brainerd, Faribault, Fergus Falls, Hastings, and Moose Lake. Together, they have approximately 3,500 mentally retarded residents. Additionally, State hospital facilities for mentally retarded persons are at Anoka, Rochester, and two at St. Peter. Of these, only the hospitals at Cambridge and Faribault serve retarded persons exclusively. The DPW also has responsibility for four other institutions serving mentally ill and chemically dependent persons.

At the time of trial, Cambridge was headed by an Administrator, who was responsible for the institution's physical plant, personnel, and budget; a Medical Director, who was responsible for health services; and a Program Director, who was responsible for training and education programs at the institution.[2] In April, 1974, the administrative organization was altered with the appointment of a single Chief Executive Officer with primary day-to-day responsibility for the operations of the facility. Ultimate responsibility for the institution has been, and continues to be, vested in the Commissioner.

Approximately 90 percent of the residents at Cambridge have been judicially committed to the institution as mentally deficient persons pursuant to the Minnesota Hospitalization and Commitment Act. About 27 percent of them have been confined there for up to four years, about 20 percent between five and nine years,

33 percent between 13 and 14 years, 12 percent between 15 and 19 years, and eight percent of the residents have been confined there for 20 years or more. Taking account of those who have been discharged, the average length of stay in the institution is between six and seven years. P. Ex. 51, Tab. 33(B).

During the past several years, Cambridge has substantially reduced its resident population. In 1961, it housed about 2,000 mentally retarded persons. A decade later, the population was about 950. At the time of trial, Cambridge had a population of about 750 residents. Its population now is about 720, about half of whom are under 21 years of age.

The vast majority of persons discharged from Cambridge over the past several years have been mildly or moderately retarded. Consequently, Cambridge is becoming populated almost exclusively with severely and profoundly retarded residents.[3] Of its current population, about 90 percent are severely or profoundly retarded.

The residents at Cambridge suffer from a variety of serious physical, intellectual, and emotional handicaps. Approximately 23 percent are incontinent, 24 percent are non-ambulatory, 28 percent are incapable of feeding themselves, 31 percent are severely physically handicapped, 46 percent suffer from seizures, 53 percent are incapable of dressing themselves, and 83 percent have speech or hearing impediments. A substantial percentage of the mildly retarded residents suffer from emotional or behavioral problems in conjunction with their retardation.

Despite these handicaps, the evidence demonstrates that most of the residents have the potential for significant improvement of their mental, physical, and emotional conditions. The extent to which betterment is possible depends, in part, upon the degree of retardation and attendant physical handicaps of the particular individual. But the testimony of the experts and documentary evidence indicate that almost all of the residents, no matter the degree or severity of their retardation, are capable of some growth and development if given adequate care and suitable treatment.

In particular, a large percentage of the residents are capable of learning basic self-care skills, including feeding, dressing, grooming, and other aspects of personal hygiene. Additionally, it was established that the mildly and moderately retarded and to a lesser extent even the severely retarded residents may be capable of learning certain vocational and homemaking skills that could permit them to live and function in the community at large, albeit under

sheltered or supervised conditions. They could, thus achieve some degree of self-sufficiency and become productive members of society.

This potential for growth and self-improvement is recognized in Cambridge's own Policy and Procedural Manual, which reads, in pertinent part, as follows:

> "We believe that all mentally retarded . . . individuals, who must be institutionalized, can be assisted to function optimally at a level in keeping with their abilities, and thus be less dependent on others; and that each individual resident should receive adequate care, treatment, training, education, rehabilitation, etc., ..." P. Ex. 37.

The expert testimony showed that improvements in the intellectual capacities and functional abilities of retarded persons may be accomplished through a comprehensive program of care and treatment known as "habilitation." A basic component of the habilitation process consists of the application of the principle of "normalization" by which the living conditions, appearances, and activities of mentally retarded persons should generally approximate those found in the rest of society. This means that, unless the disabilities of the individual resident dictate otherwise, he should participate in training programs conducted outside resident living areas; eat or be fed, unless bedridden, in established dining areas; participate in planned, supervised outdoor recreational activities on a year-round basis; be provided with, and have access to, individual storage space for personal belongings; and be afforded normal privacy for bathing, toileting, and dressing.

At least for the severely and profoundly retarded, this program of habilitation and normalization should be carried on consistently during the waking hours. This would enable skills learned in formal training programs to be continued and reinforced during portions of the days during which there are no formal programs or activities.

Residents at Cambridge are housed in thirteen residential buildings. Six of these buildings are old, two-story high structures constructed during the 1920s and 1930s, when the institution was known as the Colony for Epileptics. These buildings contain either two large dormitories or series of bedrooms housing an average of about five residents per room on the second floors; two large lounge-like dayrooms on the main floors; and dining, recreation, medication, utility, and seclusion rooms in the basements. Two of these buildings, Cottages #1 and #14, vary somewhat from this design. Cottage #1 houses about 35 mildly retarded adults, most of whom have been at the institution for long periods of time. They have semi-private bedrooms, usually with one roommate

each. Cottage #14 houses about 81 adolescents and adults of both sexes with varying degrees of retardation. They have bedrooms averaging 3-4 persons per room, resembling typical college dormitories in style.

Except for Cottages #1 and #14, the population of the other four old buildings is about 31-39 persons each.

Five of the remaining residential buildings are one-story high structures constructed during the 1950s, when the institution was known as the Cambridge State School and Hospital. These buildings are divided into a series of wards, each containing a dormitory for approximately 20 residents and a dayroom. These buildings also have one or more dining rooms, as well as activity rooms, offices, and seclusion rooms. The population of four of these buildings is between 77 and 130 residents. The Infirmary varies from this basic design. It has a number of individual or semi-private rooms in addition to several dormitories, and it houses about 35 residents on a permanent basis.

Additionally, there are two modern, homelike dwellings for children and teenagers known as the Dellwoods (North and South). These buildings were constructed in 1971, four years after the State Legislature changed the name of the institution to its present name of Cambridge State Hospital. The population of these two buildings is about 16 persons each. They contain large, carpeted playroom areas, dining areas, and semi-private bedrooms housing two persons each.

At the time of trial, Cambridge was in the process of implementing a reorganization plan under which residents are placed in six different units, grouped generally according to the nature and extent of their disabilities. They previously had been grouped in a cottage unit system according to the structures in which they resided. The aim of the reorganization is to integrate training programs with other activities for persons with relatively similar conditions of retardation and physical impairments.

Unit I consists of severely and profoundly retarded children under the age of 18, either non-ambulatory or with ambulation difficulties. About 20 of these residents live in the East ward of the Infirmary. Another 120 reside in the six wards of McBroom Hall.

Units II and III consist of severely and profoundly retarded children under the age of 18 who are ambulatory. About 77 of these persons reside in the five wards of Cottage #8, and 32 others live in the two Dellwoods.

Unit IV consists of severely and profoundly retarded adults, either non-ambulatory or with ambulation difficulties. About 20 of them reside in the South ward of the Infirmary, and 120 others live in the six wards of Boswell Hall.

Unit V consists of severely and profoundly retarded adults. About 88 of them reside in Cottage #11. The North and East wards of Cottage #11 house residents with some ambulation difficulties who previously had been assigned to McBroom and Boswell halls. Unit V also includes Cottage #9, with a population of about 39 adult men, and Cottage #12, with a population of about 31 adult women. Unit VI consists mainly of moderately and mildly retarded adults residing in Cottages #1, #3, and #4. Some severely retarded persons are also included in this group.

The final unit is the Mental Health Treatment Service (MHTS), located in Cottage #14. The 90 residents there all have emotional and behavioral problems in addition to being retarded.

With the exception of the Dellwoods, the design and construction of most of the residential buildings at Cambridge are inappropriate for long-term housing of retarded persons. They are overly large and provide minimal opportunities for privacy, comfort, or other elements of a normal living environment. These facilities are particularly unsuitable for housing children.

Some upgrading of the facilities may be forthcoming within the upcoming year by application of funds approved by the DPW for certain physical improvements, including partitions in toilet areas throughout the institution and air conditioning for the Infirmary. Currently the Dellwoods are the only air conditioned residential structures at Cambridge. The institution has requested, but has not yet received, approval from the DPW or the Legislature for $100,000 to air condition Boswell and McBroom halls.

In addition to their general unsuitability for residential purposes, the design and construction of most of the buildings at Cambridge pose health and safety dangers for the residents. These hazardous conditions include hard terrazzo floors and stairwells in the older (1920s and 1930s) buildings that exacerbate problems associated with accidental falls, falls by seizure victims, and resident-to-resident aggression. Additionally, the staff offices in these buildings generally are improperly located to assure adequate supervision of the residents. Several of the newer buildings at the institution have poor, variable temperature control. Cambridge, however, has recently met outstanding Orders

issued by the State Fire Marshal and the Department of Health and has received licenses or approval by these agencies.

Many of the living conditions at Cambridge are not consonant with what one would expect to find at large facilities for the housing of normal, non-retarded persons and thus do not conform to the normalization principle. Living quarters, bathrooms, and sleeping areas are often lacking in adequate privacy. Most residents do not have individual chests, closets, or desks to maintain personal possessions. Equipment is in short supply. Some residential areas are devoid of furnishings, and others are inadequately furnished.

Most residents sleep in large dormitories with about 20 other residents. These rooms are sparsely furnished, having virtually nothing but beds. There are not enough toys, dolls, and other playthings for all of the children who could want and use them.

Hygiene facilities also are inadequate in many respects. Toilet stools typically lack seats, although there are a number of shaped porcelain stools that are somewhat better than most of the other toilets. Toilet tissue, soap, and towels are often absent in the toilet areas and are unavailable to most residents on individual bases.

Although some of the most severely and profoundly retarded and physically handicapped residents probably could not appropriately use the kinds of basic items mentioned above, the evidence shows that with proper supervision and training most of the residents could use and would benefit from having these materials and equipment available for them.

These deficiencies in the living conditions at Cambridge are attributable primarily to a persistent shortage of funds for equipment. For the 1969-1971 biennium Cambridge requested $273,524 for special equipment, and it received only slightly more than $52,000 from the State Legislature. For the following biennium Cambridge sought $159,799 for equipment, and it received about $46,000 from the Legislature. For the current 1973-1975 biennium it requested $106,297 for special equipment, and it received $42,000 from the Legislature.

