A BRIEF HISTORY OF THE WELSCH CASE

Presented at the 1982 meeting of AAMD in Boston, Massachusetts by Luther A. Granquist, one of the counsel for the plaintiffs in the case.

Ten years ago, in the summer of 1972, a lawsuit was started challenging the conditions in six of Minnesota's institutions which had residents who were mentally retarded. That lawsuit was similar in many respects to the challenge made to Alabama institutions in Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971) and the Willowbrook case which started about the same time.

Two basic claims were made—that institutionalized mentally retarded persons are constitutionally entitled to habilitation services and that mentally retarded persons are entitled to live in the least restrictive setting.

After a decade, the Welsch case is still very much alive. A system-wide Consent Decree was entered on September 15, 1980. By its terms, that Consent Decree will run until 1987.

The Cause of it All

The pattern of institutional confinement of mentally retarded persons in Minnesota was not unique.

What is now Faribault State Hospital was opened over 100 years ago. By 1890 that institution had a resident population of 301. By 1900 the population had increased to 721. More than a thousand residents had been added 20 years later. Other institutions were added. Cambridge State Hospital, then known as

the Colony for Epileptics, grew from a 1930 population of 243 to a 1950 population of 1,104.

In 1950, Faribault's population exceeded 2,800 residents. The total number of institutionalized mentally retarded persons at that time was more than 4,400. A decade later, in 1960, some 6,000 mentally retarded persons were in Minnesota's state hospitals, more than half of them in Faribault and almost 2,000 at Cambridge. Brainerd State Hospital had been built and had a resident population of 354. The high point had been reached.

By 1970, there had been a reduction in state hospital population of almost 25 percent, although the number of state hospitals with mentally retarded residents had increased under a regionalization program. The residents discharged were, as in many other states, the higher functioning residents who had, in many respects, assisted in the overall operation of the institutions.

During the 1950's and 1960's, the quality of care provided in Minnesota's institutions had not gone unchallenged. But the legal theories which would support a systematic challenge both to institutionalization and to the quality of care were only then developing. Three major factors led to filing of the Welsch suit in 1972. One was the establishment of legal standards and legal theories.

Constitutional challenges to lack of treatment had been successful. Regulatory standards were developed at both the state and the federal level.

A second factor was the growing concern of parents and relatives

of state hospital residents with conditions and lack of treatment. This concern was shared by many professional, supervisory, and direct care staff at the institutions.

The third factor was the elimination by the 1971 Minnesota legislature of about 550 positions in the ten state institutions. The reduction of population of the institutions had not gone unnoticed by legislators.

What had not been clearly perceived was the fact that many of these residents helped make those institutions run. With a significant reduction in higher functioning residents and a significant reduction in staff positions. Minnesota's institutions were ripe for challenge when Judge Johnson led the way in the first Wyatt order.

The Litigation History in Brief

Six of Minnesota's institutions were involved in the Welsch case when it was filed in 1972--the state hospitals at Brainerd, Cambridge, Faribault, Fergus Falls, Hastings and Moose Lake. Two relatively new units for mentally retarded residents at St. Peter and Rochester State Hospitals were not included. A new unit for mentally retarded persons at Willmar State Hospital was opened shortly after litigation began. The Commissioner of Public Welfare and the Chief Executive Officers of the six institutions were named defendants.

The two attorneys of the Legal Aid Society of Minneapolis who undertook primary responsibility for the lawsuit in the first year, Neil Mickenberg and Jeffrey Hartje, soon realized that bringing this relatively new type of action involving six institutions located throughout the state would be very difficult. They asked the Court to declare the entire action a

class action (which was done) but to allow them to proceed with preparation for trial with regard to a subclass of Cambridge State Hospital residents. Cambridge was one of the larger institutions and it was located a short distance from Minneapolis.

The same description, of course, applied to Faribault State Hospital. Between these two institutions, the choice was based on the fact that Cambridge was still significantly smaller and on the fact that the lead plaintiff, Patricia Welsch, was a Cambridge resident.

A two-week trial was held in late 1973. While the center of attention was the Cambridge institution, the focus of the trial was on the possibility of habilitation. Much witness time was spent establishing the proposition that mentally retarded persons could develop even though severely handicapped. A key factual finding was made by United States District Court Judge Earl Larson in his first opinion in the case issued on February 15, 1974:

> The evidence in the instant case is overwhelming and convincing that a program of "habilitation" can work to improve the lives of Cambridge's residents. Testimony of experts and documentary evidence indicate that everyone, no matter the degree or severity of retardation, is capable of growth and development if given adequate and suitable treatment.