Most of the buildings at Cambridge are connected through an underground tunnel system. The tunnels are used extensively as a means of resident movement, particularly during colder weather. The then-Administrator of Cambridge testified that the tunnels are "extremely hot" and that the lighting conditions are dim, although gradually being improved in some areas. Steam and electrical

power lines for the institution run through the tunnels. In those portions of the system in which steam lines are insulated the temperatures are comfortable. The temperatures are very warm in the uninsulated portions.

The use of tunnels for resident movement contributes to the apparent infrequency with which residents get outdoors. There are some outdoor recreational activities available, including camping exercises conducted on and off campus for many of the residents. As a whole, however, the testimony, as corroborated by the Court's own view of the premises, showed that the residents get relatively little outdoor recreation although most could benefit from such activities.

In order to improve upon their intellectual and, in many cases, physical deficiencies, Cambridge residents should participate in organized learning or structured leisure-time activities for substantial portions of their waking hours. Moreover, certain aspects of formal training should be continued and reinforced during the times that the residents are in their living areas.

Until recently, systematic training programs at Cambridge were sparse. A few training programs were primarily vocational in nature. Otherwise, organized training basically was limited to about 65-70 children enrolled in the Federally financed Project Teach program, which is now defunct, and to emotionally disturbed residents in the MHTS.

A significant development in early 1972 was the commencement of a Day Activity Center (DAC) program for adult and certain children residents. This program, now administered under what is known as Structured Program Services (SPS), basically consists of small group sessions on weekday mornings and early afternoons in which residents are given instruction directed at eye-hand coordination, increasing their attention span, gross motor skills, and development of other basic intellectual and physical abilities.

Prior to the recent reorganization of the institution, the instructor-resident ratios were about 1:10, although the testimony established that substantially lower ratios were necessary for adequately training the severely and profoundly retarded. Additionally, DAC instructors consist of nonprofessional staff persons lacking sufficient training for teaching these individuals. A shortage of adequate equipment also hampers the program.

Some improvements were noted in the program by the expert witnesses, and by the Court, in late 1973. The instructor-pupil ratios had been lowered so that in some instances there was one instructor per five or six residents

although the ratios generally fluctuated up to 1:11.

Despite continued deficiencies in the areas of staffing, professional input, and equipment, the DAC program represents a substantial step forward in the training and treatment of the residents at Cambridge. As the program progresses, it can be expected to contribute to the improvement of the lives of the residents, particularly if furnished with sufficient numbers of trained personnel and other resources.

In addition to SPS, there are a number of vocationally oriented programs at the institution. About 70-80 residents, including some who are severely retarded, participate in an adaptive work training program that is primarily aimed at providing them with satisfaction in performing job-like tasks and projects for the institution. Additionally, Cambridge has an industrial therapy program and also participates in another vocational program in conjunction with public school educators in nearby Pine City, Minnesota.

Perhaps the most significant recent development in training occurred in September 1972. About 150 children at Cambridge then entered public school for the first time, pursuant to the State's Trainable Mentally Retarded Act (TMR) mandating public education for the trainable mentally retarded. M.S.A. §§ 120.03 subd. 4, 120.17.

During the fall of 1973 the TMR program expanded to include about 260 Cambridge residents under the age of 21. The TMR program is conducted in conjunction with the Cambridge public schools. The program has 33 State certified special educators plus 32 aides. Additionally, two or three speech therapists work with residents who suffer from language development problems.

The Court visited Cambridge on a day when the TMR program was not in session. From the testimony, it appears that the program is a commendable advancement in training and can be expected to enrich the lives of the participants.

About 100 residents under age 21 are excluded from the TMR program because of emotional or physical handicaps. Along with most of the adult population, they are trained by the institution's SPS personnel in the DAC and other programs. Consequently, virtually all residents get at least five hours every weekday of supervised training.

Despite the development of these programs, for major portions of each weekday afternoon and evening and for all of the weekends most of the residents are not engaged in any organized or structured activities. During these periods they

are for the most pa[illegible] left on their own, with underst[illegible]ffed supervisory conditions. Evidence adduced in post-trial proceedings indicates that this situation has not significantly improved following the institution's reorganization in September 1973.

The environment in which most residents spend these unsupervised periods is overly restrictive. Doors to the dayrooms in which residents ordinarily are confined during the late afternoons, evenings, and weekends frequently are locked. In some buildings the dayroom doors are open but doors to corridors or to building exits are locked. Keeping these doors locked is helpful in preventing residents from wandering away from the rooms or out of the buildings and possibly off of the campus. But this also results in confining them in relatively small areas for long periods of time without opportunity for mobility and contact with their environment.

Heavy wire mesh or security screens cover the windows in most residential areas. This poses safety problems, particularly for the more aggressive residents and those with behavioral problems.

As the Court has previously declared, residents at Cambridge have a right, grounded on the due process and cruel and unusual punishment clauses, to a humane and safe living environment. Welsch v. Likins, supra, 502-503. This right may be effectuated by providing them with basic custodial care or safekeeping from harm. They also, as previously declared, have a right under the due process clause and State law to receive habilitation. Id., 491-501. This right consists of the maintenance of a humane psychological and physical environment, qualified staff personnel in sufficient numbers, and individualized treatment plans, Id., 493, and it may be effectuated in general by providing the residents with "minimally adequate treatment designed to give each committed person 'a realistic opportunity to be cured or to improve [upon] his or her mental condition.'" Id., 499, quoting Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971).

The most critical need at Cambridge to fulfill both of these rights is for sufficient personnel to care for, supervise, and train the residents. Until 1971, the State Legislature set the staffing complements for Cambridge and the other State hospitals directly. Beginning with the 1971-1973 biennium, the DPW has set the complements, subject to legislative prescribed ceilings. Cambridge makes its budget requests through the Bureau of Residential Services division of the DPW. The DPW in turn submits to the Governor a formal biennium budget encompassing all ten State hospitals, supported by a line item budget for each of

the individual institutions. The Governor submits his budget request to the Legislature, which then makes the ultimate appropriations to the DPW and its institutions.

In 1971 the Legislature eliminated about 550 positions in the ten State hospitals serving the mentally retarded. A freeze was imposed on hiring State employees in October 1972, but it was later modified to permit replacement of some personnel upon administrative approval.

As a result of these developments, Cambridge, which had requested 93 additional staff positions for the 1971-1973 biennium, lost 141 positions in these two years. It also was forced to discharge more than two dozen part-time trainees who provided assistance primarily during the peak hours at the institution.

In 1973 Cambridge requested 267 additional positions, the DPW trimmed the request to 45, and the institution ultimately lost 28 positions in order to equalize staff complements among the State hospitals.

The authorized staff level at Cambridge was 598 at the time of trial. Since then there has been an overall increase of two authorized staff positions for a combined total of 650 at Cambridge and Lake Owasso. Although staffing has remained constant, the discharge of about two dozen residents during the period has resulted in a slight improvement in the overall staff-patient ratio. As more residents are discharged in the future, the ratio may be expected to continue to improve.

Cambridge also is a potential beneficiary of an authorization by the Legislature in 1973 to add 300 positions to the ten State hospitals.[4] Cambridge has not yet received any positions pursuant to this authorization. Whatever positions are added may be offset by reductions mandated by a legislative requirement that the DPW reduce State hospital staffs by 160 positions by January 1, 1975, and trim an additional 83 positions statewide by June 30, 1975.

The effect of these developments on the staffing complements at Cambridge is uncertain. But it appears that the overall staffing will become more troublesome in the future.

Most of the residents that Cambridge has discharged in recent years and probably will discharge in the future are mildly or moderately retarded. They necessitate less care, supervision, and treatment than the more severely and profoundly retarded individuals. Moreover, the less handicapped individuals have been performing a considerable amount of unskilled labor at the institution.

Between 1962 and 19[illegible] the institution discharged abo 500 of these resident workers. While this was a substantial and progressive accomplishment for Cambridge, it has reduced the amount of able-bodied persons capable of performing essential functions at the institution.

In addition to its staff employees, the institution maintains an effective and expanding volunteer program. During the first six months of 1973 hundreds of volunteers, mainly high school students, did about 15,000 hours of work at the institution. Their activities include helping with the DAC program and aiding in self-care (such as feeding) of the residents. Additionally, there are now 58 adult participants in the State-Federally financed Foster Grandparent program. They each spend about four hours, five days a week, giving intimate care to residents. Moreover, about 120 of the least retarded or physically handicapped residents perform labor at the institution, although this number will decrease as more of the mildly and moderately retarded are discharged.

These persons contribute important services to the institution. The Foster Grandparents alone fill the quantitative equivalent of 29 full-time staff positions. Although not professionally trained, the volunteers perform some tasks about as competently as could regular direct care employees. This is particularly so in providing comfort and what is termed "tender loving care" on an individual basis to the residents.

The staffing at Cambridge can be divided into two major components: direct care staff and professional staff. The direct care staff constitutes the bulk of the personnel at Cambridge. It is composed of psychiatric technicians, special schools counselors, senior special schools counselors, hospital and ward aides, and certain members of the nursing staff. They work directly with the residents in the wards and residential living areas.

At the time of trial, the reorganization being implemented at Cambridge directly involved 447 of the 598 staff positions. Of these, 323-1/2 positions were assigned to Residential Living Services and are of a direct care nature. Another 73 positions were assigned to SPS, which administers the DAC training program. Of the remaining positions, 40-1/2 were assigned to Health Services and the rest to Community Services and administrative positions.

The direct care staff also was restructured in the recent reorganization by transferring a number of custodial workers into direct care and program positions and by splitting 35 positions of full-time employees who recently have

left the institution into 75 part-time positions, composed mainly of high school students. The 75 split positions consist of 50 hospital aides and 25 food services employees. The purpose of this revamping was to augment staff complements during the peak, or busiest, periods at the institution.

Some of these newly-hired part-time employees have not been given sufficient training, and others have begun working in the wards with no training at all. Additionally, their youthfulness and lack of experience makes it difficult for many of them to be as effective as the more experienced and better trained employees in doing certain essential tasks such as passing medication and handling the behavioral problems of the residents.

The direct care staff under the reorganization also has assumed added custodial responsibilities. Between March 1973 and March 1974 the total number of unit service employees (including food service, housekeepers, etc.) was reduced from 117-1/2 to 49. Their duties now must be performed by Residential Living Services staff. It is not surprising, therefore, that certain buildings receive insufficient or no housekeeping or food service assistance on weekends and even occasionally on weekdays. From the evidence, it is clear that although highly dedicated and motivated and generally of high calibre, the staff is overtaxed with too many administrative, custodial, and direct care duties to handle all of them adequately.

The evidence presented at trial and during the post-trial proceedings leads to the inescapable conclusion that, with scattered exceptions, Cambridge lacks sufficient direct care staffing for purposes of basic custodial care or for effective habilitation of its residents.

The plaintiffs' witnesses who addressed themselves to the issue of staffing testified that direct care-resident ratios of 1:8 and 1:16 should be maintained during waking hours and at night, respectively, for purposes of basic custodial care or safekeeping of the severely and profoundly retarded individuals who predominate at Cambridge. Two of the defendants' witnesses testified that a 1:10 ratio during waking hours would provide minimally adequate custodial care.

It appears that one important factor in these assessments was the need for sufficient staff, particularly at night, to help evacuate residents in case of fire or other serious danger to the physical plant. But Cambridge has received the approval of the State Fire Marshal and Department of Health for meeting their standards for safety from fire dangers and plaintiffs are no longer contesting

this matter. Based on the evidence, shift ratios of 1:9 during the waking hours and 1:16 at night would appear to suffice for purposes of custodial care or safekeeping. See New York State Association for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752, 768 (E.D. N.Y. 1972) (ordering shift ratios of 1:9 during waking hours to provide residents a humane and safe living environment free from harm).

The on-duty ratios at Cambridge were shown to vary between 1:13 and 1:21 for most of the adult ambulatory population and some of the children in the institution during the non-program daytime hours (early mornings between 6 a.m. to 8:00 or 8:30 a.m., late afternoons and evenings from about 2:15 p.m. to bedtime, and weekends). In the non-ambulatory wards the ratios generally are about 1:10 although ratios as high as 1:21 are reached on a number of occasions. Night ratios average about 1:24, and in some instances they are as high as 1:46.

The evidence also established that richer, or greater, ratios are needed for purposes of habilitation, or treatment, of mentally retarded persons. Plaintiffs' witnesses testified that ratios of 1:4 during waking hours and 1:8 at night are needed for habilitation of severely and profoundly retarded residents.

These figures are identical to those set forth for "resident-living" staff by the Accreditation Council for Facilities for the Mentally Retarded (ACFMR), a national accreditation agency for facilities for the retarded operated under the auspices of the Joint Commission on Accreditation of Hospitals. Pl.Ex. 4, §§ 2.6.2.1.1-.3. Lesser ratios of an average of 1:6 during waking hours (1:4 and 1:8 during the morning-early afternoon and late afternoon-evening shifts, respectively) and 1:8 at night are dictated by the ACFMR for moderately retarded residents. Id., §§ 2.6.2.2.1-.3. Allowing for five-day work weeks plus holidays, vacations, and sick time necessitates about 1.6 persons to continuously fill one staff position around the clock. Thus, the ACFMR standards call for overall ratios of 1:1 for the severely and profoundly retarded and 1:1.25 for the other 70-75 residents at Cambridge.[5] Id., §§ 2.6.2.1.4, 2.6.2.2.4. To meet the ACFMR standards, Cambridge would now require about 700 resident-living staff.

The only evidence presented at the trial by defendants concerning ratios for habilitation was the testimony of the then-Administrator of Cambridge. He testified that 1:5 and 1:8 direct care-resident ratios for the two shifts during waking hours was satisfactory for purposes of habilitation.

In post-trial proceedings, the defendants have recognized the "probable" necessity of providing additional staff at Cambridge. They have conditionally

proposed immediate implementation of staffing requirements promulgated recently by the Department of Health, Education, and Welfare governing intermediate care facilities for the mentally retarded (ICF-MR). 39 Fed. Reg. Pt. 249. P. 2221, et seq. (January 17, 1974).

These regulations provide standards for private and public residential facilities for the mentally retarded in order to qualify for reimbursements under the Federal medical assistance program, pursuant to Title XIX of the Social Security Act. 42 U.S.C. §§ 1396, et seq. Although the regulations are not scheduled to become fully effective for Cambridge (and the other State Hospitals involved in this action) until early in 1977, 39 Fed. Reg. § 249.10(d), defendants have pledged that the Commissioner of the DPW and the Governor will urge the State Legislative Advisory Committee to authorize immediate employment of whatever additional personnel are required to satisfy the ICF-MR standards.

The ICF-MR regulations have deferred for three years setting specific staff-resident ratios. But they do prescribe certain ratios for "resident living staff" and residents. They mandate an overall ratio of 1:2 for the severely and profoundly retarded and 1:2.5 for the moderately retarded. 39 Fed. Reg. § 249.13 (b)(5)(ii)(A), (B).[6] These figures include the factor accounting for a regular work week and appropriate time off for vacations, sick time, holidays, and the like. Thus, to satisfy the ICF-MR standards, Cambridge would require a total complement of slightly more than 350 resident living staff, 325 for the approximately 650 severely and profoundly retarded residents and about 30 for the less retarded 70-75 persons at the institution. Employment of sufficient personnel to match the ICF-MR regulations would translate roughly into shift ratios of 1:8 during waking hours and 1:16 at night.

Defendants have calculated that these standards can be met at all ten of the State hospitals for the mentally retarded by the addition of 142 positions to the total of 2,035 authorized positions as of April 1, 1974. Of these, 41 positions, all professionals, would be added to the Cambridge (including the Lake Owasso annex) staff. This would not make any change in the direct care staffing complement and current direct care staff-resident ratios at Cambridge.

Nevertheless, the limited standards contained in the ICF-MR regulations should not be disregarded here. Although these regulations do not purport to be constitutionally-based, neither do the standards set forth by the ACFMR, and supported by plaintiffs' witnesses, carry a mandatory due process imprimatur.

As indicated in its statement of "POLICIES AND PROCEDURES," the ACFMR standards are not envisioned as compulsory regulations that must be strictly complied with in order to achieve accreditation. Pl. Ex. 4, STANDARDS FOR RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED, at 149 (Dec. 1972); Pl. Ex. 5. That their satisfaction may be unattainable as a practical matter, at least in the short run, is evidenced by the fact that at the time of trial only two institutions in the United States had been accredited by the ACFMR.

The ACFMR standards have been mandated by one Court. In Wyatt v. Stickney, supra, the Court ordered implementation of the overall ACFMR ratios of 1:1.25 for moderately retarded and 1:1 for the severely and profoundly retarded at an Alabama institution for the mentally retarded. 344 F. Supp. 387, 406 (M.D. Ala. 1972); see also 344 F. Supp. 373, 383-384 (facility for the mentally ill).

But the circumstances prevailing at those facilities were substantially inferior to the conditions at Cambridge. Furthermore, the defendants here have exhibited a much greater concern for and commitment to the improvement of conditions and practices at Cambridge than was true in the Wyatt litigation. See 334 F. Supp. 1341, 1344, n.3 (M.D. Ala. 1971); 344 F. Supp. 373, 375; 344 F. Supp. 387, 389, n.1, 392-393, 408.

The massive addition of personnel necessary for the immediate satisfaction of the ACFMR staffing standards at Cambridge would bring about considerable administrative difficulties in budgeting for their employment, hiring them, training them, and otherwise integrating them into the current staff. The institution is still in the early stages of its most recent reorganization. While the Court has noted the deficiencies of the current staffing arrangement, it would be very burdensome and disruptive to require the institution to now undergo another major restructuring necessarily attendant to the immediate satisfaction of the ACFMR standards.

This is not to say that the deficiencies of the past and present warrant continued shortcomings in staffing. But the overall situation at Cambridge would not significantly improve and might even deteriorate, at least in the short run, by immediate imposition of the ACFMR staffing ratios. For present purposes, the immediate attainment of the overall ratios set forth by the ICF-MR standards would be a significant and feasible stride forward and would provide minimally adequate care and treatment of the mentally retarded. In promulgating these standards, HEW presumably took account of what is practicable as well as what is minimally adequate.

Besides being feasible of immediate attainment, there are other practical advantages in adhering to the ICF-MR standards for purposes of this action. They are more feasible to monitor and also would avoid becoming locked into ratios during the various working shifts. It leaves this determination to be flexibly arrived at by those with superior expertise and familiarity with administering Cambridge, that is, the DPW in the first instance and Cambridge's own competent administrative staff. At the same time, the ACFMR standards should be relied upon insofar as they establish, in the view of medical experts, the need for staffing ratios to be twice as rich during the waking hours as at night.

The parties dispute the interpretation of the meaning of the "resident living staff" as used in the ICF-MR regulations. Defendants include DAC (or SPS) personnel in their calculations for meeting residential living staff-resident ratios. Plaintiffs strenuously contend that the "resident living staff" encompasses only those who provide direct care for residents in wards and residential living areas, the equivalent of the 323-1/2 positions now classified at Cambridge under Residential Living Services, and does not include the DAC staff.

The plaintiffs' argument is persuasive, both from the text of the regulations and the practices existing at Cambridge.[7] If so, Cambridge would have to add about 30 additional staff to its current 323-1/2 Resident Living Services positions to match the ICF-MR overall ratios, in addition to its SPS personnel.

But HEW evidently construes the regulations in accordance with defendants' position. In a letter to the Deputy Commissioner of the DPW, the Director of the Division of Long-Term Care for HEW (Region X) indicates that, while TMR personnel cannot be included, SPS staff apparently may be considered as "resident living staff" under § 249.13(b). Hiniker Depo. Ex. 6.

The Court need not resolve this question at the moment. Since the ICF-MR regulations are so new, still in their pre-implementation stage, some flexibility should be accorded their interpretation. The Court will order their immediate implementation insofar as they pertain to "resident living staff"-resident overall ratios and leave the resolution of the interpretation of "resident living staff" to be worked out between the Commissioner of DPW and HEW.[8]

Plaintiffs complain that maintenance of the overall ratios prescribed by the ICF-MR regulations would only yield ratios of 1:8 and 1:16 during waking hours and at night, respectively, and that while satisfactory for purposes of custodial care or safekeeping, these figures fall short of what the evidence

demonstrates is necessary for habilitation.