Welsch v. Likins. 373 F. Supp. 487, 495 (D. Minn. 1974). Judge Larson found a constitutional basis for the right to treatment or habilitation as well as a state statutory basis for that right under amendments to the Minnesota Hospitalization and

Commitment Act enacted after the lawsuit began. He also found a constitutional basis to plaintiffs' claim that the least restrictive setting should be provided for mentally retarded persons.

Judge Larson's February 1974 decision laid the foundation for the legal theory in the case. He granted no relief until October 1974, after a further hearing on that issue. No appeal was taken from his October 1, 1974 Judgment.

It was the hope and, at least sometimes, the expectation of the plaintiffs that the standards set in the 1974 Cambridge Orders would be applied both at that institution and system-wide. That hope proved illusory.

The 1975 Minnesota legislature did not respond to meet the requirements set for Cambridge. After the legislature adjourned in May 1975, a Supplementary Complaint was filed which added as defendants the Commissioners of Finance and Administration of the State of Minnesota. At that time, these two officials acted as the OMB of the state. A one- week trial was held in late 1975 which dealt in large part with compliance at Cambridge with the 1974 Orders.

A series of orders followed in 1976. In April 1976 Judge Larson refined and, to a limited extent, expanded his October 1974 Order. In July 1976, Judge Larson sought to provide for enforcement of his Orders by enjoining all the defendants from complying with Minnesota laws preventing the expenditure of un-appropriated funds or the hiring of staff not authorized as part of the legislatively established complement to the extent such action was necessary to achieve compliance with his Orders.

All the 1976 Orders were appealed. The Minnesota Legislature hired its own lawyer to represent it as Amicus Curiae. A number of states joined in amicus briefs as well.

In March 1977 the Eighth Circuit Court of Appeals upheld Judge Larson's April, 1976 Order establishing standards to be implemented at Cambridge. Welsch v. Likins.

550 F. 2d 1122 (8th Cir. 1977). The "financing order" was vacated, but not reversed, with a firm reminder to Minnesota officials that the standards established by the Court must be met.

The 1977 Minnesota legislature did not respond, although it did order the closing of Hastings State Hospital. Another compliance hearing was scheduled for November 1977. There was strong executive support from then Governor Rudy Perpich for reaching a resolution to the action without trial.

The closing of Hastings State Hospital together with federal funding under the CETA program provided for the possibility of assigning greater numbers of staff to Cambridge without a direct confrontation with the legislature. On the eve of the scheduled trial, the fundamental provisions of a settlement were negotiated. A consent Decree applicable to Cambridge State Hospital was approved in December 1977.

Efforts to obtain compliance with the Cambridge Consent Decree are discussed below. Again, the hope was that the new Cambridge standards would be applied system- wide. Although this hope was realized in part, plans had to be made for resolution of issues (many of them significant) still presented at the four remaining institutions. After some delays, the plaintiffs proceeded to

present their case with regard to those institutions in May 1980.

This presentation was similar in many respects to the 1973 Cambridge trial. The focus on habilitation and normalization was similar, although the development of programming efforts at the institutions required a far more sophisticated analysis of issues than had been done in 1973. The plaintiffs' case in 1980 also emphasized the need for development of community resources more than had been done in the past. (See the discussion of community alternatives below.) Judge Larson, who had now "retired" and was sitting as a Senior United States District Court Judge, scheduled the defendants' case for July 1980.

Serious settlement negotiations were undertaken as the parties prepared for the July resumption of the trial. Again, a settlement was reached at the last moment. The details of a Consent Decree were agreed to in a month-long process which ended in August 1980. The Consent Decree was expanded to include all eight of the institutions then serving mentally retarded persons. (The alternative recognized by all parties was another lawsuit directed at the three institutions which had not to that time been involved in the litigation.) The Decree was approved by the Court on September 15, 1980,

While the case was settled, compliance monitoring continued. As may be seen in the discussion of specific areas below, the Welsch case has been as active after the Consent Decree was approved as at any time in the past decade.

All of the many issues presented are not discussed here. Rather, selected areas will be discussed to show changes made by the

Court and by the parties in these areas and the enforcement problems which have become the focus of attention.