They further point out that if richer ratios are maintained during portions of the day, Cambridge cannot even achieve the 1:8 and 1:16 ratios during the remainder of the day and night shifts. Thus, plaintiffs argue that adoption of the ICF-MR standards will not effectuate the right to treatment previously declared by the Court under the due process clause and State law. Welsch v. Likins, supra, 491-501.

But the attainment of 1:8 ratios during waking hours under the ICF-MR regulations would be an improvement, albeit slight, over the 1:9 ratios that the Court has found necessary for custodial care or safekeeping. Furthermore, the raw staff complement is not the only factor that must be taken into account in assessing the quantity and quality of treatment accorded the plaintiffs. The apparently effective deployment of numerous volunteers significantly augments the number of persons involved in direct care of residents, primarily during waking hours. Although the volunteers, including the Foster Grandparents, lack the training to be the equivalent of staff employees, their services cannot be ignored. Similarly, the TMR teachers and aides boost the number of persons engaged in training and treatment of residents at Cambridge.

Additionally, the Court will require the employment of a sufficient complement of maintenance or support staff to liberate the direct care staff from the diverting domestic tasks that the evidence shows now overburden them. Thus, even without a large numerical increase in direct care, or Residential Living Services, staff, having sufficient support personnel would result in improved care and treatment accorded to the residents at Cambridge. Compliance with the mandates of this Court, therefore, will result in substantially more than basic custodial care or safekeeping.

The more demanding staffing ratios contained in the ACFMR standards should be the ultimate goal to be aimed for by the defendants. Their attainment, however, will require the large scale employment of personnel that probably cannot be achieved without thorough evaluation by and approval of the Executive Department and the Legislature.

Being under an immediate duty to achieve compliance with the ICF-MR ratios and to employ sufficient support personnel, the Commissioner will further be ordered to recommend to the Governor that there be submitted in the next budget request to the Legislature the appropriation of sufficient funds to hire the

number of employees necessary to attain the ACFMR ratios. Since neither the Governor nor any members of the Legislature are parties to this action, they cannot be held accountable in a Court of law for compliance with this recommendation. Nor should the Commissioner be subject to judicial sanctions if they fail to heed her recommendation.

It is further recommended that these non-parties recognize the importance and urgency of the request to be submitted by the Commissioner. Although immediate satisfaction of the ICF-MR standards, in addition to providing sufficient support personnel, will foster the right to treatment, at least for the time being, attainment of the ACFMR standards should be sought if plaintiffs are to be given more than merely minimally adequate care and treatment.

Many of the most objectionable practices and conditions at Cambridge are attributable, in part, to the current staff shortages. One apparent consequence is the incidence of physical injuries to Cambridge residents. The evidence showed a number of serious injuries and many instances of less severe scratches, bites, and bruises suffered by the residents, particularly children. Many of these apparently occurred while residents were left unattended or with inadequate supervision in locked dayrooms.

Accidental falls or falls during seizures evidently caused many of these injuries. Plaintiffs' witnesses also testified to instances of aggression and self-injurious behavior displayed between and by residents. On its view, the Court did not observe an abnormal amount of resident-to-resident aggression, given the number and nature of residents in the institution. It did, however, notice numerous instances of manifestations of behavioral deterioration. In the dayrooms and elsewhere, the Court frequently observed residents engaged in stereotyped behavior such as continually repeated rocking motions while seated in chairs or crouched on floors, self head-banging, extreme withdrawal, and other conduct that was testified to at trial as being symptomatic of psychological and behavioral regression.

This is not to say that personal safety poses an alarming problem at Cambridge. Any sizeable institution housing so many children as well as others with severe mental, behavioral, and physical handicaps could expect to experience many of the above mentioned instances. Additionally, the staff at Cambridge attempts in good faith to do its best to prevent these occurrences. But additional personnel and certain structural improvements would greatly contribute

to alleviating these conditions at the institution.

Substantial testimony also pointed to the inadequacy of the personal hygiene of many of the residents. Witnesses testified to observing residents not cleaning themselves or washing their hands after toileting and that the staff was unavailable to assist them. On different occasions, two witnesses observed a large group of residents washing for dinner out of the same basin. The evidence established that certain residential areas smelled strongly of feces and urine. The Court's own observations in McBroom and Boswell halls corroborated this testimony.

Testimony and photographic evidence showed residents asleep and unattended on stairwells, floors, and in bathrooms in residential living areas. Nudity is not a significant problem, although there was evidence of a small number of residents not being fully dressed on certain occasions.

These problems are largely attributable to the inadequate number of staff to care for the residents. The work of the direct care staff is not easy. Witnesses for both sides had high praise for the dedication of the staff. On its view, the Court found the staff's attitude and morale generally to be as good as one would expect to encounter at an institution of this nature. But the staff has recently been logging record amounts of overtime work, and there is little question but that its efficiency is lowered under these conditions.

A number of harsh behavior controlling techniques and devices are used by the staff in supervising the residents. These are not employed out of malevolence by the staff, but rather are attributable primarily to the lack of sufficient supervisory personnel and the inappropriate behavior engaged in by some of the residents, particularly those who are hyperactive or excessively aggressive.

The most deplorable of these restraining techniques is known as seclusion, a form of solitary confinement in locked rooms about nine feet by eleven feet in size. A seclusion room typically is barren except for a bed or mat on an otherwise unpadded concrete floor. Some of the seclusion rooms contain toilets, but none has washing or drinking facilities. In most of the old buildings the seclusion rooms are located in the basement, often out of the immediate sight and hearing range of the staff.[9]

Residents may be placed in seclusion for a maximum of 48 hours upon a physician's order, which is renewable. At the time of trial, Cambridge was recording an average of between 1,000 and 2,000 hours of seclusion monthly, a

minimum average of 1.3 hours per resident. Evidence adduced in post-trial proceedings indicates that the use of seclusion has consistently been reduced, decreasing from 1,579 hours a month in July 1973 to 1,058 hours a month the following April. Under a recently revised policy, the use of seclusion is supposed to be limited to a last resort, only to protect residents from physical harm or injury to themselves or to others. This essentially conforms to Minnesota law regarding the use of restraints in such institutions. M.S.A. § 253A.17 subd. 1. Nevertheless, there was evidence of staff confusion and instances of noncompliance with the policy.

On the Court's view, only one resident was found in a seclusion room, a 37-year-old woman in Cottage #11 shortly after the evening meal. Her body from the waist up was naked. There was no seclusion order on record for her. A staff member said that this woman had been placed in seclusion fifteen minutes earlier because of disruptive food-grabbing behavior in the dining area.

As recognized by Cambridge's revised policy and State law, seclusion is arguably justifiable only as a last resort for protecting residents from harm to themselves or others. The use of seclusion for retarded persons was condemned by several of plaintiffs' witnesses. It is specifically and categorically prohibited by the ACFMR standards, § 2.1.8.5, as well as by the ICF-MR regulations. 39 Fed. Reg. § 249.13(b)(1)(x).

In other contexts, courts also have condemned seclusion practiced in a form comparable to that existing at Cambridge, and they have strictly limited the circumstances and conditions under which it may be employed. Morales v. Turman, 364 F. Supp. 166, 177 (E.D. Tex. 1973)(juvenile offenders); Nelson v. Heyne, 355 F. Supp. 451, 455-456 (N.D. Ind. 1972), aff'd 491 F.2d 352 (7th Cir. 1974); Gates v. Collier, 349 F. Supp. 881, 900 (N.D. Miss. 1972)(prisons), aff'd 489 F.2d 298 (5th Cir. 1973); Collins v. Schoonfield, 344 F. Supp. 257, 269 (D. Md. 1972)(prisons); Lollis v. New York State Department of Social Services, 322 F. Supp. 473, 483 (S.D. N.Y. 1970), modified 328 F. Supp. 1115, 1119 (S.D. N.Y. 1971)(juvenile offenders); Jordan v. Fitzharris, 257 F. Supp. 674, 676-684 (N.D. Cal. 1966)(prisons). In its current form, the use of seclusion at Cambridge violates the cruel and unusual punishment clause of the Eighth Amendment and must be eliminated. New York State Association for Retarded Children, Inc. v. Rockefeller, supra, 768; Inmates of Boys' Training School v. Affleck, 346 F. Supp. 1354, 1360, 1366-1367 (D. R.I. 1972); Wyatt v. Stickney, supra, 344 F.

322 F. Supp. at 482.

Besides seclusion, a number of physical restraining devices are used at Cambridge to restrict the movement of residents. The devices include fully enclosed cribs, mittens, straight jackets, and tying residents to beds, tables, toilets, and wheelchairs. During the period from March 1973 to February 1974 the institution compiled a monthly average of about 8,000 hours of restraints, excluding hours spent in crib enclosures and safety braces used to tie residents to wheelchairs or other sitting positions.

As with seclusion, evidence in the post-trial proceedings shows a sizeable and relatively consistent decrease in the use of restraints at Cambridge. The staff and administrators recognize the objections to excessive use of restraints and are in good faith attempting to limit the usage accordingly.

Imposition of these restraints poses a number of safety hazards and also reduces the residents' opportunity for proper contact with and stimulation from the immediate environment. But utilization of these restraints is not per se barbaric or inhumane. Some of the restraints are necessary for purposes of positioning and supporting certain non-ambulatory residents or those with other physical defects. They also help prevent some of the more aggressive residents from inflicting injuries to themselves or others.

The evidence showed, corroborated by the Court's own view, that in some instances the residents are placed in these restraints without prior medical approval and often are left in them for long periods of time, frequently without staff supervision or activities in which to participate. On these occasions, the beneficial purposes of the restraints are secondary to their primary effect of restraining individuals so that the staff has enough time to attend to other residents. As with seclusion, the evidence showed that the use of these restraining devices could be reduced by increasing staff and programs for the residents at Cambridge.

It is in their excessive and unsupervised utilization without first attempting less onerous means of controlling behavior that imposition of these restraints violates plaintiffs' rights under the cruel and unusual punishment clause and to the least restrictive alternatives under the due process clause. Wheeler v. Glass, 473 F.2d 983, 987 (7th Cir. 1973); Covington v. Harris, 419 F.2d 617, 623 (D.C. Cir. 1967); Inmates of Boys' Training School v. Affleck, supra, 346 F. Supp. at 1369; Wyatt v. Stickney, supra, 344 F. Supp. 387, 401. See also Inmates of

Suffolk County Jail v. Eisenstadt, 360 F. Supp. 676, 698 (D. Mass. 1973); Hamilton v. Landrieu, 351 F. Supp. 549, 552 (E.D. La. 1972); Brenneman v. Madigan, 343 F. Supp. 128, 138 (N.D. Cal. 1972).

Another widely used form of restraint at Cambridge is chemical. Although there was dispute as to the percentage of residents given tranquilizing medication, the Court finds that about 70 percent of the residents have their behavior controlled by these means.

There was uncontradicted testimony that the use of behavior modifying drugs should be carefully and systematically monitored and evaluated, that changes in medication should be prescribed in writing, and that all such evaluations should be recorded in the residents' medical records. But the institution's clinical pharmacologist testified that drug evaluations are made upon oral reports by the ward staff to the physician and that these reports are based upon the staff members' subjective observations. Medical records examined by plaintiffs' witnesses did not evidence any system of drug evaluation. At best, these records contained only occasional references to the efficacy of drugs. The testimony of the then-Administrator also indicated the absence of a uniform method of assessing drug efficacy at Cambridge.

An investigation undertaken by the DPW in 1972 found no serious problems with excessive drug usage at Cambridge. But it made several important recommendations, including better record keeping and more detailed information on drug usage by individual residents. Def. Ex. G.

The witnesses disputed whether the number of residents receiving tranquilizers at Cambridge was excessive. But the evidence showed that in any event their usage could be reduced if more staff and programs were available for the residents.

Whether or not excessive, the use of tranquilizing medication at Cambridge is improperly evaluated, monitored, and supervised. Since this erodes the value of these drugs as an adjunct to therapy, it constitutes cruel and unusual punishment and violates the plaintiffs' rights to due process of law. Nelson v. Heyne, supra, 355 F. Supp. at 455; Wyatt v. Stickney, supra, 344 F. Supp. 387, 400.

Besides shortages in direct care staffing, Cambridge also lacks a sufficient number of professional staff in many fields. For example, the institution does not have any speech therapists on its staff (there are some in the TMR program) although 80 percent of the residents have speech or hearing impairments,

such professionals to the staff.

Because of these vagaries, particularly the uncertainty of availability, the Court will not now require the Commissioner to hire the additional personnel plaintiffs seek. As with direct care staff to meet the ACFMR standards, however, the Court will order her to recommend that the Governor request the hiring of many of the professionals sought by the plaintiffs, and it again urges that the executive and legislative branches heed this recommendation in order that plaintiffs are provided with more than merely minimally adequate care and treatment.

Lack of equipment also impairs the institution's ability to provide adequate programs and services. Speech and hearing therapy, recreational programs, education and training programs, and physical therapy are among the programs that are most hindered by inadequate equipment.

The evidence showed the need for providing each non-ambulatory resident with a wheelchair that is specifically adapted to the resident's size and positioning needs. Such wheelchairs are helpful in preventing muscular contractures and assuring proper posture and positioning in order to enable the resident to relate to and receive stimulation from his immediate surroundings. In the past, however, the institution has lacked the funds to purchase a sufficient number of wheelchairs on a new or a replacement basis.

Besides sufficient personnel and adequate equipment, an essential part of the habilitative process, agreed upon by witnesses for both sides, is an individualized written habilitation, or program, plan for each particular resident. Such plans should contain specific, detailed information about a resident's abilities, program goals, and methods of attaining these goals. But the evidence showed that at least some residents at Cambridge apparently have no program plan, and the plans that do exist are written in terms too general to be of much benefit to or guidance for the program or ward personnal.

In the fall of 1972, the DPW promulgated a series of detailed and complex regulations (Rule 34) which constitute standards for licensure of public and private residential facilities serving five or more retarded persons. The DPW has five residential living consultants and nine nonresidential licensing consultants and one aide responsible for evaluating and monitoring some 10,000 facilities and programs under the DPW. About 126 licenses have been granted since the promulgation of Rule 34.

Each of the units at Cambridge, except the Infirmary, was evaluated by the Licensing Division of DPW in March 1973, and each was then awarded a provisional

including 50 percent who can communicate only by gesture and 31 percent unable to speak at all. Additionally, there are no staff or consulting psychiatrists at the institution and only two psychologists, although 41 percent of the residents suffer from behavioral problems, approximately 90 of them being in a special unit (the MMTS) for behavioral disorders. Two physical therapists are on the staff for the 300 physically handicapped residents.

In certain instances, the failure to provide adequate therapeutic services can have detrimental effects on the residents. There was uncontradicted expert testimony at the trial that not providing physical therapy for physically handicapped persons can result in permanent muscle contracture, which can be ameliorated only with surgery and then a regular program of physical therapy.

The parties have agreed during the course of the post-trial proceedings to the hiring of certain additional professional staff in several areas: registered nurses, physicians, physical therapists, speech and hearing therapists, social workers, and psychologists. The parties are in disagreement over the number of professional staff and aides to care for the dental needs of the residents and over plaintiffs' proposal to add professional staff in several other areas (physiatrists, psychiatrists, occupational therapists, special educators, vocational therapists, and recreational therapists).

Plaintiffs' proposals are complicated by several factors. Some of the services that these proposed additional staff would do currently is being provided at Cambridge, although not by persons directly on the staff. For instance, the TMR personnel provide special educational services, in conjunction with the DAC programs. The volunteers, including the Foster Grandparents, also make important, albeit non-professional, contributions.

Moreover, it is questionable whether some of the additional professional positions sought by the plaintiffs would be particularly suitable for the severely and profoundly retarded until they at least have first improved upon their present conditions. Thus, it is doubtful that they would now have a need for the services performed by vocational therapists. See Wyatt v. Stickney, supra, 344 F. Supp. 387, 406 (prescribing 1:60 ratios for vocational therapists for the mildly and moderately retarded, none for the severely and profoundly retarded).

Above all, there is a lack of information concerning the availability of personnel to fill the positions sought by the plaintiffs. Even if they are available, it is uncertain whether Cambridge, as a publicly funded institution, can provide the kind of benefits, monetary and otherwise, necessary to attract

license. The conditions attached to the granting of the licenses included rectifying deficiencies in numerous aspects of programming, services, living conditions, and the physical facilities at the institution. Correction of these deficiencies will require additional appropriation and expenditure of funds. The former State director of licensing for facilities for the retarded testified that it would cost about $750,000 just to bring the physical plant up to the requirements of Rule 34, plus another $75,000 at the Lake Owasso annex.

In February-March 1974 the Licensing Division again evaluated the six units at Cambridge. Its written report of its examination showed that Cambridge still suffered at that time from a multitude of deficiencies and that most of the shortcomings identified in the 1973 report continued to exist at the institution.

The Licensing Division then recommended that the provisional licenses that were issued in 1973 be revoked for every unit at Cambridge. At the request of the new Chief Executive Officer at Cambridge, the Division has agreed not to act upon this recommendation for an additional six months. A formal licensing review is scheduled to be undertaken at Cambridge by September 1974, and it is expected that this report will make specific recommendations to the Director of the Licensing Division.

The Director and her staff have demonstrated a significant degree of competance and expertise in their duties. The evidence showed that they have in the past and probably will continue to apply Rule 34 in a uniform manner to State-operated and private facilities for the retarded.

Full and continued compliance with Rule 34 would provide adequate care and treatment in many respects for the residents at Cambridge. But it also has numerous shortcomings as the standard for rectifying conditions and practices at Cambridge. The Rule does not contain any concrete standards regarding staffing of facilities. Although minimum staffing levels were included in proposed amendments to Rule 34, issued in 1973 by the Commissioner, they were subsequently withdrawn. A Court Order, therefore, is necessary to guarantee immediate implementation of the ICF-MR ratios and for the recommended attainment of the more rigorous ACFMR standards.

Furthermore, despite sincere efforts on the part of the staff at Cambridge and the good faith and even-handed administration of Rule 34 by the Licensing Division of the DPW, compliance with the Rule was shown to be improbable in the immediate future at Cambridge.

The DPW would then, applying the same principles as to private facilities, be faced with the prospect of closing the institution. Although a possibility, closure does not appear to be a realistic option for the State. See Employees of Department of Public Health and Welfare v. Department of Public Health and Welfare, 452 F.2d 820, 827 (8th Cir. 1971), aff'd 411 U.S. 279 (1973); New York State Association for Retarded Children, Inc. v. Rockefeller, supra, 768.

Even if closure were practicable, this would be more harmful than beneficial to the plaintiffs. Some could be suitable for discharge. Yet, the evidence showed the lack of suitable facilities for their placement. Others could be transferred to different State institutions, but this would aggravate the problems similar to those existing at Cambridge at these institutions. Consequently, alterations of the current provisions in Cambridge's licenses under Rule 34 or further time extensions in which to comply with the requirements of the Rule appear to be more likely.

Thus, while the provisions of Rule 34 will continue to govern at Cambridge to the extent they are consistent with or incorporated in the Order of this Court, defendants' proposal to place primary reliance upon Rule 34 as the vehicle for vindicating plaintiffs' rights in this action must be rejected.

The large decline in the resident population of Cambridge over the years is largely attributable to the discharge of residents to community-based facilities such as nursing or boarding homes. In some instances, residents have been discharged to the custody of their parents or next of kin, but as a general rule relatives are unavailable or incapable of taking care of those who reside at Cambridge. Thus, as a practical matter, discharge of residents depends primarily upon the availability of community facilities specially tailored for the retarded.

There currently are a number of residents at Cambridge awaiting placement to community-based facilities. But there is a severe shortage of these facilities in Minnesota. At the time of trial, for instance, there were no community facilities in Minnesota for severely and profoundly retarded adults. Consequently, some residents have remained at Cambridge for up to four years following their referral, and many others who would be capable of placement have not even been referred.

The Court has previously decreed that the plaintiffs are entitled to have the State attempt to place them in the least restrictive practicable modes of

confinement after being judicially committed.

There was little disagreement between the parties that placement in community-based facilities would constitute a less restrictive alternative to institutionalization in a State facility such as Cambridge and would be consistent with the purposes of habilitation.

In the post-trial proceedings, defendants have come forward with several constructive and potentially fruitful means of effectuating this right to the least restrictive alternatives. The DPW has been shown to be committed to encouraging the development and construction of privately-owned community facilities for the retarded. Its policy is to encourage the private sector to replace the State in the provision of direct services to the retarded.