Staffing Requirements of the Welsch Orders

In his first decision in February 1974, Judge Larson held that one of the essential conditions to fulfill the right to habilitation was "qualified staff personnel in sufficient numbers… 373 F. Supp. at 493. A major focus of the Welsch case from the 1973 trial to the present time has been on the need for adequate staff, both at Cambridge and now system-wide.

Throughout the entire course of the Welsch action the plaintiffs have sought, without success, to have an overall direct care staff ratio of 1:1 incorporated in the Court's Orders or Consent Decrees. Initially the choice posed to the Court was between the ICF/MR regulations and the richer standards then incorporated in the ACFMR standards. Judge Larson recognized the desirability of the richer standards but refused to order them in October 1974 and in April 1976.

The 1980 Consent Decree, while not put in terms of either standard, represents the latest step in what has proven to be a steady increase in direct care staff requirements. The result is still less than what the plaintiffs contend is necessary and what they believe they have proven is necessary, especially for the lower present resident population. At the same time, plaintiffs recognize that this slow increase in staffing standards may have been necessary both to develop the supervisory capability to deal with increased direct care staff and to avoid even greater confrontations with the legislative actors involved.

In development of staffing standards, the Welsch orders have included a number of specific staff-to-resident ratios for particular positions. The origin of these standards was largely the Wyatt orders issued early in the history of that case.

The 1980 Consent Decree continues a number of those specific requirements, but that Decree sets overall supervisory, professional, and semi-professional standards for residential living area and daytime program staff which are intended to provide substantial latitude at each institution to choose the type of professional staff to be hired. From the plaintiffs' point of view, it was a pragmatic choice.

Given recruitment difficulties in some areas, it made sense to allow a variety of qualified professional persons to be hired. Furthermore, key institutional leaders expressed their concern at being bound into certain professional categories. The plaintiffs' concern throughout the litigation has been to strengthen the mid-level supervisory capability. In retrospect, the primary deficiency in the early Cambridge Orders was to ignore this area which has proven to be crucial to development of effective programming,

No institution can operate without support staff. In all probability, no set of staffing standards applicable at more than one institution can define adequately the standard for support staff. The development of staffing standards in the Welsch orders demonstrates this fact. Staffing standards at Cambridge were developed to respond to that institution's organization.

In the 1977 Cambridge Consent Decree, for the first time an overall number of total staff required at that institution was

established. The 1980 Consent Decree established an overall number of "MR staff" for the entire system. That Decree also placed limitations on reduction in basic support staff.

The direct care staff requirements of the 1980 Consent Decree also are based on overall ratios, rather than unit-by-unit or class-by-class ratios. In this respect, the 1980 Consent Decree is similar to Judge Larson's initial order for Cambridge in 1974 which used overall ratios.

These overall ratios were changed in the 1976 Cambridge Order and the 1977 Cambridge Consent Decree to more detailed requirements. From plaintiffs' point of view, the specific unit-by-unit ratios at Cambridge were necessary and helpful during that period of time in order to monitor the overall requirement. However, an emphasis on unit-by-unit ratios places a premium on having units of the size which most nearly fits the ratio. No purpose is served by consolidation of living units to lower the total number of staff necessary to meet a ratio.

Substantial flexibility in structuring living units to meet resident needs is lost when pressure comes from the central office, as did happen, to achieve compliance by consolidation of living units. The 1980 Consent Decree, with only a few exceptions, allows for direct care staff assignments at the discretion of the institution administration.

Problems with staffing remain. A major portion of the post-Consent Decree enforcement effort has been directed at staffing requirements. These issues are noted below. Key positions such as physical therapy and occupational therapy positions continue to be difficult to fill. The increase in the number of professional and supervisory positions has caused some

complaints both from direct care staff and from others outside the systems who object to "all those professional persons sitting in their offices."

Finally, no staffing requirement, even if met by filling positions, can assure quality and competence. This latter point is obvious but deserves mention. The ultimate requirement in both institutional staff and in the staff for community-based services is quality. Given a civil service system and the reluctance of any supervisory person to fire, the system as a whole will provide "qualified staff personnel in sufficient numbers" only with an effective, on-going quality control system. Given the reluctance of legislatures to fund such a system, the need for litigation both with respect to institutions and community-based services is not likely to disappear.