A key element in this approach is the recently promulgated DPW regulations dealing with rate schedules for private residential facilities for the retarded. Under DPW Rule 52, private facilities for the retarded are to be reimbursed by the State on the basis of the reasonable costs incurred in providing care and treatment for the retarded.

Besides this incentive for the development of community-based facilities, the DPW has commenced negotiations with officials of the Minnesota Housing Finance Agency (HFA) in an effort to have the HFA make available certain funding for the construction of such facilities. Under the plan proposed by the defendants, an estimated $5,000,000 expected to be derived from bond issuances by the HFA would be available for loans to private parties for the construction of community-based residential facilities for the retarded. If this proposal is implemented, the reimbursement provisions of Rule 52 could be relied upon, at least in part, to repay the interest and principal of whatever loans are transacted.

The Commissioner also has been directed by the Legislature to prepare and submit a report this autumn dealing with the operations of the State hospitals and local facilities for the treatment of the mentally retarded, mentally ill, and chemically dependent. To be included in this report is a systematic plan for the closure and demolition of old or obsolete buildings in the State Hospital system.

Additionally, the Commissioner has appointed a task force to conduct a comprehensive examination of the entire State Hospital system and seek to develop alternative plans for the care and treatment of their residents. Included in the objectives of the task force are the examination of the funding patterns currently existing within the State Hospital system, the integration of services rendered by

the State to all of its institutionalized residents, and further refinement and development of individualized treatment programs.

It is anticipated that the end product of these studies will be the consolidation of some programs and possible closure of certain institutions. In post-trial proceedings, the Commissioner, with the apparent support of the Governor, has pledged to seek legislative approval to use whatever State funds are saved from these cutbacks for use in unspecified ways of improving the quality of care given to mentally retarded, mentally ill, and chemically dependent persons in Minnesota.

While impressive indicia of defendants' concern for and commitment to the principle of least restrictive alternatives, defendants' proposals are not without their shortcomings. They are largely speculative and dependent in the long run on the attitudes and approval of others, notably private developers, the HFA, and the Legislature. There is no assurance that sufficient private funding will be available or that any of the action already begun and proposed to be undertaken by the DPW and the Commissioner will in fact bring about a measurable change in the current shortage of community-based facilities.

Despite this uncertainty, the DPW does not now have a written plan for the provision of community residential facilities for the retarded. It also does not intend to have a contingency plan in the event that the private market fails to provide sufficient facilities or fails to provide facilities by the time that residents are ready and capable of discharge.

But the problems associated with the right to the least restrictive alternatives are more difficult than perhaps any other issue involved in this case. Plaintiffs apparently recognize these complexities in their final post-trial brief, noting the "difficult problems of zoning, federal and state regulations, community hostility and decreasing availability of federal funds . . . ." Plaintiffs' Memorandum in Reply to Defendants' Proposal for Settlement, at 6.

In short, establishment of community-based residential facilities for the retarded are wrapped in a complex web of relationships, some of which are beyond the control of this Court. For instance, a great deal of resistance has been demonstrated in several communities in the Twin Cities area to the proposed establishment of residential facilities for the retarded and others who comprise the population of the State Hospital system. This hostility has delayed or deferred proposals for community facilities for the retarded in at least three suburbs of the metropolitan area in recent months.

Besides these factors, there remains a serious question whether the mass establishment or construction of community-based facilities will in fact improve the lot of the residents of Cambridge as well as the other residents of the institutions involved in this action. If all of the approximately 720 residents of Cambridge were to be placed in community facilities of 16 persons each throughout the metropolitan Twin Cities area, there would have to be some 45 such facilities. Unless numbers of them are located near each other, professional staff would have to spend considerable time traveling between the various facilities in order to treat the residents. In contrast, maintenance of large institutions such as Cambridge provides centralization that reduces the strain on personnel resources associated with integration of the retarded in a scattering of community-based facilities.

Given these complexities, defendants' proposals, particularly their dealings with the HFA, represent at least "good faith attempts" in satisfaction of their duty to seek out the least restrictive alternatives for the plaintiffs. Welsch v. Likins, supra, 502. They should, therefore, press forward in their negotiations with the HFA, provided that they keep the Court informed of their progress and success, if any, in this venture. They should also continue their other current efforts aimed at effectuating the right to the least restrictive alternatives and adhere to their above mentioned pledges regarding seeking out funding from the Legislature and others. Above all, they must see to it that the plaintiffs are given the kind of treatment that will provide those who are capable with at least the opportunity to become prepared for being discharged and integrated into the community at large. In this respect, the right to treatment, or habilitation, is closely aligned with and a necessary ingredient of the other rights of the plaintiffs.

Although many of the developments that underlie the current conditions at Cambridge antedate the defendants' assuming their present positions, certain of the problems, particularly those pertaining to staffing, could have been alleviated had more forceful action been taken by the DPW within the last few years.

According to the testimony of the Director of Administrative Management of the DPW's Bureau of Residential Services, the ten State hospitals generated a surplus of more than $400,000 in fiscal year 1971-1972 and a surplus in excess of $1.2 million the following fiscal year. All of these monies were returned to the State treasury. Although empowered to approach the Legislative Advisory

Committee in each of these years to seek funding for additional staff hiring, the Commissioner did not do so.

In 1973 the DMW's presentation to the State Legislature did not relate the seriousness of the staff situation at Cambridge, according to the testimony of the then-Administrator of Cambridge. It was in that year that Cambridge's request for 267 additional staff positions was trimmed to 45 by the DPW, and the institution ultimately lost 28 positions in an administrative shuffling of personnel between State hospitals. The testimony of the Director of the Mental Retardation Division of the DPW also related that the legislative presentation in 1973 inaccurately portrayed the needs of the State hospitals and their residents.

This testimony does not establish lack of concern on the part of the DPW. But it does illustrate the need for more effective and vigorous advocacy on its part if the mandates of this Court are to be satisfied.

Although detailing many shortcomings and prescribing relatively detailed steps that must be undertaken to correct them at Cambridge, the Court does not view this as an indictment of the institution or the defendants themselves. The care and treatment of the mentally retarded has long been a hotly-disputed subject in this State and elsewhere. For at least a generation, it has been a matter of considerable attention by concerned citizens throughout the State and a much talked about political topic.

While improvements have been slow in coming, they have not been altogether absent. New ideas that have permeated the field of treatment of the retarded, or have been imposed by judicial decisions throughout the country, have been reflected at Cambridge. The evidence in this case demonstrates that Cambridge has made progress over the last decade or more in medical treatment, training, living conditions, record keeping, and personal liberties granted to its residents. The substantial reduction in resident population, curbing new admissions of the mildly and moderately retarded, encouraging more input from parents, other relatives, and consumer groups, and better care and treatment programs are among the major improvements in recent years. Defendants have attempted and, to a limited extent, succeeded in ameliorating some of the most objectionable features of life at Cambridge State Hospital.

The prevailing conditions and practices at Cambridge appear to be superior to those existing at other State institutions that have generated legal actions

similar to the instant case. See, e.g., Inmates of Suffolk County Jail v. Eisenstadt, supra; New York State Association for Retarded Children, Inc. v. Rockefeller, supra; Inmates of Boy's Training School v. Affleck, supra; Wyatt v. Stickney, supra, 325 F. Supp. 781, 344 F. Supp. 387. Witnesses for both sides agreed on this point. Hence, less elaborate steps need be ordered here.

Cambridge, thus, is not an abysmal and a degrading "Pit." While indicating numerous objectionable circumstances at the institution, the Court cannot say that the overall situation at Cambridge is "'so bad as to be shocking to the conscience of reasonably civilized people'" in violation of the cruel and unusual punishment clause. Martarella v. Kelley, 349 F. Supp. 575, 597 (S.D. N.Y. 1972), enforcement 359 F. Supp. 478 (S.D. N.Y. 1973), quoting Holt v. Sarver, 309 F. Supp. 362, 373 (E.D. Ark. 1970), aff'd 442 F.2d 304 (8th Cir. 1971). Cambridge's relative superiority to other institutions of its kind does not, of course, absolve those responsible for the situation at the facility but it does indicate that there are feasible steps that can be undertaken in order to remedy the present defects and vindicate plaintiffs' constitutional and statutory rights.

For their part, the defendants have conducted themselves in good faith in the events that precipitated this action, in the proceedings themselves, and in abiding by the prior rulings of the Court. But, as the Court previously has observed, good faith is not enough to protect plaintiffs' rights. Welsch v. Likins, supra, 498. While Cambridge has progressed in recent years, the journey towards humane and adequate care and treatment of these persons still has a long way to go.

The measures prescribed herein are means of reaching those goals. In so doing, the Court continues to reflect its concern for "the practical limits of its abilities to resolve what is essentially a question of conflicting legislative priorities." Id. There is little to be gained by ordering relief that cannot realistically be effectuated, yet for which the defendants would be accountable for noncompliance. Thus, to mandate that the Commissioner add several hundred direct care employees at Cambridge would unfairly subject her to potential judicial sanctions for circumstances that are beyond her immediate control and ultimately dependent upon approval by the Governor and Legislature. But neither the Governor nor the Legislature are parties to this action, and the Court has no direct control over them.

On the other hand, compelling the defendants to undertake certain significant measures and to further require the Commissioner to recommend authorization

of other large scale improvements at Cambridge would be practical and, buttressed by the authority of this Court, likely to result in substantial compliance by those with ultimate authority in the matter.

On the basis of the evidence in this case the Court believes that the provisions to be ordered herein are feasible and practicable means of achieving minimally adequate conditions and practices at Cambridge and will bring about a new and substantially better day for the mentally retarded.

It will then take the resolve and cooperation of the executive and legislative branches of State government, in conjunction with other instrumentalities, to remedy the years of neglect and inadequate care and treatment that the plaintiffs have suffered. They should be mindful that "[h]umane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations . . . ." Jackson v. Bishop, 404 F.2d 571, 580 (8th Cir. 1968). See also Rozecki v. Gaughan, 459 F.2d 6, 8 (1st Cir. 1972); Inmates of Suffolk County Jail v. Eisenstadt, supra, 687; Martarella v. Kelley, supra, 359 F. Supp. at 481; Wyatt v. Stickney, supra, 344 F. Supp. 373, 377; Brenneman v. Madigan, supra, 139; Hamilton v. Love, 328 F. Supp. 1182, 1194 (E.D. Ark. 1971). By retaining jurisdiction of this action, the Court will be in a position to dictate more demanding requirements should the responses of the non-parties fail to heed this admonition and conditions at Cambridge warrant further relief.

1. The Lake Owasso Children's Home is a satellite institution of Cambridge, funded under Cambridge's budget but operated independently. Seventy-seven mentally retarded children reside there. The Home is situated on ten acres and consists of seven buildings leased from Ramsey County. It has been operated as an annex to Cambridge since 1961. The lease with Ramsey County terminated this summer. The DPW has recommended to the State Legislature non-renewal of the tenancy and closure of the Lake Owasso facility. Pl. Ex. 51, p. 11.

2. Until April, 1972, the institution was run under a so-called "troika" framework, presided over by a Medical Director. The position of Medical Director had been vacant since April, 1972. One of the institution's physicians had been designated as Chief of Health Services.

3. Although guidelines vary for the classification of the retarded, they are generally based on intelligence quotient levels (I.Q.) as measured by standard I.Q. tests. Those with I.Q. scores between 50-70 are considered mildly retarded, between 35-50 are moderately retarded, between 20-35 are severely retarded, and below 20 are profoundly retarded. Forty-four of the 98 persons admitted to Cambridge in 1972 were classified as borderline, mildly, or moderately retarded. Pl. Ex. 45.

4. The 300 authorized positions for the 1973-1975 biennium have not been completely filled. As of early September, 1973, shortly before commencement of the trial, only 5,106 of the 5,400 authorized positions in the State Hospital system were filled. This difference apparently was attributable to the "lag time" in getting positions approved by various administrative agencies and a desire by the DPW to avoid filling all positions so as to obviate the need for lay-offs in view of the staff reductions that the Legislature built into the new complement. By early March, 1974, only 5,250 of the positions were filled, and the DPW had by that time begun to reduce the authorized complement.

5. The ACFMR standards also call for 1:16, 1:8, and 1:16 shift ratios and an overall ratio of 1:2.5 for residents in vocational training programs and adults working in sheltered employment situations. §§ 2.6.2.3.1-.4. These ratios do not appear to be pertinent in this action.

6. An overall ratio of 1:5 is prescribed for residents in vocational training and adults in sheltered employment situations. § 249.13(b)(5)(ii)(C).

7. Although not explicitly defining "resident living staff," the ICF-MR regulations call for "a direct care staff which conducts a resident living program designed to provide training in activities of daily living and development of self-help and social skills . . . ." § 249.12(c)(5). It further requires that the resident living staff be primarily concerned with training residents "in activities of daily living and in the development of self-help and social skills." § 249.13(b)(1)(i)(A). These duties envisioned for the resident living staff are essentially equivalent to those performed by the Residential Living Services, under the reorganized structure now in effect at Cambridge.

   Furthermore, the ICF-MR regulations require that "[i]n addition to the resident-living services . . . residents shall be provided with professional and special programs and services, in accordance with their needs for such programs and services." § 249.13(c)(1) (emphasis supplied). The tasks of the special programming personnel are to provide training and habilitation, in terms of "the facilitation of the intellectual, sensorimotor, and affective (sic) development of the individual." § 249.13(c)(3)(i). These functions fall within the domain of the DAC program conducted by SPS staff at Cambridge.

   Thus, the regulations envision different staff for purposes of caring and treating for residents in wards and living areas and for purposes of training and habilitation. This dichotomy is currently reflected at Cambridge.

Footnote 7, Cont.

The DAC program is conducted in separate buildings, has a separate administrative structure, and maintains a separate staff. From this it may be concluded that only the 323-1/2 staff classified as Residential Living Services may be counted as "resident-living staff" under the ICF-MR standards.

8. If SPS personnel are included with Residential Living Services staff in calculating the ICF-MR ratios, Cambridge would now be well over the minimal requirements. At present it has 323-1/2 Residential Living Services positions and 73 SPS positions, or a total of nearly 400 employees that defendants contend fall within the ICF-MR standards. Thus, the institution could eliminate about 50 positions and still satisfy the ICF-MR for the 720 residents under defendants' interpretation of those standards. To prevent this the Court will require that no matter how the ICF-MR regulations are interpreted, there be no reduction in the combined staffing complements for Residential Living Services and SPS, or their equivalents, below the current ratio of about 4:7.

9. Seclusion is distinguishable from a procedure known as "time out" in which a resident is placed in isolation for short periods of time lasting no longer than 15 to 20 minutes as part of the resident's program for controlling behavior. This procedure was recommended by two of plaintiffs' witnesses as a substitute for seclusion in instances of resident aggression.

ORDER

Accordingly, on the basis of the record and proceedings herein and the Findings of Fact and Conclusions of Law entered by this Court in this and previous rulings pursuant to Rule 52 of the Federal Rules of Civil Procedure,

IT IS ORDERED:

1. That defendants Commissioner of the Department of Public Welfare Vera J. Likins and Dale Offerman, administrator and now chief executive officer of Cambridge State Hospital, their successors in office, agents, employees, and all persons in concert or participation with them, are hereby enjoined from failing to implement, in accordance with their respective responsibilities under law, the standards set forth in Appendix A annexed hereto and incorporated in this Order.

2. That within ninety (90) days of the date of this Order, defendant Commissioner, her successor in office, or her designated agent, shall submit to the Governor of the State of Minnesota or the Governor-elect, as the case may be, a statement of the estimated expenses necessary for compliance with the Order of this Court and for carrying out the further recommendations required by this Order and shall request the Governor to immediately seek all necessary authorization for expenditure of these amounts. Should additional appropriations be necessary to achieve full and continued compliance with this Order, the Commissioner shall request the Governor to seek approval of such amounts from the Legislature or other authorized sources during and/or after the 1975 legislative session.

3. That defendant Offerman, his successor in office, or his duly authorized representative, shall within twenty (20) days of the date of this Order

(a) Call a meeting of all unit directors or group supervisors at Cambridge State Hospital, including supervisory personnel of Structured Program Services, Health Services, and Community Services, and

(b) at said meeting provide copies of this Order for all personnel present, and

(c) direct all personnel present at said meeting to hold meetings for all staff under their supervision within ten (10) days thereafter for the purpose of reviewing the requirements of this Order, and

(d) direct all personnel present at said meeting to report in writing to him the date, time, and place of staff meetings held, a list of those personnel present, and a brief summary of the content of those meetings, and

(e) maintain such written reports on file at Cambridge State Hospital.

4. A copy of this Order shall be posted in every staff office, nursing station, and visitor's lounge at Cambridge State Hospital.

5. Copies of this Order may be served upon the defendants and other persons employed by the Department of Public Welfare or by Cambridge State Hospital by the Office of the Minnesota Attorney General.

6. That this Court shall maintain continuing jurisdiction over this action.

LET JUDGMENT BE ENTERED ACCORDINGLY.

October 1, 1974.

/s/ Earl R. Larson
United States District Judge

APPENDIX A.

DEFINITIONS--The following definitions are applicable to the terms used herein:

(a) Institution--The Cambridge State Hospital.

(b) Resident--Any person who is now and is in the future confined at the Cambridge State Hospital following a judicial order for civil commitment.

(c) Habilitation--The process by which a resident is assisted by others at the institution to acquire and maintain skills that enable the resident to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental, behavioral, and social efficiency. Habilitation includes, but is not limited to, formal, structured programs of education and treatment.

(d) Direct Care Staff--The persons employed at Cambridge State Hospital and classified pursuant to State Civil Service Classifications as psychiatric technician or senior psychiatric technician, special schools counselor or senior special schools counselor, hospital aide, and registered or licensed nurse assigned to resident living or program areas and spending a majority of the time working directly with residents. In computing direct care staff-resident shift ratios, regular Cambridge State Hospital direct care staff or public school staff who spend a majority of the time working directly with residents in Structured Program Services or in the Trainable Mentally Retarded programs, or other equivalent programs, may be included in computing direct care staff-resident shift ratios, provided that the minimum ratios are in fact provided at all times.

(e) Support Staff--Employees whose duties do not require regular contact with or supervision of residents, such as custodial or food service workers.

(f) Semi-professional Staff--Employees who aid and work in conjunction with licensed or professional staff employees with degrees, such as dental hygienists and aides.

(g) Non-ambulatory Resident--Any resident who cannot achieve independent mobility by use of his legs. All other residents shall be considered ambulatory.

(h) Seclusion--The placement of a resident alone in a locked room.

(i) Community Residential Facility--A private or publicly operated residential facility for the mentally retarded located in or near a population center and housing between four and fifty residents.

(j) Natural Home--A resident's parental home or the home of any other natural relative.

* * * * * *

1. No mentally retarded person shall be admitted to the Cambridge State Hospital following a judicial order for civil commitment if services and programs in the community can afford adequate habilitation to such person.

2. No person classified as borderline, mildly, or moderately retarded, in accordance with standards that have been applied for the classification of residents at Cambridge State Hospital, shall be admitted to the institution following a judicial order for civil commitment unless that person suffers from such psychiatric or emotional disorders in addition to his retardation as would make it appropriate for that person to be treated at the Mental Health Treatment Service or an equivalent program at the institution.

3. Within ninety (90) days of this Order, defendant Commissioner, or her successor in office, shall seek the necessary authorization to bring the staffing levels at Cambridge State Hospital in conformance with the "resident living staff"-resident overall ratios prescribed by the Department of Health, Education, and Welfare for Intermediate Care Facilities for the Mentally Retarded, as contained in 39 Fed. Reg. § 249.13(b)(5)(ii)(A), (B) (January 17, 1974).

4. Within one hundred and fifty (150) days of this Order, there shall be employed at Cambridge State Hospital sufficient personnel to satisfy the overall ratios identified in Paragraph 3 above, and the on duty ratios shall be at least twice as great during the waking hours shifts as at night. As evidence of the attainment of the overall ratios prescribed in Paragraph 3 above, the Commissioner, or her successor in office, shall submit to the Court and counsel for the plaintiffs a written statement from the Department of Health, Education, and Welfare, by the appropriate official of that Department, that the institution is in compliance with the ratios set forth in 39 Fed. Reg. § 249.13(b)(5)(ii)(A),(B) (January 17, 1974). Defendants shall not be considered to be in compliance with the above mentioned ratios unless the total number of positions classified at Cambridge State Hospital as Residential Living Services and Structured Program Services, or their equivalents, is at least four-sevenths (4/7) the total number of residents at the institution.