Development of Alternative Community Services As was noted above, the first Welsch decision recognized that there was a constitutional basis for the doctrine of least restrictive alternatives. To a large extent, the Cambridge aspect of the Welsch case during the years from 1973 to 1977 did not focus on this issue.

In part, the reason was the Court's reluctance to become involved in the "complex web of relationships" which governs the community sector. October 1, 1974 Order, at 30. The Court's Orders with regard to the development of alternative community services are accurately summarized as "keep up the good work." During the early years of Welsch litigation, the good work was kept up.

From 1972 to 1976 the number of mentally retarded residents of

Minnesota state hospitals decreased from 4186 to 3256. Early on, Minnesota chose to fund group homes through Medical Assistance.

While there are a number of large community "institutions," the development in the 1970's was largely in smaller facilities for fifteen residents or less. However, prior to the 1980 trial, it became apparent that the development of community facilities for the residents then in state institutions had slowed. For that reason, the plaintiffs pursued the need for development of community-based services more vigorously in the 1980 trial.

The settlement reached in 1980 provided for a reduction in state hospital population of mentally retarded persons from 2650 in 1980 to 1850 in 1987. This was a most modest goal. It was based on plans developed by the Minnesota Department of Public Welfare. A more demanding goal would not have been incorporated in any settlement.

At the present time, interim state hospital depopulation goals have been met. But depopulation alone is not enough. The 1980 Consent Decree requires that persons discharged from state institutions "shall be placed in community programs which appropriately meet their individual needs." Paragraph 24. As of this date, the Court is considering a compliance motion addressed to the appropriateness of day-program reductions by the responsible county.

Whether the plaintiffs' position—that the Commissioner of Public Welfare is required by the Decree to take necessary action to assure the availability of placements and programs meeting individual needs—will be enforced remains to be seen.

Given Minnesota's present rather dismal fiscal posture, the need for an enforceable quality standard for community-based programs is evident. If it becomes clear that further discharges will be to community programs which cannot meet the individual needs of individual residents, plaintiffs' attorneys will face the wholly unpleasant but necessary task of challenging such discharges. Further court action seems unavoidable.

The Welsch Decree does not address the question of what happens to the 1850 mentally retarded persons who will remain in state hospitals in 1987. Nothing in the Decree suggests that this population is an appropriate "residual population." Plaintiffs surely do not take that position.

As a practical matter, if the suitability of community-based services for the entire spectrum of mentally retarded persons is demonstrated in the next five years, only the availability of an effective funding mechanism for a broad-based community delivery system will stand in the way of further reduction of state hospital population. If that system is not developed, further challenges to institutionalization are likely.

Political issues necessarily will be raised at any time closure of an institution is proposed. The unit for mentally retarded persons at Rochester State Hospital was closed by legislative action in 1981, but not without considerable political furor. All of the rest of the institutions are located in smaller communities than Rochester. Nothing which has happened in the past decade gives any hope for careful long-term planning for phasing out the existing institutions.

Physical Plant Changes

The Minnesota institutions of 1972 were cold, barren, noisy and over-crowded places. Another of the essential requirements for habilitation which Judge Larson noted in his first decision were a "humane psychological and physical environment…" 373 F, Supp. at 493. The early Cambridge Orders included requirements for air conditioning for buildings with physically handicapped residents and carpeting in many buildings. During the past several years, both state and federal regulations have required substantial physical plant changes for life safety purposes and to create smaller living units. Throughout the entire system, substantial change was made in the physical plant.

In 1980, plaintiffs sought few physical plant changes. The only truly mandatory section of the Consent Decree involving the physical plant dealt with toileting and bathing areas. In many respects, the change in focus followed necessarily from the increased attention paid to depopulation requirements.

There is simply no need to spend money on institutions which will not be needed. The perspective with regard to Cambridge in 1973 was different. No reasonable possibility existed then of closing major areas of that institution. At the present time, the physical plant in Minnesota's institutions is better in many areas than in many other institutions. The question is whether those areas will have to be used.

Use of Major Tranquillizers

The use of major tranquillizers to control resident behavior has been an issue throughout the course of the Welsch action. In his October 1974 ruling Judge Larson noted but did not resolve the dispute between the parties whether the number of Cambridge

residents receiving tranquillizers was excessive. He did find that the number of residents receiving such medications could be reduced if more staff and programs were provided to meet resident needs. Most importantly, he found that "the use of tranquillizing medication at Cambridge is improperly evaluated, monitored, and supervised." October 1, 1974 Order, at 24.