5. In addition to attainment of the ratios identified in Paragraphs 3 and 4 above, sufficient support staff shall be provided to assure that all supportive services are adequately provided without requiring the routine assistance of "resident living staff" personnel for supportive duties. This Paragraph does not prohibit "resident living staff" employees from engaging in administrative

duties as part of th[illegible] responsibilities or from assisting in support [illegible] unusual or emergency situations.

6. That this Order shall not in any other way affect Cambridge State Hospital in meeting the standards or requirements imposed upon the institution by the regulations set forth in 39 Fed. Reg. §§ 249.12, 249.13 (January 17, 1974).

7. As soon as such persons become available, and in no event later than June 1, 1975, there shall be employed at Cambridge State Hospital professional staff reflecting the following staff-resident ratios:

(a) Registered Nurses

Severely or Profoundly Retarded	1:40
All Other Residents	1:100

Additionally, there shall be made available to Cambridge State Hospital its proportionate share of the following nursing positions that defendants have indicated will be available on a systemwide basis for all ten State institutions for the mentally retarded:

Hospital Units	67
Special Units	18
Health Service Supervisors	10
Nurses Working in Administrative Capacities	68

(b)	Physicians (licensed to practice in the State of Minnesota)	1:175
(c)	Physical Therapists (licensed to practice in the State of Minnesota)	1:100
(d)	Speech and Hearing Therapists (with at least a bachelor's degree in their respective specialties)	1:100
(e)	Social Workers (with at least a bachelor's degree in social work from an accredited program)	1:60
(f)	Psychologists (with at least a master's degree from an accredited program)	1:100
(g)	Dentists (licensed to practice in the State of Minnesota)	1:350

Defendants may contract outside the institution for dentists, rather than employing them directly on the staff, provided that there is a dentist on call for emergency work at all times.

8. There shall be available sufficient appropriately qualified semi-professional personnel to assist the professional staff members listed in

Paragraph 7 above. Within one hundred twenty (120) days of this Order, defendant Offerman, or his successor, shall submit to the Court and counsel for the plaintiffs a list of the number and qualifications of the semi-professional staff required to comply with the provisions of this Paragraph and, unless otherwise ordered by this Court, semi-professional staff in accordance with this listing shall be employed no later than thirty (30) days after the employment of the respective professional personnel.

9. Within ninety (90) days of this Order, the defendant Commissioner, or her successor in office, shall make a formal, written recommendation to the Governor of the State of Minnesota, or the Governor-elect, as the case may be, urging that there be included in the Governor's requested budget to the 1975 session of the Minnesota State Legislature the appropriation of sufficient funds for at least the following:

(a) The employment at Cambridge State Hospital of personnel so as to attain on duty direct care staff-resident shift ratios by September 1, 1975, as follows:

(i) Not less than 1:4 during waking hours and 1:8 at night in medical units and in those units serving non-ambulatory residents, and

(ii) Not less than 1:4 during waking hours and 1:16 at night in those units serving ambulatory residents who are under the age of 18, severely or profoundly retarded, or emotionally disturbed.

(b) The employment at Cambridge State Hospital of professional staff reflecting the following staff-resident ratios, provided, however, that professional staff provided by the public school or Trainable Mentally Retarded program may be considered in calculating these ratios to the extent that such persons are actually available for services to residents:

(i) Certified Special Teachers (with certification by the State of Minnesota in special education)	1:30
(ii) Recreational Therapists (graduates of accredited programs in recreational therapy)	1:250
(iii) Occupational Therapists (licensed to practice in the State of Minnesota)	1:125
(iv) Vocational Therapists	1:60 mildly and moderately retarded residents
(v) Physiatrists (Board certified)	1:100 physically handicapped residents

(c) Along with submission of the recommendation required under this Paragraph, the Commissioner, or her successor, shall submit a list of the number and qualifications of semi-professional support staff to assist the professional staff members listed in Paragraph 9(b) above, and shall also urge that there be included in the Governor's requested budget to the 1975 session of the Legislature the appropriation of sufficient funding for at least such support positions.

10. Each resident at Cambridge State Hospital shall be provided with an individualized habilitation, or program, plan and programs of training and remedial services as specified in Department of Public Welfare Rule 34 (as dated November 17, 1972) and these plans shall be periodically reviewed, evaluated, and, where necessary, altered to conform to the condition of the particular resident.

11. The provisions of Department of Public Welfare Rule 34, Part II, Sections A and B (including subdivisions thereof) which specify physical plant, equipment and related standards shall be fully complied with at Cambridge State Hospital by January 1, 1977.

12. Air conditioning shall be installed in McBroom and Boswell Halls and the Infirmary at Cambridge State Hospital by June 1, 1975. Carpeting shall be installed in the dayrooms, dormitories, stairwells, corridors, and activity rooms in all residential living areas at Cambridge State Hospital by July 1, 1975. Carpeting shall also be installed in all program areas at the institution by September 1, 1975, unless the nature of the programmed activities conducted there reasonably dictates that carpeting not be used. Installation and maintenance of carpeting and air conditioning pursuant to this Paragraph shall conform with current regulations of the Minnesota Board of Health for the licensing of Nursing Homes and Board Care Homes.

13. Heavy wire mesh (not including security screens) and bars shall forthwith be removed from all basement and first story windows in residential living areas and program areas at the institution.

14. Tunnels shall not be used by ambulatory residents except during inclement weather, unless in the opinion of a physician, registered nurse, or licensed practical nurse, inability to use the tunnels would endanger the health or safety of a resident. Such opinion and the basis therefor shall be recorded in the medical records of the particular resident and shall specify the time

for which such resident may be permitted to use the tunnels. Within thirty (30) days of the date of this Order, defendant Offerman, in consultation with the institution's medical staff, shall establish a written policy regarding the inclement weather conditions in which use of the tunnels would be permitted. Such written policy shall be called to the attention of all personnel at the institution and copies of it shall be posted in every staff office and nursing station in the institution and furnished to the Court and counsel for the plaintiffs.

15. Upon compliance with the provisions of Paragraph 4 above, seclusion shall not be employed at the institution. Until such time, seclusion shall be employed only when a resident presents a clear, immediate and continuing danger to the safety of himself or other residents or staff. When such danger has passed, the resident shall be immediately removed from seclusion. Staff shall check the status of any resident in seclusion at least once every thirty minutes and record this status in the resident's medical records. In no instance may seclusion be used as punishment. All provisions of the institution's Policy on Restraint and Seclusion, pertinant portions of Rule 34, and State law that are not inconsistent with this Paragraph are incorporated herein.

16. Physical and chemical restraints may be employed, subject to the limitations on their uses specified in Rule 34.

17. Each resident who requires a wheelchair shall be provided with one adapted to his size and personal needs as soon as funds for such wheelchairs become available, and in no event later than July 1, 1975.

18. Within ninety (90) days of the date of this Order, defendant Offerman shall submit to defendant Commissioner a written report detailing additional equipment and materials that, in the judgment of the institution's staff, are reasonably necessary to carry out adequate programs of care and treatment of the residents at Cambridge State Hospital. Copies of such report shall also be furnished to the Court and to counsel for the plaintiffs. The Commissioner shall calculate the expenses estimated to be necessary for procurement of these items and shall urge in the recommendation required under Paragraph 9 above that the Governor include in the budget request to the 1975 legislative session the appropriation of sufficient funds for at least these items.

19. No resident may be placed in a community residential facility unless it has been duly licensed by the Department of Public Welfare, pursuant to Rule 34, and by the State Board of Health. No resident may be placed in a foster

care arrangement unless the resident will receive programs, living conditions, and care that is equivalent or superior to the programs, living conditions, and care at Cambridge State Hospital at the time of placement.

20. Defendants shall make a written determination of the eligibility of each resident at Cambridge State Hospital for community placement, and for those determined not to be qualified for such placement defendants shall specifically state the reasons why the resident is incapable of placement and what additional steps, if any, must be taken before the resident will be ready for such placement. A redetermination of eligibility for community placement shall be made at least annually. In no case may the institution return a resident to his natural home unless the parent or other relative is willing and, in the judgment of the institution's staff, capable of caring for the resident.

21. Defendant Commissioner shall submit to the Court and counsel for the plaintiffs by January 1, 1975, the comprehensive plan for the future of State institutions being prepared by the Department of Public Welfare for submission to the 1975 session of the Minnesota State Legislature.

22. Within twelve (12) months of the date of this Order a written plan shall be developed to provide, upon an orderly basis, community residential placements for all residents at Cambridge State Hospital who are capable of such placement. Copies of this plan shall be provided to the Court and to the counsel for the plaintiffs. In developing such a plan, defendants shall specifically consider methods by which severely and profoundly retarded residents can be placed in facilities and homes that offer or can arrange for programs and care that are equivalent or superior to those afforded at Cambridge State Hospital.

23. Defendants shall continue with their efforts to make five million dollars ($5,000,000) in low interest loans available through the Minnesota Housing Finance Agency for the development of community residential facilities for the mentally retarded. Within sixty (60) days of the date of this Order the defendant Commissioner shall submit a written report to the Court and counsel for the plaintiffs concerning defendants' progress in securing these funds.

24. No resident may be transferred to other State institutions to facilitate compliance with this Order. All future transfers between Cambridge State Hospital and other State institutions shall be reported to counsel for the plaintiffs at least ten (10) days prior to each transfer. The report shall contain the name of each of the residents to be transferred, the institution

to which each transfer is being made, and the reason for each such transfer.

25. Defendant Commissioner shall submit to the counsel for the plaintiffs by December 1, 1974, all Rule 34 licensure reports, recommendations, and official notifications for the year 1974 pertaining to Cambridge and all other State Hospitals, as well as any subsequent reports or notifications for twelve (12) months following the date of this Order.

26. Defendants shall allow the counsel for the plaintiffs, and others with their authorizations, reasonable access to the grounds, buildings, and pertinent records at Cambridge State Hospital for the purposes of observation and examination during the twelve (12) months following the date of this Order.

27. Defendant Commissioner may not achieve compliance with this Order by transferring staff from any State institution for the mentally ill, mentally retarded, or chemically dependent unless, following such transfer, the staff-resident ratio at the transferring institution is the same or higher than it was as of the date of this Order.