The Orders issued by the Court and the provisions incorporated in Consent Decrees have addressed the question of drug use in the context of how those medications are evaluated and monitored.

The October 1974 Order simply stated that chemical restraints were subject to the limitations in the Department's Rule 34--chemical restraint could not be used as punishment, for the convenience of staff, or as a substitute for programs, October 1, 1974 Order, p. vi, 116.

Whether the use of major tranquillizers had increased at Cambridge was disputed in the November 1975 trial. However, the failure to provide the evaluation and monitoring required by the Court was established, April 1976 Order, at 14-15. The Court's Order was expanded to require quantification of the targeted behavior both before and after changes in medication dosages.

The 1977 Cambridge Consent Decree went into even further detail in requiring procedures to be established to quantify the incidence of targeted behaviors. That Order also required that each resident receiving major tranquillizer be provided a twenty-day period free from administration of such medication within a thirteen-month period from the effective date of the Consent Decree.

Finally, that Decree specifically authorized the Cambridge State Hospital medical director to administer major tranquillizers to residents in a manner inconsistent with the provisions of the Decree so long as the basis for the clinical judgment was recorded in the residents' file.

The 1980 Consent Decree continued the Cambridge Consent Decree provisions at Cambridge alone for a period of approximately one year. Provisions similar to the Cambridge Decree, but without the requirement of a medication-free period, were applied in the 1980 Decree to one of the four institutions subject to trial then. Continuation of the 1980 Consent Decree provisions at Cambridge and application of them to three institutions which had not been involved in the trial was made subject to further orders of the Court.

The Cambridge medication orders led to a significant number of detailed studies of the efficacy of drug use being undertaken at that institution. While earlier Cambridge standards were not binding on any of the other institutions, the effort to reduce drug use system-wide was made and was generally effective. Indeed, at the 1980 trial plaintiffs sought no relief with regard to drug use at three of the institutions. Brainerd State

Hospital had initiated a medication assessment program and a minimum effective dosage program which was largely the model for the orders the plaintiffs had sought. At both Faribault and Fergus Falls State Hospitals, consistent monitoring efforts were underway to reduce medication usage. When the question of medication usage at the three new institutions was reviewed after approval of the 1980 Consent Decree, it was found that efforts to reduce and to monitor the use of major tranquillizers were in place.

The thrust of the Orders in the Welsch case has been to establish an effective system for evaluation and monitoring of the use of major tranquillizers. To be sure, the plaintiffs sought the effect of a reduction in drug use. The arguably excessive use of major tranquillizers was a major complaint of parents prior to initiation of the action.

As was mentioned above, the effort was made system-wide to implement the standards of the Cambridge orders. The results are interesting. In late 1980 and early 1981, plaintiffs' counsel surveyed medication usage in the entire system. At that time, 25.6% of the mentally retarded residents of the state hospitals in Minnesota were receiving major tranquillizers.

The percentage of residents receiving such medications varied from a low of 12.4% at Brainerd State Hospital to a high of 40.1% at Cambridge State Hospital. We know of no reason to believe that there is a significant difference in the Cambridge population as opposed to the rest of the system.

Ironically, Cambridge was the only institution subject to a Court order during the previous years.

Control of Aversive Procedures

The Welsch Orders with regard to use of certain aversive procedures have become far more complicated and demanding during the course of this litigation. At Cambridge in 1973, seclusion was widely used with minimal limitations. October 1, 1974 Order, at 23. (Crib enclosures were still present at Cambridge then, but have disappeared from the system without prompting from the Court.) The October 1974 Order allowed seclusion to be used only in the case of a clear, immediate, and continuing danger to self or others and limited physical restraint in accordance with

Minnesota DPW Rule 23 as was done with chemical restraint. Page vi, 11 15 and 16.

Further restrictions on the use of seclusion were included in the April 1976 Order and the 1977 Cambridge Consent Decree. The use of that technique was limited to one unit at Cambridge and to specific residents for whom the alternative identified by the institution staff was placement in a more secure institution.

The 1980 Consent Decree, in contrast, imposes far more detailed limitations on the use of mechanical restraint, seclusion and what is termed "separation." Approximately nine pages of the Decree define and limit the use of these procedures. No detailed explanation will be given here. Other aversive practices are not governed by the Decree.

Counsel for the plaintiffs sought these detailed provisions because of an increase in the use of the covered procedures as a part of planned behavior management programs. The situation at the four institutions involved in the 1980 trial was different from that present at Cambridge in earlier years. Although there were exceptions, the relatively uncontrolled use of seclusion found at Cambridge was not present. Plans had generally been written; data was generally kept. But the use of these procedures appeared to have increased.

No detailed study has been done to establish the reason for the increased use of restraint procedures, but two hypotheses can be made. First, the reduction in use of chemical restraint may have led to increased use of other forms of restraint.

Second, the hiring of professional staff with a behavior modification background may have led to increased incorporation

of these procedures into program plans. With minimal exceptions, these procedures were used only after approval of an institution review committee.

The use of these procedures has decreased since the Consent Decree was approved. Indeed, in this area compliance has been generally widespread. The very detail necessary in plans which would meet the Consent Decree requirements has likely been a partial factor.

In some of the institutions, the Consent Decree requirements were seized upon by persons who clearly wanted to increase program emphasis on the development of positive behaviors. At one institution, Willmar State Hospital, no change occurred, for the procedures were not used at all.

Enforcement and Compliance Monitoring

Welsch is no different from other similar cases, Federal court orders have not been self-implementing. The process of seeking compliance has changed in the course of the lawsuit, but compliance is still a goal, not a reality.

The initial Cambridge Orders were monitored by plaintiffs' counsel. Primary attention was paid to staffing requirements. The pattern which developed was to prepare each year for compliance hearings before the Court. The 1977 Cambridge Consent Decree for the first time provided for a part-time monitor. Funding of $15,000 was provided for the first 18 months under the Decree. This position was subsequently continued by stipulation.

The Cambridge Monitor reviewed compliance reports and submitted intermittent reports to the Court. The primary function,

however, was to review staffing compliance on an annual basis. In the course of these compliance proceedings, the monitor assisted in a process which led to less dependence on CETA positions and more reliance on state complement positions to meet staffing standards. Agreement was generally reached on the standards to apply.

One non-negotiable position taken by the defendants when the 1980 Consent Decree was negotiated was that the monitoring mechanism adopted would not be like the Willowbrook Review Panel. Also rejected by the Department was any provision which would allow monitor recommendations to become part of the Decree if no objection was raised. The monitor functions adopted provided for review of compliance, hearing allegations of non-compliance in accordance with a process similar to a grievance procedure, and recommending action to the Court after a hearing, which recommendation required Court action before it became mandatory. A limited budget of $55,000 was approved, subject to an annual adjustment.

The parties agreed that the monitor should be mental retardation professional. The monitor selected by agreement of-the parties is Dr. Lyle Wray, who had been a Building Director at Brainerd State Hospital. Dr. Wray has exercised his option under the Decree of retaining a hearing officer to preside over and to prepare decisions at contested evidentiary hearings.

Where availability of funding is not an issue, the compliance process followed under the 1980 Consent Decree has been for the Court monitor, either as a result of his own investigation or in response to review of reports from plaintiffs' counsel, to develop an action plan with the responsible institution of

central office staff to resolve the issue. In many instances, this process has worked well.

Where availability of funding is the issue, Court action has been necessary. Again, staffing standards have been involved. Plaintiffs alleged non-compliance on staffing standards within two weeks after the Consent Decree was approved.

The compliance process under the Decree is lengthy, so that no resolution was reached in that fiscal year. In the present fiscal year, plaintiffs renewed their complaint.

At the heart of the issue was whether the required number of staff were provided when funding for those positions had been reduced. The record submitted to the monitor and subsequently to the Court consisted of stipulated facts and exhibits together with one deposition. The Court, in a decision issued March 23, 1982, agreed with the monitor's finding of non-compliance but limited relief in the form of an order requiring funding of positions to the fiscal year beginning July 1, 1983. That Order has been appealed. Whether compliance will be achieved is still uncertain.

In other situations, the monitor review and Court hearing process has been followed to, in effect, provide for a declaratory judgment as to what the Decree requires. The process is slow and frustrating. Whether it will be a sure process as well is not yet clear.

One major provision of the Decree is that all state hospital residents will have an individual habilitation plan appropriately adjusted to meet individual needs. With only one

Court monitor, ongoing review by him of compliance with this provision is impossible.

Plaintiffs' counsel have hired a full-time developmental disabilities professional to assist them in review of habilitation plans A conscious decision was made to have this person examine a limited number of habilitation programs in depth rather than to survey a greater number of programs. Reviews made within the past several months have generally been favorably received. The effort is to achieve compliance by presenting a careful analysis of programs rather than by the more formal process established in the Decree. Whether this effort will be successful remains an open question.

APPENDIX

Chronology of Key Events and Decisions in Welsch Case.

September, 1972 — Complaint filed as Welsch v. Likins.

May 1973 — Court allows action to focus initially on Cambridge State Hospital.

September-October. 1973 — Cambridge State Hospital Trial.

October 1973 —Judge Larson viewed Cambridge State Hospital.

February 15, 1974 — First decision, Welsch v. Likins 373 F. Supp.487 (D. Minn. 1974) established legal theory for the case.

May 10, 1974 One day hearing directed at questions of relief.

October 1, 1974 — Court issued detailed Findings of Fact and Order regarding Cambridge State Hospital. This decision is not officially reported. It was not appealed.

May 22, 1975 — Plaintiffs' awarded costs over objection of defendants that Eleventh Amendment barred such action. Welsch v. Likins, 68 F.R.D. 589 (D. Minn. 1975).

June 1975 — Plaintiffs allowed to file Supplementary Complaint adding Commissioners of Finance and Administration as defendants.

November 17, 1975 — Welsch v. Likins. 525 F. 2d 987 (8th Cir. 1975) — Court of appeals affirms cost order.

November-December 1975 — Compliance hearings before Court regarding Cambridge.

March 31, 1976 — Court rules on evidentiary issue from November 1975 hearing — excludes survey of staffing patterns in other Midwest institutions.

April 15, 1976 — Court issues Order detailing compliance findings and granting further relief with regard to Cambridge State Hospital.

May 19, 1976 — Court rejects plaintiffs' request for three-judge court to consider compliance requests and finds proposal to attach federal Medicaid funds paid to Minnesota barred by the Eleventh Amendment.

July 28, 1976 — Court enjoins compliance with Minnesota fiscal and complement control laws which prevented implementation of Court's Orders.

March 9, 1977 — Welsch v Likins. 550 F. 2d 1122 (8th Cir. 1977) — Court affirms March 31, 1976 and April 15, 1976 Orders, vacates

July 28, 1976 — "Financing" order.

November 1977 — Another Cambridge compliance hearing scheduled — settlement reached in part because of closing Hastings State Hospital.

December 28, 1977 — Consent Decree approved for Cambridge State Hospital — case now known as Welsch v. Dirkswager.

July 14, 1978 — Court awards costs and attorneys' fees for Consent Decree phase of case.

October 1979 — Cambridge Monitor report and recommendations defining meaning of "full-time equivalent position" and discussing use of "public service workers" under CETA program.

Case now captioned Welsch v. Noot.

May 1980 — Plaintiffs' case presented regarding Brainerd, Faribault, Fergus Falls, and Moose Lake State Hospitals.

June 1980 — Stipulation before Cambridge Monitor on staffing issues.

July 12, 1980 — Memorandum of Understanding executed by parties — defendants' portion of trial not held.

July-August 1980 — Negotiation of Consent Decree.

August 15, 1980 — Stipulation to Consent Decree including three additional institutions.

September 15, 1980 — Consent Decree approved by Court.

January 30, 1981 — Cambridge Monitor findings issued arising out of November 25, 1980 hearing on staffing issues.

May 21, 1981 — Monitor decision on compliance with two issues under 1980 Consent Decree — staffing questions and the Commissioner's response to Decree requirements for specific legislative proposals.

July-August 1981 — AFSCME strike — plaintiffs' counsel support state position in action in state court brought by other unions.

December 7, 1981 — Monitor findings and recommendations on staffing issues — hearing had been held on November 5, 1981.

December 7, 1981 — Court rules that Monitor precluded by terms of Decree from accepting outside funding.

January 13, 1981 — Court upholds Monitor recommendations on compliance with legislative proposal section of Decree.

March 23, 1981 — Court rules on staff funding issues - this ruling has been appealed.

April 7, 1982 and May 11, 1982 — Monitor findings and recommendations on cutback in day programming for discharged state hospital residents — the issue is now pending before the Court.